

Health Policy Review

The CY 2027 Medicare Physician Fee Schedule and the Continuing Struggle to Balance Cost, Quality, Access, and the Survival of Interventional Pain Management

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Background: On July 16, 2026, the Centers for Medicare and Medicaid Services (CMS) released the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Proposed Rule (CMS-1848-P). The rule arrives one year after the CY 2026 final rule institutionalized two structural changes of unusual consequence for procedural specialties: a recurring efficiency adjustment that reduces work relative value units (RVUs) for non–time-based services, and a redesign of the indirect practice expense (PE) methodology that shifts payment away from facility-based procedural care toward office-based evaluation and management (E/M). CY 2027 also marks the first performance year of the mandatory Ambulatory Specialty Model (ASM), which places interventional pain management (IPM) physicians at direct financial risk for the longitudinal management of low back pain.

Objectives: To analyze the CY 2027 PFS Proposed Rule and its implications for the cost, quality, access, and financial sustainability of independent interventional pain practices.

Methods: We reviewed the CY 2027 Proposed Rule, the CY 2026 final rule, American Society of Interventional Pain Physicians (ASIPP's) 2026–2027 CPT-level payment comparison and independent-physician modifier proposal, Medicare Trustees and MedPAC reports, CBO and OIG analyses, and relevant peer-reviewed literature.

Results: The CY 2027 qualifying-APM conversion factor (CF) is projected at \$33.1693, a decrease of \$0.42 (–1.19%) from CY 2026, and the non-qualifying CF at \$32.8409 (–1.68%), driven largely by expiration of the temporary 2.5% statutory increase that applied only during CY 2026. Because the –2.5% efficiency adjustment and the PE redesign were embedded in the CY 2026 baseline, most IPM procedures face additional year-over-year reductions of approximately 2% to 6% in CY 2027, with selected codes—sacroiliac joint arthrodesis (–14.9%), trigeminal and occipital nerve blocks (–17% to –20%), and percutaneous neurostimulator implantation (–6% to –7.5%) declining substantially more. A representative independent practice is projected to lose roughly 2% of Medicare-allowed revenue year-over-year, compounding a cumulative inflation-adjusted decline of approximately 47% for IPM services from 2001 to 2026. Independent physicians remain disproportionately exposed because more than 40% practice in ASCs and hospitals, where the PE redesign concentrates its reductions and inappropriately applies to independent physicians.

Conclusions: The CY 2027 Proposed Rule perpetuates a structural mismatch between rising practice costs and declining procedural reimbursement, now amplified by a mandatory specialty model imposed on physicians who do not control upstream utilization. Without permanent, inflation-indexed CF updates, reconsideration of the efficiency adjustment and PE redesign, a distinct payment identifier for independent physicians, and a voluntary redesign of ASM, access to office- and ASC-based interventional pain care for Medicare beneficiaries is likely to erode. Our study offers evidence-based policy recommendations to preserve independent practice while protecting program solvency.

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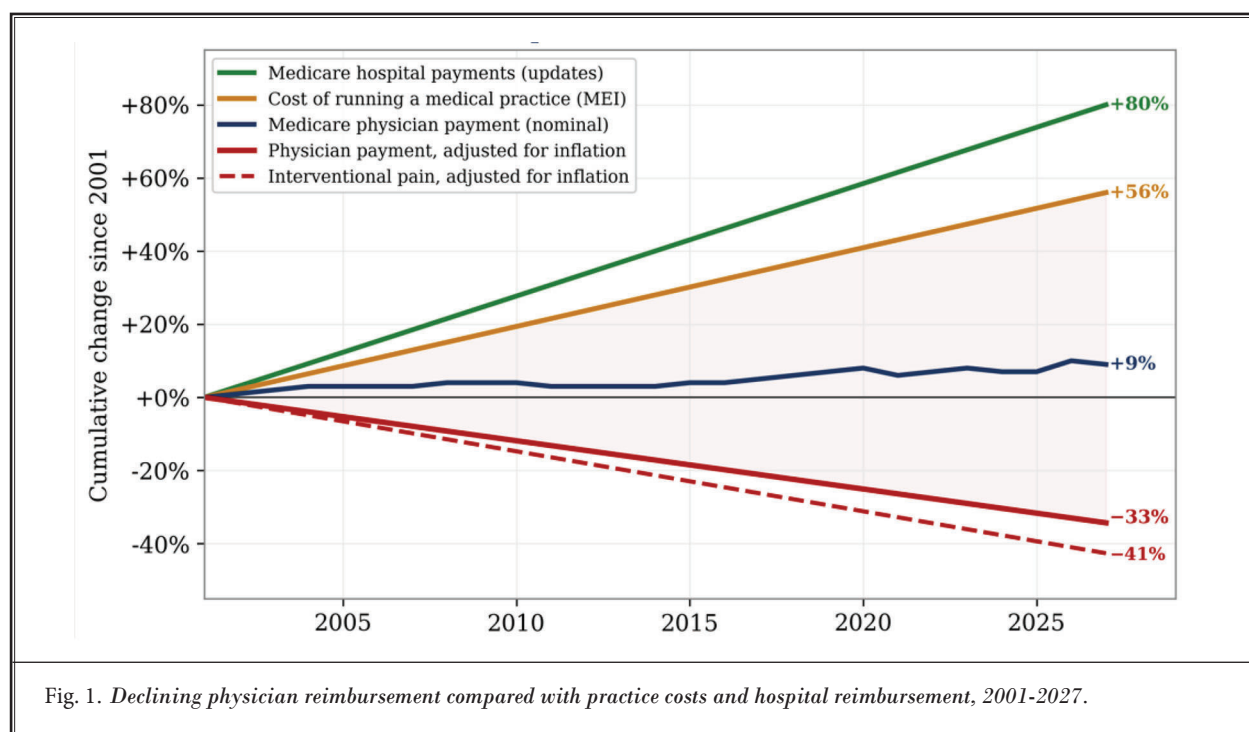
On July 16, 2026, the Centers for Medicare and Medicaid Services (CMS) published the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Proposed Rule, formally titled Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1848-P) (1). Like its predecessors, the proposed rule states admirable aims: to modernize payment systems, refine the accuracy of relative value units (RVUs), advance chronic disease management, and preserve access for Medicare beneficiaries (2,3). Yet for procedural specialties, and for interventional pain management (IPM) in particular, the CY 2027 rule cannot be read in isolation. It is the second act in a structural transformation that began with the CY 2026 final rule, which for the first time embedded a recurring efficiency adjustment reducing work RVUs for non-time-based services and initiated a redesign of the indirect practice expense (PE) methodology that systematically reduces payments by 7%–11% for independent physicians performing services in ASCs and HOPDs with mistaken projections leading to cuts for 40% of physicians (1-3).

The context is a physician payment environment already in crisis. Under current law, the Medicare conversion factor (CF) is not indexed to inflation. As a result, and as the June 2026 Medicare Trustees Report acknowledges, physician payment adjusted for practice-cost inflation declined by approximately 33% between 2001 and 2026 (3), and Medicare physician payment fell from 82% of private commercial rates in 2011 to 68% in 2024; absent legislative change, the Trustees project this ratio could reach 23% by the end of their 75-year window (4). For interventional pain physicians, the erosion is steeper still—on the order of 45% in inflation-adjusted terms since 2001, even with-

out including the ongoing 2% sequestration reduction, because procedural services have absorbed a disproportionate share of budget-neutrality redistributions and RVU reductions (3-11).

Four features distinguish CY 2027 from prior cycles. First, the temporary 2.5% statutory increase that Congress applied to the CY 2026 CF expires at the end of 2026, mechanically lowering the CF for CY 2027 even before budget-neutrality effects. Second, the efficiency adjustment and PE redesign finalized for CY 2026 continue to compound, so that the modest year-over-year procedural reductions in CY 2027 sit atop a materially reduced 2026 base. Third, and most consequentially, CY 2027 is the first performance year of the mandatory Ambulatory Specialty Model (ASM), which holds specialists, including IPM physicians financially accountable for the longitudinal management of low back pain, a condition whose upstream utilization these physicians do not control. Fourth, the 2% federal sequestration reduction, which has applied to Medicare payments since 2013, remains in effect and is scheduled to continue through 2032. (6-12).

These developments arrive as non-physician health-care workers negotiate and strike for inflation-indexed wage increases, while physicians absorb repeated reductions, an ongoing 2% sequester scheduled to run through 2032, and the persistent threat of a 4% Statutory Pay-As-You-Go (PAYGO) reduction as shown in Fig. 1 (3,6-12). Meanwhile, supply costs have risen 56% to 80% since 2001, and administrative burden, including prior authorization, evolving coverage policy, and audit exposure affecting nearly 30% of interventional pain physicians at any given time, has intensified despite the diffusion of electronic medical records (EMRs) and artificial intelligence (AI) (3,5-7,12). The paradox is sharpened by CMS's continued generosity toward Medicare Advantage (MA): CMS finalized MA and Part



D rate increases averaging well above zero for 2026, even as documented MA overpayments, favorable selection, risk-adjustment discrepancies, and duplicative coverage of veterans approach or exceed \$100 billion annually (13-16).

This present investigation, therefore, analyzes the CY 2027 Proposed Rule and its consequences for independent interventional pain practices. We examine the conversion factor and RVU changes, the efficiency adjustment, the practice-expense redesign and its site-of-service implications, budget neutrality, telehealth, the evolution of the Quality Payment Program (QPP), and the now-mandatory ASM. We quantify the impact on major IPM procedures using CMS and ASIPP payment data, model the effect on a representative independent practice, and situate these findings within the broader economics of independent medicine. Our study concludes with evidence-based policy recommendations including implementation of a modifier for independent physicians and elimination of ASM (3,17-19).

Historical Background: From the SGR to the Two-Conversion-Factor Era

Since 1992, Medicare has reimbursed physicians and other billing professionals under the resource-based PFS for services furnished in offices, hospitals, ASCs, clinical laboratories, and patients' homes (1-3,20).

Payment for each service equals the sum of three RVU components, work, practice expense, and malpractice (MP), each adjusted by a geographic practice cost index (GPCI) and multiplied by a national CF. The CF is therefore the single lever that scales the entire fee schedule, and its trajectory is the clearest summary of physician payment policy over three decades.

The Sustainable Growth Rate and Its Repeal

From 1998 through 2015, CF updates were governed by the Sustainable Growth Rate (SGR) formula, which tied aggregate physician spending to growth in gross domestic product (GDP). When spending exceeded the target, as it routinely did, the SGR called for automatic reductions, culminating in a threatened 21% cut in 2015. Congress overrode the SGR seventeen times through short-term "doc fix" patches before repealing it in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (21). MACRA replaced the SGR with a schedule of statutory updates and a two-track Quality Payment Program.

MACRA, MIPS, and Alternative Payment Models

MACRA created the Merit-based Incentive Payment System (MIPS), which adjusts payment based on performance across quality, cost, improvement

activities, and promoting interoperability, and the Advanced Alternative Payment Model (A-APM) track, which offers incentive payments and, beginning in 2026, a higher “qualifying APM” conversion factor. MACRA specified statutory updates of 0.5% annually through 2019, a payment freeze from 2020 through 2025, and, beginning in 2026, divergent updates of 0.75% for qualifying APM participants and 0.25% for all other clinicians (21). Critically, none of these updates approximate the growth in the Medicare Economic Index (MEI), the government’s own measure of practice-cost inflation. MIPS has been widely criticized as administratively burdensome and weakly correlated with meaningful quality improvement, and participation in Advanced APMs has grown more slowly than anticipated, leaving most physicians on the non-qualifying track (22).

Annual Conversion-Factor Changes and Cumulative Reductions

Because MACRA’s statutory freeze coincided with budget-neutrality-driven redistributions, most notably the 2021 revaluation of office E/M services, the CF declined in nominal terms across the early 2020s even before inflation. The CF fell from \$36.09 in 2020 to \$34.89 in 2021, \$34.61 in 2022, \$33.89 in 2023, \$32.74 in 2024, and \$32.35 in 2025, a nominal decline of roughly 10% over five years (21,23). Congress partially offset several of these reductions through short-term relief, but each patch was temporary and none was built into the baseline. There was no patch for 2025. For CY 2026, Congress provided a one-time 2.5% statutory increase and, under MACRA, established two separate conversion factors; the qualifying-APM CF was set at \$33.5875 and the non-qualifying CF at \$33.4009 (1-3). Because the 2.5% increase applied only to services furnished between January 1 and December 31, 2026, it expires at year-end, mechanically reducing the CY 2027 CF as described below.

Table 1 summarizes major milestones in Medicare physician payment policy, and Table 2 presents the conversion-factor trend through the CY 2027 proposal. The central lesson is structural: hospitals, skilled nursing facilities, and other institutional providers receive annual inflation-based “market basket” updates, whereas physicians do not. Over 2001 to 2026, Medicare payments to hospitals rose roughly 80% cumulatively while physician payments remained essentially flat in nominal terms and fell about 33% in inflation-adjusted terms (Table 3 and Fig. 2) (3-5, 24-36).

METHODS

This is a health-policy analysis and does not constitute human-subjects research and therefore, institutional review board approval was not required. We reviewed the CY 2027 PFS Proposed Rule (CMS-1848-P, 91 FR 43842) in full, together with the CY 2026 PFS final rule, the CMS CY 2027 fact sheet, and the American Medical Association (AMA) summary of the proposed rule (1,3,25,26). Interventional payment data were drawn from the ASIPP 2026-versus-2027 payment comparison for major IPM CPT codes, which reports non-facility (office) and facility (ASC/HOPD) national allowed amounts under the CY 2026 CF of \$33.57 and the CY 2027 proposed CF of \$33.17, excluding the 2% sequester and potential 4% PAYGO reductions (27). For each code we tabulated the 2026 and 2027 allowed amounts, the dollar change, and the percent change by setting (Table 4). We then constructed a representative independent practice model by applying illustrative annual Medicare procedural and E/M volumes to the 2026 and 2027 facility and office rates to estimate the aggregate revenue effect (Table 5). Macro-level context, national health expenditure projections, conversion-factor history, and inflation comparisons was obtained from the CMS Office of the Actuary, the June 2026 Medicare Trustees Report, MedPAC Reports to Congress (March and June 2025; March 2026), the CBO, the OIG, and peer-reviewed literature identified through July 2026 (3-7,24,28-31). All monetary figures are national, unadjusted for geographic indices unless otherwise noted, and reflect proposed, not final CY 2027 values.

Health Policy Analysis of the CY 2027 Proposed Rule

Conversion Factor for 2027

Consistent with MACRA, CMS proposes two conversion factors for CY 2027. To calculate them, CMS began with the CY 2026 conversion factors excluding the temporary 2.5% statutory increase that applied only through December 31, 2026, applied the required budget-neutrality adjustment (a positive 0.53%), and then applied the statutory MACRA updates of 0.75% for qualifying APM participants and 0.25% for non-qualifying clinicians (1). The result is a proposed CY 2027 qualifying-APM CF of \$33.1693 and a non-qualifying CF of \$32.8409. Relative to CY 2026, these represent decreases of \$0.42 (–1.19%) and \$0.56 (–1.68%), respectively (1,26). Two anesthesia conversion factors

Table 1. *Milestones in Medicare physician payment policy, 1992–2027.*

Year	Milestone
1992	Resource-based Physician Fee Schedule (PFS) implemented; payment = (work + PE + MP RVUs) × GPCI × conversion factor.
1998	Sustainable Growth Rate (SGR) formula ties aggregate physician spending to GDP growth.
2003–2014	Congress overrides SGR-mandated cuts 17 times via temporary "doc fix" patches.
2015	MACRA repeals the SGR; establishes MIPS and the Advanced APM track; sets statutory update schedule.
2020–2025	Statutory payment freeze; budget-neutrality redistribution (E/M revaluation) drives nominal CF declines.
2021	Office/outpatient E/M values increased; large budget-neutrality offset reduces the CF for all other services.
2026	Two conversion factors established (qualifying vs non-qualifying APM); one-time 2.5% statutory increase; efficiency adjustment (–2.5%) and PE redesign finalized; ASM finalized as mandatory.
2027	Proposed: CF declines as the 2026 temporary increase expires; PE redesign and site-of-service methodology continue; ASM first performance year begins January 1, 2027.

APM, alternative payment model; ASM, Ambulatory Specialty Model; CF, conversion factor; E/M, evaluation and management; GPCI, geographic practice cost index; MACRA, Medicare Access and CHIP Reauthorization Act of 2015; MIPS, Merit-based Incentive Payment System; MP, malpractice; PE, practice expense; RVU, relative value unit. Sources: (1-3,21).

are similarly proposed, with the non-qualifying anesthesia CF set at \$20.2143. The proposed CFs are shown in Table 2.

The headline reduction understates the pressure on procedural specialties. Because the CF decline is driven principally by the sunset of a one-time increase rather than by a new across-the-board cut, it is often described as "modest." But for IPM the CF is only one of three compounding forces: the CF reduction, the residual effect of the CY 2026 efficiency adjustment now baked into work RVUs, and the continued migration of indirect PE dollars away when independent physicians provide surgeries in facility settings. ASIPP and other specialty societies continue to urge CMS to support MedPAC's recommendation to repeal current-law updates and instead tie annual updates to the MEI, and the AMA has renewed its call for an inflation-based baseline update (5,26,28).

Relative Value Unit Revisions: Work, Practice Expense, and Malpractice

The proposed rule adjusts hundreds of individual code values based on recommendations from the AMA/Specialty Society Relative Value Scale Update Committee (RUC) and CMS's own review. Consistent with statute, aggregate RVU changes are constrained by budget neutrality increases or decreases in RVUs may not change estimated Part B expenditures by more than \$20 million without a compensating adjustment to the CF (1). The CY 2027 budget-neutrality adjustment is a positive 0.53%, reflecting the net effect of proposed misvalued-code changes. Malpractice RVUs are updated using contemporary premium data and

Table 2. *Medicare conversion factor (CF) trend, 2020–2027 (proposed).*

Year	Conversion factor (\$)	Notes
2020	36.09	End of pre-freeze schedule.
2021	34.89	E/M revaluation; partial congressional relief.
2022	34.61	Relief partially expires.
2023	33.89	Continued nominal decline.
2024	32.74	≈3.4% nominal reduction vs 2023.
2025	32.35	≈1.2% nominal reduction vs 2024.
2026	33.5875 (QP) / 33.4009 (non-QP)	Two CFs; includes one-time +2.5% statutory increase (2026 only) plus MACRA updates.
2027 (proposed)	33.1693 (QP) / 32.8409 (non-QP)	–1.19% (QP) / –1.68% (non-QP) vs 2026; reflects sunset of the 2.5% increase, +0.53% budget neutrality, and MACRA updates of +0.75% / +0.25%.

QP, qualifying APM participant. CFs are national and exclude the 2% sequester and any potential 4% PAYGO reduction. Sources:(1, 21,23).

revised GPCIs. The practical consequence for IPM is unchanged from prior years: because interventional procedures are disproportionately represented among "potentially misvalued" and revalued codes, they bear a larger share of downward redistribution than time-based E/M services.

The Efficiency Adjustment

The efficiency adjustment, finalized in the CY 2026 final rule, reduces the work RVU and the intraservice portion of physician time for non-time-based services on the theory that technological progress makes procedures faster over time. CMS finalized an adjustment of –2.5% applied to the intraservice work of affected

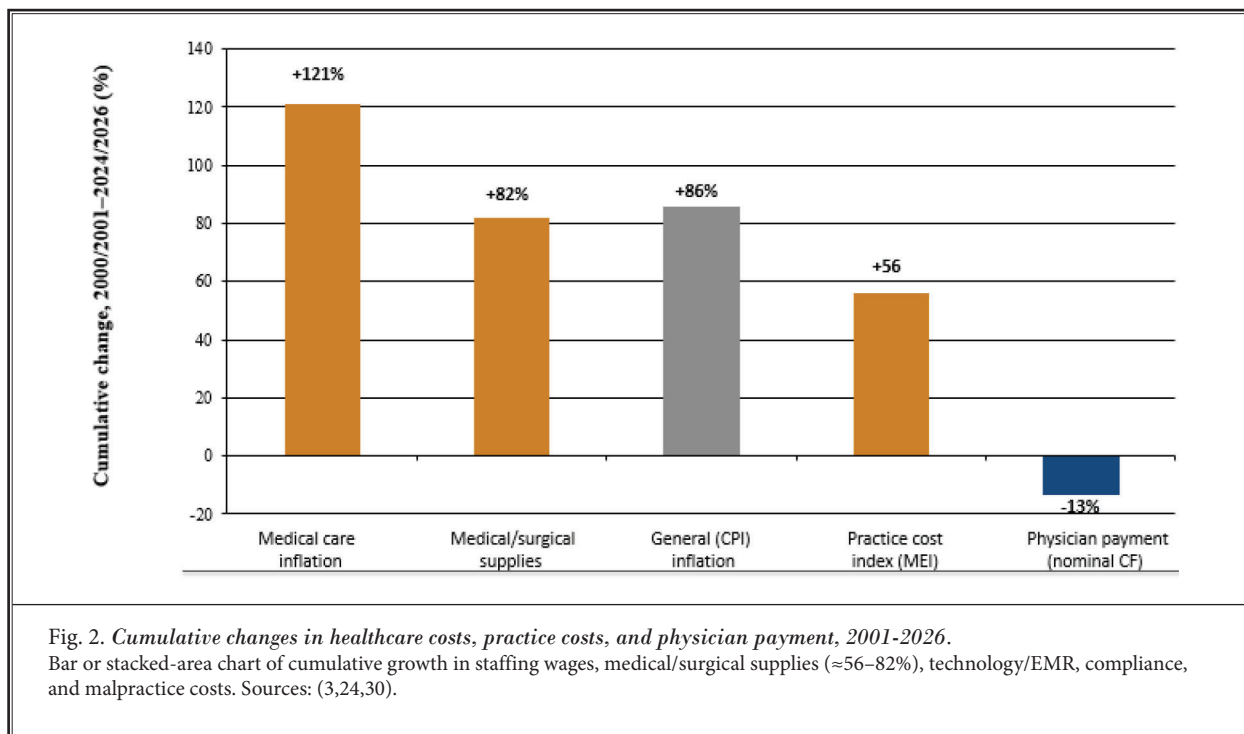
codes and specified that it will be reapplied every three years; the next scheduled application is CY 2029 (1-3). The magnitude is derived from the cumulative MEI productivity adjustment over a five-year look-back (CY 2022–2026); CMS noted that using more recent Bureau of Labor Statistics data would have produced a larger 3.6% reduction. Time-based codes, E/M, care management, behavioral health, telehealth, and maternity global codes are exempt, as are new codes for the applicable year.

The growing burden of medical documentation, particularly with the widespread adoption of electronic health records (EHRs), has contributed to physician burnout and decreased job satisfaction (32,33). The intricate structure of medical notes, combined with the time-consuming data entry process, and physicians often limited typing proficiency, has considerably impeded their ability to prioritize patient care (34,35). The recent rise of artificial intelligence (AI) in health-care presumably offered a promising solution to alleviate the burden of documentation and optimize clinical workflows (32,36). While proponents of AI in health-care put great confidence in the technology ignoring the fact that most of the physicians are not using AI in their documentation and expenses incurring with utilization of extensive technology which may range

Table 3. *Inflation versus physician reimbursement, 2001–2026.*

Metric	Change
Physician payment, inflation-adjusted (2001–2025)	≈ –33%
Interventional pain reimbursement, inflation-adjusted (2001–2026)	45%
Medicare physician payment as share of private commercial rates	82% (2011) → 68% (2024)
Cumulative Medicare hospital payment updates (2001–2026)	≈ +80%
Medical inflation vs general (consumer) inflation (2000–2024)	+121.3% vs +86.1%
Practice cost inflation (Medicare Economic Index, 2001–2026)	≈ +56%
Medical/surgical supply costs (2001–2026)	≈ +56% to +82%
Interventional pain reimbursement, annual (2014–2023, Wiest et al)	–3.63%/yr (vs –0.87%/yr for E/M)

E/M, evaluation and management. Sources: (3-5,24,43,44).



CY 2027 Medicare Physician Fee Schedule and Interventional Pain Management

Table 4. *Payment comparison for major interventional pain management CPT codes: CY 2026 versus proposed CY 2027 (national allowed amounts, \$).*

CPT		Office			Facility		
		2026	2027 (P)	Δ%	2026	2027 (P)	Δ%
22513	Percutaneous kyphoplasty, thoracic	\$5,836.72	\$5,484.66	-6.0%	\$456.85	\$439.50	-3.8%
22514	Percutaneous kyphoplasty, lumbar	\$5,845.44	\$5,488.97	-6.1%	\$426.31	\$411.64	-3.4%
27096	Sacroiliac joint injection	\$176.57	\$174.47	-1.2%	\$73.85	\$72.31	-2.1%
27279	Sacroiliac joint arthrodesis, percutaneous	-	-	-	\$779.10	\$663.07	-14.9%
62263	Percutaneous adhesiolysis, 2–3 days	\$670.68	\$645.82	-3.7%	\$300.76	\$290.24	-3.5%
62287	Lumbar Disc Decompression	-	-	-	\$473.00	\$429.22	-9.3%
62321	Cervical/thoracic interlaminar epidural, w/ fluoro	\$278.61	\$269.34	-3.3%	\$96.34	\$93.21	-3.2%
62323	Lumbar/caudal interlaminar epidural, w/ fluoro	\$275.59	\$267.35	-3.0%	\$89.96	\$87.57	-2.7%
62361	Implant spine infusion pump	-	-	-	\$469.95	\$447.46	-4.8%
62362	Implantable spinal infusion pump	-	-	-	\$374.61	\$358.90	-4.2%
63650	Spinal cord stimulator trial, percutaneous	\$2,408.80	\$2,265.84	-5.9%	\$377.97	\$366.53	-3.0%
63685	SCS pulse generator insertion	-	-	-	\$319.90	\$307.82	-3.8%
64400	Trigeminal nerve block	\$122.52	\$98.18	-19.9%	\$47.33	\$38.15	-19.4%
64405	Greater occipital nerve block	\$79.56	\$66.34	-16.6%	\$46.32	\$41.13	-11.2%
64451	Sacroiliac joint nerves, injection	\$244.04	\$238.16	-2.4%	\$72.51	\$71.98	-0.7%
64479	C/T transforaminal epidural, 1st level	\$287.00	\$276.31	-3.7%	\$117.15	\$113.44	-3.2%
64483	L/S transforaminal epidural, 1st level	\$266.86	\$255.08	-4.4%	\$100.37	\$96.52	-3.8%
64484	L/S transforaminal epidural, add-on	\$118.16	\$112.78	-4.6%	\$43.97	\$43.45	-1.2%
64490	C/T facet joint nerve block, 1st level	\$206.78	\$204.00	-1.3%	\$95.00	\$91.55	-3.6%
64493	L/S facet joint nerve block, 1st level	\$191.33	\$190.40	-0.5%	\$81.57	\$79.94	-2.0%
64553	Implantation of a neurostimulator electrode	\$4,902.87	\$4,536.00	-7.5%	\$455.85	\$393.73	-13.6%
64555	PNS electrode implant, peripheral nerve	\$2,249.36	\$2,106.63	-6.3%	\$296.74	\$285.93	-3.6%
64590	Peripheral neurostim pulse generator insertion	\$432.01	\$415.62	-3.8%	\$268.88	\$260.38	-3.2%
64624	Genicular nerve branches, radiofrequency	\$413.89	\$392.07	-5.3%	\$134.27	\$130.03	-3.2%
64625	Sacroiliac joint nerves, radiofrequency	\$499.48	\$473.00	-5.3%	\$177.91	\$172.15	-3.2%
64628	Basivertebral nerve ablation, 1st level				\$366.89	\$354.59	-3.4%
64633	C/T facet RF thermoneurolysis, 1st level	\$461.89	\$438.51	-5.1%	\$174.22	\$168.50	-3.3%
64635	L/S facet RF thermoneurolysis, 1st level	\$468.60	\$444.15	-5.2%	\$174.55	\$168.84	-3.3%
64636	L/S facet RF thermoneurolysis, add-on	\$252.09	\$239.49	-5.0%	\$50.02	\$49.42	-1.2%

Office = non-facility; Facility = ASC/HOPD. Δ% = percent change from CY 2026 to proposed CY 2027. Dashes indicate the service is not separately payable in that setting. Values reflect CY 2026 CF \$33.57 and proposed CY 2027 CF \$33.17; they exclude the 2% sequester and potential 4% PAYGO reduction. CPT® is a registered trademark of the American Medical Association. C/T, cervical/thoracic; L/S, lumbar/sacral; PNS, peripheral nerve stimulation; RF, radiofrequency; SCS, spinal cord stimulation. Source: reference (27).

Table 5. *Illustrative annual Medicare revenue impact on a representative independent interventional pain practice (office E/M + ASC procedures).*

Component	Annual volume	2026 revenue (\$)	2027 revenue (\$)	Change (\$)
Facility (ASC) procedures — 14 major IPM services	3,530	362,100	351,700	−10,400
Office E/M (99204, 99214, 99213)	4,300	540,600	532,300	−8,300
Total modeled Medicare-allowed revenue	7,830	902,700	884,000	−18,700

Illustrative model applying CY 2026 and proposed CY 2027 facility and office allowed amounts (27) to representative annual volumes. Net year-over-year change $\approx -2.1\%$ (procedural component $\approx -2.9\%$). Figures are rounded and exclude sequester, PAYGO, geographic adjustment, and any ASM payment adjustment (-9% to $+9\%$). Individual practices will vary by case mix, setting, and payer mix.

almost \$10-15,000 per year per physician. In fact, recent literature highlights failures of AI to improve efficiency or activity creates more work. AI may cause:

- The omission and hallucination risk.
- The training and adoption gap. The 2026 JAMA study (37) exposed that only 32% of physicians used the AI tool in more than half of the visits.
- Infrastructure limitations. A health system report revealed that while 93% of health networks have developed third party AI tools, 63% are still building the basic IT data infrastructure to properly support them.

In fact, recent large-scale medical studies revealed a nuanced reality: AI medical documentation tools offer only modest, measurable efficiency gains, but they do not completely or even partially eliminate administrative burden. The landmark JAMA study published in April 2026 (37) utilizing a massive multisite longitudinal population conducted by researchers at UCSF and Mass General Brigham tracked 8,581 ambulatory clinicians across 5 academic health systems. The efficiency gains they documented were on average, adopting an AI scribe was associated with 16 fewer minutes of documentation time and 13.4 fewer minutes of total EHR time for an 8-hour shift. Further, there was a significant power user effect showing that benefits were highly dependent on usage. Clinicians who used the AI scrub in 50% or more of their patient visits saved 27 minutes of charting time per day. The most crucial aspect was that there was no after-hours relief as the study found

that after-hours EHR work (pajama time) did not decrease significantly overall. The study showed that doctors simply reallocated the saved time to other pressing clinical tasks, such as answering inbox messages, reviewing lab results, or adding a modest increase in patient visit volume.

The second study of UCLA health randomized clinical trial published in November 2025 (38) showed efficiency gain of individual notes by 41 seconds from 4.5 minutes down to 3.8 minutes and reportedly the study noted modest improvements in validated measures of physician burnout, cognitive workload, and work exhaustion. However, the time saved per note was incremental rather than revolutionary.

Another study published in the New England Journal of Medicine in December of 2025 (39) showed that consultation durations did not sink. Instead, doctors spent the exact same length of time in the room but shifted their focus maybe away from the computer screen and towards direct patient interaction.

Consequently, none of these studies have shown any benefits beyond the usual time spent and costs an additional \$10-15,000 per physician. In addition, the empirical premise is also contested. The empirical basis for assuming uniform procedural efficiency gains remains uncertain. Although AI-assisted documentation tools may modestly reduce EHR documentation time, published studies demonstrate heterogeneous adoption and limited effects on after-hours workload. More directly relevant to procedural payment, large operative datasets have shown stable or increasing intraservice times rather than systematic reductions. Childers et al (40), analyzing 1.7 million operations, reported increasing operative times across most evaluated procedures, while Society of Thoracic Surgeons data similarly demonstrated increased intraservice times for coronary bypass surgery. These findings suggest that technological advancement should not automatically be equated with reduced physician work for non-time-based services. Multiple analyses of interventional pain utilization and physician time likewise find that efficiency has not improved and that administrative time has grown (3,5-7,42-45). In fact, in interventional pain management, efficiency has been reduced by 30-40% to meet ever-changing requirements with documentation based on medical policies, LCDs, and other regulations. Thus, penalizing physicians for unproven productivity gains, while administrative burden demonstrably increases, remains in ASIPP's view, methodologically unsupported. For CY 2027, no new efficiency reduction

is proposed, but the CY 2026 reduction persists in the work RVUs that anchor 2027 payment. Consequently, ASIPP with extensive advocacy submitted a request for a modifier at the request of CMS (1,2,17,18)

Practice Expense Redesign and Site-of-Service Effects

The most consequential structural change for independent procedural physicians is the ongoing PE redesign. Historically, indirect PE RVUs were built from the AMA's 2008 Physician Practice Information Survey. Beginning with CY 2026 and continuing in CY 2027, CMS recognizes greater indirect costs for office-based than for hospital settings reflecting in CMS's framing, the decline of private practice and the rise of hospital employment, and increasingly uses auditable external data, such as the Hospital Outpatient Prospective Payment System (OPPS), to set relative rates for certain technical services as shown in Fig. 3 (1-3). CMS continues to refine a "site-of-service" methodology and to review codes valued with a facility/non-facility differential.

The distributional effect is to raise office-based E/M and in-office procedure payments while reducing payment for the same procedures when performed in an ASC or HOPD. CMS's stated rationale assumes that most physicians are hospital-employed and therefore unaffected by facility-side reductions. That assumption does

not hold for interventional pain management while 40% of physicians remain independent, with >70% of IPM physicians practicing independently and a substantial proportion perform their procedures in ASCs and HOPD settings, without any payments, benefits, or practice management by the facilities (1-3,5,45-65). The redesign therefore transfers dollars from independent proceduralists to the office-based and hospital-employed segments, precisely inverting the policy's stated goal of protecting independent practice. Table 6 illustrates the resulting office-versus-ASC-versus-HOPD payment divergence for representative IPM services. Table 6 shows steep reductions in payments for IPM services from 2001-2027, with 40% in facility settings and 40% in office settings.

Budget Neutrality

Budget neutrality, established by the Omnibus Budget Reconciliation Act of 1989, requires that RVU changes not increase aggregate Part B spending beyond a \$20 million threshold (24,42). In practice it converts every targeted increase into an offsetting, across-the-board reduction in the CF, so that gains for one service are financed by losses for all others. Because the office E/M increases that CMS favors are large in aggregate, budget neutrality forces compensating reductions that fall heavily on procedural specialties.

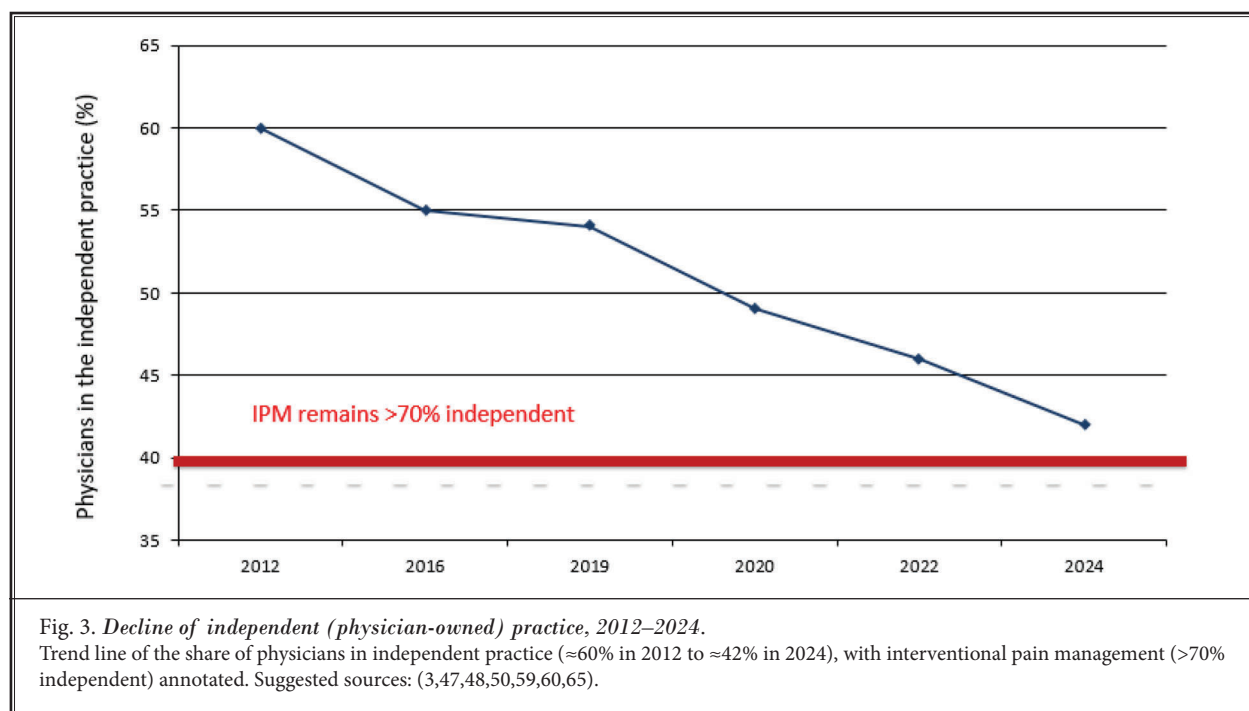


Table 6. Physician reimbursement rates for 2001, 2026, and proposed 2027, with percentage change from inflation-adjusted 2001 values

CPT – Description	Physician Payment Rates (In Facility)					Office Payment Rates				
	2001*	2026	Δ%	2027P	Δ%	2001*	2026	Δ%	2027P	Δ%
27096: SI joint, arthrography	\$180.75	\$73.85	-59%	\$72.31	-60%	\$893.77	\$176.57	-80%	\$174.47	-80%
62310 or 62321: C/T interlaminar epidural	\$144.62	\$96.34	-33%	\$93.21	-36%	\$399.92	\$278.61	-30%	\$269.34	-33%
62311 or 62323: L/ Caudal interlaminar epidural injection	\$146.06	\$89.96	-38%	\$87.57	-40%	\$392.09	\$275.59	-30%	\$267.35	-32%
63650: Implant microelectrodes (Trial)	\$829.37	\$377.97	-54%	\$366.53	-56%	\$816.21	\$2,408.80	195%	\$2,265.84	178%
63685: Implant pulse generator	\$963.14	\$319.90	-67%	\$307.82	-68%					
64479: C/T transforaminal epidural injections	\$214.03	\$117.15	-45%	\$113.44	-47%	\$454.00	\$287.00	-37%	\$276.31	-39%
64483: Lumbosacral transforaminal epidural injections	\$185.11	\$100.37	-46%	\$96.52	-48%	\$422.69	\$266.86	-37%	\$255.08	-40%
64470 or 64490: C/T facet joint injections	\$178.60	\$95.00	-47%	\$91.55	-49%	\$420.56	\$206.78	-51%	\$204.00	-51%
64475 or 64493: L/S facet joint nerve	\$135.94	\$81.57	-40%	\$79.94	-41%	\$375.01	\$191.33	-49%	\$190.40	-49%
64622 or 64633: C/T radiofrequency thermolysis	\$304.42	\$174.22	-43%	\$168.50	-45%	\$543.66	\$461.89	-15%	\$438.51	-19%
64626 or 64635: L/S radiofrequency thermolysis	\$316.71	\$174.55	-45%	\$168.84	-47%	\$530.14	\$468.60	-12%	\$444.15	-16%
Average			-47%		-49%			-15%		-18%

* 2001 Consumer price Index inflation-adjusted payment rate: \$1.00 in 2001 is equivalent to \$1.86 in 2027.

https://www.bls.gov/data/inflation_calculator.htm

Δ% – Percentage of change from 2001. Calculations do not include 2% sequester cuts.

ASIPP and MedPAC have both identified the rigidity of budget neutrality, and the absence of an inflation update, as core drivers of the multi-decade decline in real physician payment (5,28). MedPAC's June 2025 report specifically recommended reforming fee-schedule updates and improving the accuracy of relative payment rates, and its March 2026 report reiterated the recommendation to replace current-law updates with an MEI-based update (28,29). In fact, it has been the subject of multiple Congressional Acts (66-68).

Telehealth

The CY 2027 rule continues the post-pandemic normalization of telehealth. Consistent with the CY 2026 final rule, CMS proposes to simplify the process for adding services to the Medicare Telehealth Services

List, to make permanent certain flexibilities (including specified frequency limitations and direct-supervision-via-two-way-audio-video provisions), and to clarify definitions governing telehealth originating sites and interactive communication (1). For interventional pain practices, telehealth is most valuable for evaluation, medication management, and post-procedure follow-up; it cannot substitute for procedural care. ASIPP with its advocacy achieved a 2-year extension until December 2027, with congressional action (69). Continued telehealth stability supports access and continuity but does not offset procedural reductions.

Quality Payment Program: MIPS and APM Evolution

For the CY 2027 performance year (2029 payment

year), CMS proposes incremental MIPS refinements, including adjustments to scoring for limited-measure situations and continued development of MIPS Value Pathways (MVPs). CMS estimates approximately 587,000 MIPS-eligible clinicians with roughly \$51.7 billion in allowed charges in the CY 2027 performance period (1). The qualifying-APM conversion factor continues to grow 0.5 percentage points faster per year than the non-qualifying factor, a differential CMS frames as an incentive for value-based care. For most independent interventional pain physicians, however, meaningful Advanced APM options remain scarce, leaving them on the non-qualifying track and subject to MIPS reporting burden without commensurate reward.

The Ambulatory Specialty Model: From Proposal to Mandatory Reality

The single most significant development for interventional pain management is that ASM proposed in the CY 2026 cycle was finalized in the CY 2026 final rule as a mandatory model tested under section 1115A of the Act, with five performance years beginning January 1, 2027, and ending December 31, 2031, and performance-based payment adjustments occurring two calendar years after each performance year (1-3,7,19). ASM targets two high-spending chronic conditions, low back pain and heart failure, and selects individual specialists by a combination of taxpayer identification number and National Provider Identifier. Low back pain specialties include anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation, but exclude primary care, chiropractic, and physical therapy, the disciplines that manage the overwhelming majority of low back pain and drive its upstream utilization.

The CY 2027 proposed rule does not withdraw ASM as we requested; it refines it. Proposed modifications include revising and adding model definitions; clarifying participant identification and exceptions arising from TIN changes; adding an option to terminate participants under specified circumstances; permitting individual- or group-level data submission for the improvement-activities category; adjusting benchmarking and scoring; and, notably, adding an administrative claims-based low back pain imaging quality measure and replacing the patient-reported outcome measure for low back pain with a functional-status outcome process measure (1). First-year payment adjustments range from -9% to +9%, and CMS applies a redistribution

mechanism retaining a portion of any reductions rather than returning the full amount to high performers that guarantee net Medicare savings by design. Because the model operates as a tournament in which adjustments for high performers cannot exceed penalties for low performers, most participating physicians can expect net reductions regardless of measured performance, and the maximum penalties exceed those in MIPS and the Hospital Value-Based Purchasing Program.

The core objection is one of accountability without control. Interventional pain physicians typically enter the low back pain care pathway as tertiary referrals often after primary care, imaging, physical therapy, and sometimes surgery have already occurred, yet ASM holds them financially accountable for total upstream spending they neither initiate nor direct. ASIPP maintains that ASM should be withdrawn pending evidence of effectiveness and validated appropriateness criteria, and that if implemented it should be voluntary, should include the primary-care and rehabilitative disciplines that actually manage low back pain longitudinally, and should exclude specialties; anesthesiology, pain management, and interventional pain management that lack control over the relevant expenditures (3,6,7).

Impact on Interventional Pain Management

Table 4 presents CY 2026 and proposed CY 2027 national allowed amounts for major IPM procedures in office (non-facility) and ASC/HOPD (facility) settings, with the dollar and percent change by setting, derived from the ASIPP payment comparison (27). Several patterns are evident.

Most spinal axial procedures decline modestly but consistently in CY 2027. Lumbosacral transforaminal epidural injection (64483) falls 4.4% in the office and 3.8% in the facility; cervical/thoracic transforaminal injection (64479) falls 3.7% and 3.2%; lumbar interlaminar epidural with fluoroscopy (62323) falls 3.0% and 2.7%; and lumbosacral facet joint nerve block (64493) falls 0.5% and 2.0%. Radiofrequency neurotomy, among the highest-volume interventional services declines more sharply, with cervical/thoracic (64633) down 5.1% in the office and lumbosacral (64635) down 5.2%, and sacroiliac and genicular radiofrequency (64625, 64624) each down approximately 5.3%.

Advanced and implantable procedures face the deepest office-setting reductions. Percutaneous spinal cord stimulator trial (63650) declines 5.9% in the office; percutaneous peripheral nerve neurostimulator electrode implantation (64555) declines 6.3%; and

cranial neurostimulator electrode implantation (64553) declines 7.5%. Vertebral augmentation is similarly affected, with thoracic and lumbar kyphoplasty (22513, 22514) each declining approximately 6% in the office. Intrathecal drug-delivery procedures decline 4% to 5% (e.g., 62362, -4.2%; 62361, -4.8%).

A subset of services faces severe, code-specific reductions that warrant particular attention. Percutaneous sacroiliac joint arthrodesis (27279) declines 14.9% in the facility setting; trigeminal nerve block (64400) declines 19.9% in the office and 19.4% in the facility; greater occipital nerve block (64405) declines 16.6% and 11.2%; and disc decompression (62287) declines 9.3%. These outliers reflect targeted revaluation and, in some cases, the interaction of the efficiency adjustment with PE reallocation. Conversely, a small number of predominantly office-based, non-fluoroscopic services see marginal increases (e.g., lumbar interlaminar epidural without fluoroscopy, 62322, +1.5%), illustrating the policy's systematic tilt toward office E/M-adjacent services and away from image-guided procedural care.

The clinical significance of these reductions is amplified by their concentration in exactly the settings where independent interventional pain physicians work. Because more than 40% of physicians are independent and this percent is higher for interventional pain management and perform the significant proportion of their procedures in ASCs, the facility-side reductions in Table 4 fall directly on independent practice revenue. When layered on the cumulative inflation-adjusted decline documented by Wiest et al (44) (interventional pain reimbursement falling an average of 3.63% annually from 2014 to 2023, versus 0.87% for E/M) and Park et al (43) (inflation-adjusted Medicare reimbursement for interventional pain procedures declining approximately 60% for both facility and non-facility settings from 2000 to 2023), the CY 2027 changes extend a two-decade trajectory of erosion (6).

The Medicare Program and Private Payers

Paradoxically, policies that erode lower-cost independent and ASC-based care may raise total program spending by shifting volume to HOPDs. Private payers, many of which benchmark to Medicare rates, propagate the reductions, compounding the revenue pressure on independent practices across their entire book of business.

Cost Drivers Compounding the Squeeze

Independent practices face rising costs across every

input category: staffing wages (with non-physician workers pursuing inflation-indexed increases), medical and surgical supplies (up 56% to 82% since 2001), technology and EMR licensing and maintenance, cybersecurity and AI-implementation costs, escalating compliance and audit-response burden, and malpractice premiums (3,7,12,24,30,65). Medical inflation has outpaced general inflation healthcare costs rose 121.3% versus 86.1% for consumer goods from 2000 to 2024 so that the real value of a flat or declining CF falls faster than headline inflation implies as shown in Figs. 1 and 2 (3,24). Unlike hospitals, physicians cannot pass these costs through an annual update, and unlike other sectors, they cannot readily raise Medicare prices.

Independent Practice Survival

The survival of independent medical practice is inseparable from physician-employment trends. Consolidation has advanced steadily: by January 2022, roughly three in four physicians were employed by hospitals or corporate entities, up from 62% in 2019, a shift accelerated by the COVID-19 pandemic (47,48). Large hospital systems now encompass a majority of U.S. hospitals and the majority of staffed beds, concentrating market power and raising monopolization concerns (49). Yet the picture is more nuanced than CMS's working assumption that hospitals employ roughly 80% of physicians. Using Census Bureau and Bureau of Labor Statistics data, Popover et al (50) found that private practices still account for a majority of physician employment despite hospital growth, and that small practices though declining, remain central to the delivery system. In interventional pain management specifically, >70% of physicians remain independent (Fig. 3).

Several forces threaten this remaining independent base. Declining reimbursement compresses margins precisely as operating expenses rise. Administrative burden, prior authorization, shifting local coverage determinations, and audit exposure affecting nearly 30% of interventional pain physicians at any time consumes clinical time and adds staff cost (3,12,65). Workforce shortages and wage pressure raise labor costs. Physician burnout, driven by these same pressures, reduces the effective supply of proceduralists and accelerates early retirement (51,52). The consequences fall hardest on rural and underserved areas, where a single retirement or practice closure can eliminate regional access to interventional pain care, lengthening wait times and pushing patients toward emergency departments or long-term opioid therapy. The reimbursement litera-

ture across specialties; orthopedics, neurosurgery, and otolaryngology documents parallel declines, underscoring that the phenomenon is systemic rather than specialty-specific (53-56). CMS has acknowledged that safeguarding beneficiary access requires the survival of independent practice; the CY 2027 rule, by concentrating reductions on independent proceduralists, works against that stated aim.

Quality and Value

A central question is whether the CY 2027 payment reforms actually advance the value goals CMS invokes improving quality, reducing cost, maintaining access, supporting innovation, and encouraging evidence-based care. The available evidence is not reassuring. Small independent practices consistently deliver cost-efficient care: the CMS Bundled Payments for Care Improvement initiative found that physician group practices saved the program more than hospital participants, reflecting tightly managed overhead and strong physician-patient continuity (57,58). Redirecting payment away from these settings toward hospital-based care therefore risks raising, not lowering, total cost.

On quality, MIPS has not demonstrated a robust link between its scores and improved outcomes, and ASM's tournament design guarantees penalties for most participants irrespective of measured performance, which is difficult to reconcile with genuine quality improvement (7,12,22). On innovation, the deep reductions to neurostimulation and advanced procedures (Table 4) blunt incentives to adopt evidence-based device therapies. On evidence-based care, the systematic devaluation of image-guided, guideline-supported interventional procedures relative to office E/M, may push practice patterns away from the very services that comparative-effectiveness guidelines endorse for appropriately selected patients (17,18,59-64). In short, the reforms are more consistent with short-term budget management than with a coherent theory of value.

Discussion

The CY 2027 Proposed Rule is best understood not as a discrete event but as the consolidation of a structural realignment begun in CY 2026. Four mechanisms operate together. First, the conversion factor declines because a temporary statutory increase expires, leaving the underlying no-inflation-update problem fully exposed. Second, the efficiency adjustment premised on productivity gains that empirical time studies contra-

dict remains embedded in the work RVUs that anchor procedural payment. Third, the practice-expense redesign, justified by the assumption that most physicians are hospital-employed, disadvantages independent proceduralists who practice in ASCs, which in fact, is less than 60% (64A). Fourth, the 2% Federal sequestration cut which applies to Medicare payments made by traditional Medicare and managed care. Plans continue in 2027 through 2032, from 2013. For interventional pain management, these mechanisms converge on the same population: independent physicians delivering guideline-concordant, image-guided procedures in ASCs. Thus, adoption of ASIPP's proposed modifier is crucial.

Layered atop the fee schedule is the mandatory Ambulatory Specialty Model. Whereas prior payment cycles reduced the price of interventional services, ASM introduces a second, orthogonal risk: financial accountability for the total cost of low back pain care, a pathway dominated by referrals and by disciplines outside the interventional pain physician's control. The model's redistribution and tournament features guarantee aggregate savings by construction, meaning that even measurable quality improvement does not protect a participant from net reductions. That design is difficult to reconcile with the statutory purpose of section 1115A models, which is to test whether payment innovation can preserve or enhance quality while reducing spending. Ironically, CMS will retain 15% of the revenue.

The counterargument deserves fair statement. CMS and some analysts contend that the CF reduction is small, that the office E/M increases benefit the many physicians who furnish predominantly cognitive care, that the efficiency adjustment corrects genuine historical overvaluation of procedural time, that OPPS-based PE benchmarking improves transparency relative to a stale 2008 survey, and that value models like ASM are necessary to bend the cost curve for high-spending conditions. Each point has merit in the abstract. But each also rests on an aggregate view that obscures distributional reality: the "small" CF cut compounds with two other reductions for proceduralists; the office increases do not reach physicians whose caseload is procedural; the efficiency premise is contradicted by the best available operative-time data; OPPS data carry their own inaccuracies; and ASM's savings guarantee is achieved by penalizing physicians who lack control over the spending being measured. A payment policy can be defensible in aggregate and still be inequitable in inci-

dence and it is the incidence that determines whether independent interventional pain practices survive.

Limitations

This analysis has several limitations. First, it evaluates a proposed rule; the final CY 2027 rule may modify the conversion factors, RVU values, PE methodology, or ASM parameters in response to public comment. Second, the payment figures are national allowed amounts that exclude geographic adjustment, the 2% sequester, and any potential 4% PAYGO reduction; actual local payments will differ. Third, the representative practice model in Table 5 relies on illustrative volumes and a specific office-and-ASC case mix; individual practices will experience different effects depending on payer mix, procedure distribution, and setting. Fourth, we did not model the interaction between fee-schedule changes and ASM adjustments at the individual-practice level, nor secondary effects on commercial contracts. Finally, several authors and source organizations are actively engaged in physician-payment advocacy. Although the analysis relies on publicly available payment data and cited literature, this perspective may influence the selection and interpretation of policy concerns.

Policy Implications and Recommendations

The goal of physician-payment policy should extend beyond the survival of independent practice to its revival, so that beneficiaries retain access to cost-efficient, guideline-concordant interventional care. Drawing on the analysis above and on recommendations from MedPAC, the CBO, and the OIG, we propose the following evidence-based measures, summarized in Table 7 (2,4,6).

1. **Adopt permanent, inflation-based annual updates.** Replace current-law updates with a permanent baseline update tied to the MEI, consistent with MedPAC's March 2026 recommendation (MEI minus one percentage point) and the AMA's call for inflation indexing. This is the single most important structural reform (5,26,28,29).
2. **Enact permanent physician payment reform rather than annual patches.** Build any relief into the baseline so that it compounds forward, ending the cycle of temporary fixes that expire and mechanically reduce the following year's CF the precise dynamic that produced the CY 2027 reduction.
3. **Eliminate or modify budget neutrality.** Raise or index the \$20 million threshold and exempt inflation updates from the offset, so that necessary revaluations do not force across-the-board reductions on procedural specialties (23,42,69).
4. **Reconsider the efficiency adjustment.** Suspend or repeal the recurring –2.5% efficiency adjustment pending empirical time studies; current operative-time data show times increasing, not decreasing (3,6,7).
5. **Protect independent physicians with a distinct payment identifier.** Adopt the modifier or identifier as submitted by ASIPP that distinguishes independent physicians from hospital-employed physicians so that PE reductions premised on hospital employment do not fall on independent proceduralists furnishing services in ASCs (3,4,17,56).
6. **Reduce administrative burden.** Streamline prior authorization, harmonize local coverage determinations, and curb inappropriate audit exposure to lower overhead, mitigate burnout, and return clinical time to patient care (3,12,51).
7. **Withdraw or make ASM voluntary and appropriately scoped.** Withdraw ASM pending evidence of effectiveness and validated appropriateness criteria; if retained, make it voluntary, include the primary-care and rehabilitative disciplines that manage low back pain longitudinally, exclude specialties without control over upstream spending, and remove the redistribution/tournament features that guarantee penalties (3,6,7).
8. **Provide specialty-specific and site-neutral corrections.** Where site-of-service differentials disadvantage independent physicians practice in ASCs and HOPDs for identical services, move toward genuine site-neutrality that does not simply channel volume to higher-cost hospital settings (45,46).
9. **Finance reform through Medicare Advantage integrity, not beneficiary or physician cuts.** ASIPP's non-partisan proposal identifies approximately \$120 billion in annual savings from correcting MA overpayments, favorable selection, risk-adjustment discrepancies, duplicative veteran coverage, and excessive rate increases, more than sufficient to fund permanent physician-payment reform, sequester relief, and telehealth continuity while improving program solvency (7,13-15,31).

Future Outlook

The trajectory of Medicare physician payment will be determined by whether Congress converts episodic relief into permanent, inflation-indexed updates. The June 2026 Trustees Report is unusually direct: absent

Table 7. Evidence-based policy recommendations.

Recommendation	Rationale / basis
Permanent inflation-based CF update (MEI or MEI – 1 point)	Ends the structural mismatch between practice-cost inflation and flat payment (MedPAC Mar 2026; AMA).
Permanent reform, not annual patches	Builds relief into the baseline; prevents expiring increases from mechanically cutting the next year's CF.
Eliminate or modify budget neutrality	Exempt inflation updates and raise/index the \$20M threshold so revaluations don't cut procedural specialties across the board.
Reconsider the efficiency adjustment	Empirical operative-time data show times increasing, not decreasing (Childers et al; STS).
Distinct payment identifier for independent physicians as proposed by ASIPP	Prevents PE reductions premised on hospital employment from falling on independent proceduralists in ASCs.
Reduce administrative burden	Streamline prior authorization, harmonize LCDs, and curb inappropriate audits to lower overhead and burnout.
Withdrawal or Make ASM voluntary and appropriately scoped	Withdraw or make voluntary pending evidence; if retained, include primary care/PT, exclude specialties without cost control, remove tournament/redistribution.
Genuine site-neutrality	Avoid channeling volume to higher-cost HOPDs; equalize without disadvantaging ASCs.
Finance via Medicare Advantage integrity	≈\$120B/yr in MA overpayment corrections can fund reform without beneficiary or physician cuts.

ASC, ambulatory surgery center; CF, conversion factor; HOPD, hospital outpatient department; LCD, local coverage determination; MA, Medicare Advantage; MEI, Medicare Economic Index; PE, practice expense; PT, physical therapy. Sources: (5,7,24,26,28,29,31,40,41).

legislative change, access to Medicare-participating physicians will become a significant long-term concern, with physician payment projected to fall to a fraction of private rates over the projection window (4). The physician workforce is aging, burnout remains elevated, and the pipeline of proceduralists willing to sustain the fixed costs of independent practice is thinning. If current policy persists, consolidation will continue, and interventional pain care will migrate toward higher-cost hospital settings, raising rather than reducing total spending.

Technological change cuts both ways. Artificial intelligence and digital health tools promise genuine efficiencies in documentation, scheduling, and image analysis, but their acquisition, integration, cybersecurity, and maintenance costs fall on practices without an offsetting payment update, and as the efficiency-adjustment debate shows their promised productivity gains can be turned into payment reductions before they materialize. Payment modernization should reward demonstrated value and evidence-based innovation rather than presuming efficiency and clawing it back. A sustainable payment framework should pair inflation-indexed baseline payment with value-based models that use validated outcomes and hold clinicians accountable primarily for expenditures and care processes they can reasonably influence. Whether the next several rulemaking cycles stabilize or further consolidate specialty practice will depend substan-

tially on whether these structural payment issues are addressed.

CONCLUSIONS

The CY 2027 Medicare Physician Fee Schedule Proposed Rule continues structural pressures facing independent interventional pain practices. The expiration of the temporary CY 2026 statutory increase lowers the conversion factor, while the previously implemented efficiency adjustment and practice-expense redesign continue to influence procedural payment. Most major IPM procedures experience additional proposed reductions, with selected services affected substantially more.

These payment changes occur as independent practices face rising operating costs and the implementation of the mandatory Ambulatory Specialty Model, which may hold interventional pain physicians financially accountable for components of low back pain spending that occur outside their direct control. Permanent inflation-based physician payment updates, reconsideration of procedural efficiency and practice-expense assumptions, appropriate recognition of independent physicians furnishing services in facility settings, reduced administrative burden, and better-aligned value-based models warrant consideration. Addressing these structural issues may be important not only for the sustainability of independent interventional pain practice but also for maintaining beneficiary access to lower-cost outpatient procedural care.

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