September 11, 2025

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The Honorable Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Comment on The Centers for Medicare & Medicaid Services (CMS) Proposed Rule: CY 2026 Payment Policies under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies (CMS-1832-P)
Section C. Ambulatory Specialty Model Pertaining to Low Back Pain

Dear Administrator Oz:

The U.S. Pain Foundation is pleased to provide comments on the CMS Proposed Rule: CY 2026 Payment Policies under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies (CMS-1832-P). We are commenting on Section C of the PFS, the Ambulatory Specialty Model (ASM) as it pertains to low back pain.

The U.S. Pain Foundation is a national nonprofit 501(c)(3) organization serving people who live with chronic pain from a myriad of diseases, conditions, and serious injuries. Our mission is to empower, educate, support, connect, and advocate for those living with pain, as well as their caregivers and health care providers. Our audience includes nearly 37,000 mailing list subscribers and more than 225,000 social media followers.

We are pleased that CMS has decided to focus on enhancing the quality of care and improving care coordination for beneficiaries living with chronic low back pain by testing and implementing a new alternative payment model for the care of these patients. As CMS has pointed out, chronic low back pain affects an enormous number of beneficiaries and a large share of the expenditures of Medicare Parts A and B.

While there are aspects of the proposed model we agree with, we have concerns that must be addressed before this proposed model is implemented.

Areas of Agreement

CMS has expressed the view that patients in the initial stages of evaluation and management of low back pain are advised to get expensive imaging, and are too often recommended for unnecessary procedures and surgeries. We agree that more conservative care should be offered, especially in the early stages of managing low back pain.

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We agree with CMS's proposal to include depression screening and follow-up in the low back pain measure set. It is undoubtedly the case that individuals with chronic pain conditions are at an increased risk for developing comorbid depression, and that depression can exacerbate pain and negatively impact function, treatment adherence, and overall health outcomes. We agree that including this measure in the ASM low back pain measure set would prompt health care providers to prioritize mental health screening and follow-up care, and likely would contribute to better overall health outcomes.

We agree with CMS's proposal to include the Functional Status Change for Patients with Low Back Impairments measure in the ASM measure set. Tracking and assessing a patient's functional status over time with a survey-based patient reported outcome measure such as this is a patient-centered way to reward meaningful improvement in the ASM participant.

Obesity can exacerbate chronic low back pain and is a potentially modifiable risk factor. Including BMI screening and follow-up care with weight management plans and strategies could help to reduce low back pain and prevent acute flare-ups. Consequently, we agree with CMS's proposal to include Body Mass Index Screening and Follow-Up Plan in the ASM low back pain measure set.

We strongly support CMS's idea to include the Patient Activation Measure in the low back pain measure set. We view patient activation as a critical component in successful management of any chronic pain condition. Patients must acquire the knowledge and skills necessary to assume an active role in the self-management of their pain condition. We believe the ASM clinician should be strongly encouraged and incentivized to educate patients about self-management, including key skills such as goal-setting, pacing and shared decision-making, among others.

<u>Concerns</u>

Best practice in chronic pain care, including chronic low back pain, is an individualized, multidisciplinary treatment plan developed by the patient's primary care provider in partnership with the patient, coordinated by the primary provider and taking into consideration the patient's preferences. A primary provider is most often a PCP (primary care physician) but could also be a specialist such as a pain management physician, neurologist, anesthesiologist, or other relevant physician specialist, or a nurse practitioner or physician assistant. Evidence-based therapies are selected from five broad treatment areas: medication, restorative therapies, behavioral therapies, interventional treatments, and complementary and integrative treatments.

One important concern we have with the ASM, as proposed, is its inclusion of and focus on specialized physicians and PCPs and its exclusion of the other non-physician health care providers essential to the low-risk multidisciplinary treatments CMS says it wants to promote. These providers, whom we view as essential to comprehensive multidisciplinary pain care, include psychologists, and physical therapists, and may include occupational therapists, acupuncturists, chiropractors, social workers, massage therapists, and others.

Indeed, CMS has proposed incorporating both mental health screening and follow-up care for comorbid depression and BMI-related lifestyle changes, including some form of movement and weight management, in the ASM measure set. These would need to be conducted by psychologists, physical therapists, dietitians, and

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other health care professionals whose services CMS has not included in the ASM. If CMS intends for these non-physician providers to be captured in the model only if they are employed by a participating physician, then what happens in the more-common scenario of the patient seeing a non-physician provider in an independent practice? How would these be captured in the model, and how would CMS be able to compare outcomes of these different delivery models?

We are also concerned that the measures of success and quality of the ASM are skewed to focus more on reduction of services, procedures, surgeries, and medication, and not enough on measures that are important to individuals with chronic pain such as quality of life, functional status, ability to socialize with others, and whether the ASM clinician educates and empathizes with the patient.

We are seeking clarity on who would be "mandated" to use the ASM in order to be paid for treating people with chronic low back pain. We are concerned that the mandate may have the unintended consequence of discouraging providers from treating complex or severe cases of low back pain.

CMS has proposed to use the prescribing of "high-risk" medications as a measure in the low back pain measure set to reduce the quality ratings of ASM providers. The medications that providers would be disincentivized to prescribe include muscle relaxants and tricyclic antidepressants. While we agree that cautious prescribing in this population is certainly warranted, providers should be encouraged to individualize medication regimens depending upon the unique needs of each patient, rather than being automatically penalized for prescribing a medication on CMS's "high-risk" list. For example, many with low back pain have lived with chronic pain for years and even decades, and may have been on these medications for a long time. Sudden discontinuation of such medications can cause harmful side effects and increases in pain. In addition, the pain reduction from these medications often allows patients to be functional, perform gentle exercise, or socialize and engage in pleasurable activities, all of which can be conducive to improved health. ASM providers should be encouraged to carefully consider each person's individual circumstances when it comes to prescribing medications, including what other medications the individual may be on, rather than worrying about reductions in quality ratings or financial disincentives when it comes to the appropriate prescribing of medications for their patients.

We encourage CMS to create an Advisory Board that includes individuals living with chronic low back pain prior to finalizing and implementing the ASM, and to continue soliciting input from the Advisory Board after implementation to make improvements to the model in real-world use.

We are pleased that CMS recognizes the challenge that chronic low back pain poses to the health and well-being of CMS's beneficiaries. We hope you will take our views into consideration as you determine how best to improve health insurance coverage and care of the vast population of Americans living with chronic low back pain who obtain their health care through CMS. If you have questions about our comments, please feel free to contact me using the information listed below.

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Sincerely,

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