



Pacific Spine and Pain Society

August 21, 2026

Re: CMS-1850-P — Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; CY 2027 Proposed Rule

Administrator,

The Pacific Spine & Pain Society (PSPS) is a multispecialty consortium of medical providers in the specialty of Pain Medicine. We are appreciative of Center for Medicare and Medicaid Services' attention to following changes in medical practice, technology, cost data and other factors as responsible stewards of the nation's healthcare resources as they relate to practice of pain medicine. On July 7, 2026 Centers for Medicare & Medicaid Services (CMS) published a proposed revision which would take effect on January 1, 2027. Elements of this proposal, CMS-1850-P relate to reimbursement of neuromodulation procedures, namely peripheral nerve stimulation and spinal cord stimulation. We are grateful for the opportunity to provide input to CMS on how these changes are anticipated to impact on the practice of pain medicine.

Anticipated Implications:

1. Single Peripheral Nerve Stimulation Lead Restriction

As a society, PSPS does concur with single-lead peripheral nerve stimulation (PNS) unless we are treating a mononeuropathy, or a pain associated with one nerve. Most of the conditions treated by peripheral nerve stimulation involve multiple nerves. Examples include pain of the shoulder, knee, groin, foot. If these joints and locations were innervated by only one nerve, then perhaps we could accept this recommendation, but anatomic reality is that most locations have multiple nerves that require stimulation in order to reduce pain and improve function. For example, the shoulder is innervated by three nerves, the suprascapular, axillary, and lateral pectoral nerves. If we only chose one of those nerves, the patient would only derive partial benefit. By stimulating both the suprascapular and axillary nerves, we are addressing 90-95% of the patient's pain. With all due respect, this proposal, if passed, would be nonsensical. The number of leads should be determined by the patient's anatomy and clinical indication. With this proposal, we fear physicians will be financially discouraged to provide complete care to those patients who would benefit from dual lead placement.

We agree that two leads should NOT be used on the same nerve. The clinical benefit has not been proven, and therefore, it would be economically wasteful. We agree with one lead per one nerve.

2. Avoid Incentivizing Staged Procedures and Increasing Total Medicare Costs

PSPS is concerned that the proposed reduction in reimbursement for a second PNS and Spinal Cord Stimulation (SCS) lead may unintentionally encourage providers to stage clinically appropriate treatment into separate procedures rather than completing care during a single encounter. CMS has long recognized that payment policy influences provider behavior. A significant payment differential may incentivize treatment of a second clinically indicated nerve target after the first global period. While intended to reduce reimbursement, this could instead increase total Medicare expenditures through additional physician and facility payments, repeat procedure planning, imaging, and follow-up care. Although PNS and SCS are relatively minimally invasive, they are nonetheless procedural interventions that come with risk. This proposal could cause Medicare beneficiaries to undergo an additional procedure increasing cumulative risks of infection, bleeding, procedural complications, and repeat anesthesia or sedation when applicable. CMS's bundled payment initiatives are designed to encourage completion of clinically appropriate care within a single episode of care rather than fragmented treatment across multiple encounters. Additionally, CMS's own Transforming Episode Accountability Model (TEAM) model focuses on decreasing fragmented care. We respectfully encourage CMS to evaluate this proposal based on total episode of care costs ensuring that reimbursement promotes efficient and patient-centered care rather than creating unintended financial incentives that fragment treatment.

3. Influencing practice model changes

The PSPS is concerned that limiting the scope of treatment with peripheral nerve stimulation therapy will influence physician practice models to be negatively impacted. The reimbursement model favors these procedures occurring in hospital settings, rather than ambulatory surgery centers. This would compound the current concerning trend of pay structures leading physicians to leave private practice for hospital- or corporate-employed positions, if not early retirement altogether. These trends have been well described, including by the Physician Advocacy Institute which published that the aggregate studies demonstrate that total physician hospital employment rose from 45% to 64% for interventional pain and from 67% to 79% for neurosurgery between January 2019 and January 2022. Though not the intention, medical services compensation has a strong influence on physician's practice choices.

4. Patient care provided at HOPDs is more expensive than ASCs

There is accepted data that a same procedure done within an ambulatory surgery center (ASC) setting vs a hospital outpatient department (HOPD) setting is on average 44% lower. More specifically, the issue of one vs two lead peripheral nerve stimulators, CPT 64555, is not immune to this trend. In 2026, the same peripheral nerve stimulator placement is 22% higher in the HOPD

setting vs the ASC setting. This shows that keeping procedures within the ASC setting is more financially responsible than a HOPD. Continuing to decrease these reimbursements for indicated procedures will prevent physicians from practicing in a private setting and leave the field which in turn puts these patients in a more expensive setting at the hospital and thereby further straining the healthcare system.

5. Patient Access

As previously stated, this proposal stands to further shift procedures to hospitals. This places an undue burden on patients. Specifically, rural populations are at risk of experiencing limited access, due to paucity of hospitals and HOPD sites of service in their communities. Chronic pain care and interventional pain care is already limited in rural settings, and this proposal would further threaten an already vulnerable and disadvantaged population.

6. We are concerned that it may push providers to utilize more invasive surgical procedures rather than PNS?

This proposal raises the concern that the reimbursement reduction for PNS procedures would influence physicians to shift toward invasive procedures interventional pain procedures with more favorable reimbursement including spine surgeries. Maintaining the current reimbursement would avoid unintended practice patterns away from less invasive and costly neuromodulation procedures that have shown considerable long-term efficacy and safety.

7. Preserve Appropriate Reimbursement for Clinically Necessary Second SCS Lead

We are concerned that applying multiple-procedure discounting to a second SCS electrode array assumes efficiencies that do not accurately reflect the lead-specific work required to perform the procedure safely and effectively. The mechanism of action of spinal cord stimulation is dependent on the shape of the electrical field. The field can only be shaped with the use of two leads. The other advantage to the second lead is that if there is an issue with electrodes on one lead, or the rare event where one lead moves, the patient maintains their therapy and does not require a revision surgery. Such a proposal to drive physicians toward one lead could lead to more revision surgeries, more explants, and more cost to the system.

Although certain encounter-level resources are shared, such as room setup, patient preparation, monitoring, and portions of pre- and post-procedure care, placement of a second percutaneous SCS lead remains a distinct technical component. It typically requires a separate epidural access trajectory, independent needle and lead advancement, repeated fluoroscopic localization,

optimization of mediolateral and cephalocaudal position, confirmation of appropriate anatomic or paresthesia coverage depending on the stimulation platform, and securement of the additional lead. The lead-specific procedural work and resource utilization therefore should not be presumed to be reduced by 50 percent simply because the second lead is placed during the same operative session.

Dual-lead configurations also have important clinical and engineering value. Two parallel epidural leads are commonly utilized to broaden bilateral or axial-and-extremity coverage and to provide greater flexibility in shaping and steering the electrical field across the dorsal columns. Computational studies have demonstrated that dual parallel leads provide greater flexibility in mediolateral current steering and can facilitate more precise targeting of the volume of neural activation. Major prospective SCS studies utilized two-lead configurations. For example, the pivotal 10-kHz SENZA randomized clinical program utilized two percutaneous epidural leads, while the prospective randomized DELIVERY study specifically evaluated placement of two leads. Medicare contractor billing guidance also recognizes placement of up to two SCS leads and permits two units of percutaneous SCS lead placement on the same date of service.

These considerations demonstrate that a clinically indicated second lead is not merely a duplicative “add-on” service. For many patients, it is an integral component of treatment planning, electrical-field design, optimization of stimulation coverage, and the ability to individualize therapy according to the patient's anatomy and pain distribution. A reimbursement policy that substantially discounts the second medically necessary lead may unintentionally encourage selection of a single-lead strategy based on reimbursement considerations rather than clinical judgment and optimal neuromodulation coverage. We respectfully recommend that CMS not apply a multiple-procedure payment reduction to a clinically indicated second percutaneous SCS lead and instead preserve appropriate payment for each separately placed and appropriately documented lead.

8. Reducing Access to Non-Opioid Pain Management Therapies

CMS payment policy should also consider the broader clinical value of maintaining access to effective non-opioid treatment options for patients with chronic refractory pain. The CDC Clinical Practice Guideline for Prescribing Opioids for Pain recommends maximizing nonpharmacologic and non-opioid therapies for subacute characterized as guaranteeing opioid discontinuation, and opioid outcomes vary among individual patients and across studies. Nevertheless, a meaningful body of evidence supports the opioid-sparing potential of SCS in appropriately selected patients.

A systematic review and meta-analysis of randomized controlled trials found that patients receiving SCS had significantly greater odds of reducing opioid consumption compared with patients receiving conventional medical therapy. In addition, a nationwide analysis of 8,497 patients undergoing SCS demonstrated that within one year, 60.4% experienced some reduction in opioid use, 34.2% moved to a clinically important lower opioid dosage group, and 17.0% discontinued opioids entirely. Other systematic-review evidence has similarly identified reductions in opioid dosage following SCS. At the same time, some longer-term comparative analyses have not demonstrated significant opioid reduction, underscoring that opioid reduction should appropriately be characterized as an important potential clinical benefit rather than a universal outcome.

For Medicare beneficiaries with chronic refractory pain, preserving access to appropriately selected neuromodulation therapy is consistent with the broader objective of reducing avoidable long-term reliance on opioid pharmacotherapy while improving pain control and function. Reimbursement policies that make clinically optimized SCS—including use of a medically necessary second lead—economically unsustainable may have the unintended consequence of narrowing access to an evidence-based non-opioid interventional treatment option and prolonging dependence on chronic pharmacologic management for some patients.

The appropriate policy analysis therefore extends beyond the isolated cost of the second electrode array. CMS should consider the complete episode of care and the potential downstream effects of successful neuromodulation, including improved pain control and function, reduced medication burden in appropriate patients, decreased exposure to the risks associated with long-term opioid therapy, and potentially reduced utilization associated with inadequately controlled chronic pain.

We respectfully encourage CMS to preserve appropriate access and reimbursement for clinically optimized SCS and to consider its potential opioid-sparing and functional benefits when evaluating the proposed payment changes.

Conclusion/Position:

The Pacific Spine and Pain Society has appreciation for CMS's commitment to maintaining currency and accountability in compensation for medical services. In keeping with this commitment, we strongly encourage CMS to reconsider the reclassification of CPT codes related to SCS and PNS. As mentioned above, we are deeply concerned about patient safety, access issues and paradoxical increases in Medicare expenditures with the proposed changes. We do believe that two leads on the same nerve unilaterally should be subject to the multiple procedure payment reduction (MPPR), but that the MPPR should not apply to the same nerve if performed in a bilateral fashion.

Recommendations:

- We greatly appreciate this offer to comment on the proposed changes and ask the following:
 - o ***Revoke the proposed changes for SCS/PNS leads and IPGs. We agree with one lead per one nerve.***
 - o ***The MUE for 64555 should remain at 2 even though there are anatomic locations that could benefit from 3 or 4 leads.***
 - o ***The MUE for 63650 should remain at 2 in order to shape the electric field for patient beneficence. Such a diminution in the MUE could result in worse outcomes for patients.***

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