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Health Policy Review

Practice Expense, Site of Service, and the Survival of the Independent Interventional Pain Practices: With Medicare Policies Leading the Way

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Background: Practice expense (PE) accounts for approximately 45% of relative value units (RVUs) under the Medicare Physician Fee Schedule (PFS), yet it receives substantially less analytic attention than physician work. For interventional pain management (IPM), a specialty in which physicians frequently own the procedural suite, imaging equipment, and clinical infrastructure and employ the clinical and administrative staff, or perform surgical interventions in an Ambulatory Surgery Center (ASC) or hospital setting, PE is not merely an accounting abstraction but a major determinant of practice viability.

Objective: To examine how Medicare values practice expense, how the calendar year (CY) 2026 PFS final rule and CY 2027 proposed rule alter that valuation, and why the resulting site-of-service payment architecture produces outcomes for independent interventional pain physicians that are inconsistent with the stated policy rationale.

Study Design: Narrative health policy review with descriptive quantitative synthesis.

Setting: United States Medicare program; traditional fee-for-service Part B.

Methods: We reviewed the CY 2026 PFS final rule, the CY 2027 PFS proposed rule, published specialty-society analyses, peer-reviewed utilization studies of interventional techniques in the Medicare population, national practice-cost and physician-employment data, and relevant local coverage determinations. Payment, cost, and utilization trends were assembled and compared descriptively. No patient-level data were used, and no statistical inference was performed.

Results: Between 2001 and 2025, practice costs measured by the Medicare Economic Index (MEI) increased 59%, while inflation-adjusted Medicare physician payment declined approximately 33% across all specialties and approximately 41% in interventional pain management. Sequestration, applied to Medicare's share of each claim rather than to the fee schedule, further reduced realized revenue by approximately 1.6% for 13 of those 25 years. The CY 2026 final rule reduced indirect PE allocated per work relative value unit for facility services to 50% of the non-facility amount, producing an estimated 7% to 10% increase for office-based services and an estimated 8% to 11% decrease for services furnished in hospital outpatient departments (HOPDs) and ASCs, along with a 2.5% efficiency adjustment applied to non-time-based codes. Because ASCs and hospital outpatient facilities do not provide practice management support to independent physicians, this reallocation penalizes a substantial proportion of the independent physicians the policy rationale was intended to protect. Utilization of interventional techniques per 100,000 beneficiaries declined 16.8% between 2019 and 2024. Nationally, the proportion of physicians practicing in physician-owned practices declined to 18% by January 2026. However, the proportion of independent physicians remains above 40%, with approximately 70% of interventional pain physicians practicing independently.

Limitations: This is a narrative rather than a systematic review. Specialty-level payment impact estimates are aggregate projections and do not reflect an individual practice's case mix, payer mix, geographic adjustment, or site-of-service distribution. CY 2027 provisions are proposed and may change in the final rule.

Conclusions: The facility/non-facility binary serves as a proxy for a question it does not actually address: who bears the indirect cost of providing care. Aligning PE allocation with independent physician vs. hospital employed physician status through an independent-practice modifier would more faithfully advance the stated rationale of the CY 2026 rule than the current site-of-service distinction. An annual inflation update and modernization of the budget-neutrality threshold remain necessary preconditions for durable physician payment reform.

Key words: Practice expense, Medicare Physician Fee Schedule, relative value units, interventional pain management, site of service, ambulatory surgery center, indirect practice expense, budget neutrality, physician consolidation, health policy

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Discussion of Medicare physician payment tends to focus on a single number: the conversion factor. Each autumn, specialty societies calculate whether it has increased or decreased, and each winter, practices adjust accordingly. The conversion factor, however, is only the final term in the payment equation. The larger question of how Medicare determines what a service is worth is addressed earlier through the assignment of relative value units (RVUs). Within that assignment, the component that most directly influences whether an independent practice can remain financially viable is not physician work, but practice expense.

Practice expense (PE) represents approximately 45% of RVUs across the fee schedule (1,2). It is intended to capture everything required to deliver a service other than the physician's own time and judgment. In the office setting, these expenses include clinical staff in the procedure room, needles and contrast, the fluoroscope and its service contract, lead aprons and the dosimetry program, sterilization workflow, front desk personnel, schedulers, prior-authorization coordinators, billers, rent, and the electronic health record (EHR) license. For surgical procedures performed in Ambulatory Surgery Centers (ASCs) and hospital outpatient departments (HOPDs), many physician practice expenses remain, except those directly associated with the procedure suite, fluoroscopic equipment, supplies, and facility clinical staff. In contrast, for a hospital-employed physician, many indirect practice expenses are borne by the institution. Independent physicians continue to bear the costs of maintaining their practices, including the front desk, answering services, schedulers, prior-authorization coordinators, billers, medical records personnel, rent, electronic systems, and pre- and post-operative follow-up. These expenses represent a substantial portion of the difference between gross collections and physician compensation.

Interventional pain management occupies an unusual position within this payment architecture. It is a procedural specialty practiced substantially in office-based procedure suites, ASCs, and HOPDs (3-9). Coverage for many procedures is governed by local coverage determinations (LCDs) that have repeatedly narrowed the indications for core interventional techniques. Documentation, prior authorization, and appeal burdens are substantial; by the American Society of Interventional Pain Physicians (ASIPPs) estimate, approximately 30% of interventional pain physicians are under audit at any given time (3). It is also important to recognize that more than 70% of physician revenue may now be consumed by practice overhead, compared with approximately 30-40% a few years ago. The specialty is therefore particularly sensitive to changes in PE policy and provides an important measure of whether such policies are functioning as intended. In addition to increasing practice expenses, utilization patterns have demonstrated significant declines in interventional techniques since the COVID-19 pandemic, secondary to numerous factors related to the Affordable Health Care Act (ACA), the COVID-19 pandemic, LCDs, and medical policies (10-15).

The calendar year (CY) 2026 Physician Fee Schedule (PFS) final rule, issued October 31, 2025, made the most consequential change to PE methodology in more than a decade (4,5,16-18). It reduced the indirect PE allocated per work relative value unit for services furnished in facility settings to half the amount allocated for non-facility services, based on the stated rationale that paying both a physician and an institution for the same indirect costs is duplicative (17,18). Within a budget-neutral fee schedule, this reallocation shifts payment toward office-based practice. The rationale of avoiding duplicative payment is reasonable and has long been supported by organized medicine. However, its implementation relies on a facility versus non-facility classification that identifies where a service is performed rather than who actually bears the physician's practice overhead. For interventional pain physicians, these are fundamentally different questions.

This article examines the PE architecture, traces

the cumulative divergence between physician payment and practice costs, analyzes the CY 2026 and CY 2027 rules with particular attention to their specialty-level consequences, and argues that the site-of-service binary has become a central unresolved issue in payment policy for independent practices.

How Medicare Values Practice Expense

The Relative Value Architecture

Since 1992, Medicare has paid for physician services under a resource-based relative value scale. Each service is assigned three RVUs: work, practice expense, and malpractice. Each component is adjusted by its corresponding geographic practice cost index, and the adjusted values are summed and multiplied by a national conversion factor (1):

Payment = [(Work RVU × Work GPCI) + (PE RVU × PE GPCI) + (MP RVU × MP GPCI)] × Conversion Factor

Across all services, work accounts for approximately 51% of total relative value, PE approximately 45%, and malpractice approximately 4%; however, these proportions vary substantially by specialty and site of service (1,2). The substantial contribution of PE to total relative value is often overlooked because much of the public debate focuses on the conversion factor, which is a single scalar applied uniformly across services. PE, by contrast, is where the fee schedule differentiates among specialties and sites of service and, consequently, where significant differences in payment are created.

Direct and Indirect Practice Expense

PE is calculated through two distinct pools that are constructed using substantially different methodologies (Table 1). Direct PE comprises clinical staff time, medical supplies, and medical equipment directly attributable to a specific service. These expenses are determined from code-level input lists, including staff type and minutes and supply and equipment prices, derived largely from recommendations of the AMA/Specialty Society Relative Value Scale Update Committee (RUC). Because the underlying price files are updated on a multi-year cycle, direct PE may lag behind rapidly changing input costs, requiring practices to absorb the difference until revaluation occurs.

Indirect PE comprises the remaining costs of maintaining a medical practice, including rent and utilities, administrative and billing staff, information technology, professional liability, accounting and legal services, and general overhead. Critically, indirect PE is not measured directly at the code level. Instead, it is allocated to individual services using specialty-level practice expense per hour (PE/HR) survey data in combination with the service's work relative value units. The indirect pool represents the larger of the 2 PE components for many office-based specialties, and it is within this component that many of the methodological and payment policy disputes of 2026 and 2027 are occurring.

Two consequences follow. First, because indirect PE is allocated in proportion to work RVUs, any policy that reduces work RVUs, such as the CY 2026 efficiency adjustment, mechanically reduces the indirect PE allocated to the same service, thereby compounding the overall payment reduction. Second, because indirect PE depends on specialty-level survey data, the accuracy of the entire allocation methodology depends on the currency and quality of those data. Centers for Medicare and Medicaid Services (CMS) declined to use the American Medical Association (AMA) Physician Practice Information Survey (PPIS) to update PE relative values or Medicare Economic Index (MEI) weights for CY 2026

Table 1. *Direct and indirect practice expense under the Medicare Physician Fee Schedule.*

	Direct practice expense	Indirect practice expense
Components	Clinical staff time, medical supplies, and medical equipment attributable to a specific service	Rent and utilities, administrative and billing staff, information technology, professional liability, accounting and legal services, general overhead
Method of valuation	Code-level input lists specifying staff type and minutes, supply prices, and equipment prices	Allocated to codes using specialty-level practice expense per hour survey data together with the service's work RVUs; not measured at the code level
Principal vulnerability	Input price files refreshed on a multi-year cycle; the practice absorbs price increases until revaluation	Anchored to specialty survey data collected in 2007 or earlier; subject of the CY 2026 and CY 2027 methodology changes
Relevance to interventional pain	Additional rent for procedure suite, fluoroscopy equipment, contrast, needles, sterilization, radiation safety program	Office rent, scheduling, prior authorization and audit response, compliance with local coverage determinations

(17,19), leaving indirect PE allocation anchored to specialty cost data collected in 2007 or earlier. Ironically, CMS itself now cites the age of these underlying data as a rationale for replacing the existing methodology (18).

Historical Practice Expense Per Hour Calculation

The implementation of the AMA PPIS data resulted in a substantial shift in PE allocation, particularly benefiting independent interventional pain practices by separating interventional pain management from the traditional anesthesia crosswalks (Table 2).

CMS uses these indirect PE/HR baselines in conjunction with code-level allocations to calculate non-facility (office-based) and facility RVUs.

- Interventional Pain vs. Anesthesiology: Because Interventional Pain Management (IPM) ($156.79/hr) has a substantially higher baseline than Anesthesiology ($29.36/hr), an injection code attributed to the Interventional Pain specialty designation receives substantially higher indirect PE allocation than the same code attributed to Anesthesiology under the facility model (20).
- The "Zero Out" Rule: When these procedures are performed in a hospital or ASC, CMS substantially reduces or eliminates direct inputs, including clinical labor and supplies, because these resources are considered to be provided by the facility. Consequently, physician reimbursement is based on the lower facility RVU schedule.

Immediate Structural Risk: The CY 2027 Phase-Out

While CMS has maintained these AMA survey-based specialty baselines for well over a decade, this framework is now scheduled for substantial change. The CY 2027 Proposed Rule outlines a two-year phase-out of the Indirect Practice Cost Index (IPCI). CMS, using analyses developed with the RAND Corporation, is transitioning toward a methodology that eliminates specialty-specific averages, such as $156.79/hr for IPM compared with $29.36/hr for Anesthesiology. Instead, indirect allocations would be determined using standardized, code-level inputs, including Work RVUs, regardless of the specialty of the physician performing the procedure. Additionally,, under the mandatory CMS Ambulatory Specialty Model (ASM), scheduled to begin January 1, 2027, low-back-pain and interventional pain specialists in selected regions face payment adjustments of up to 9% based on cost-efficiency and outcome performance (21,22).

The Facility / Non-facility Differential

For a service furnished in a physician's office, Medicare pays a single non-facility rate reflecting the full range of resources required to provide the service. For the same service furnished in a HOPD or an ASC, the physician receives a lower facility rate because the institution bills separately under a different payment system for the facility resources associated with the encounter (18). The arithmetic difference between the two rates, therefore, represents Medicare's estimate of the practice expenses associated with providing the service in the physician's office.

The logic is coherent when the institution receiving the facility payment is genuinely distinct from the physician and also bears the physician's practice overhead.

However, as described repeatedly above, the present formula, which applies a 50% reduction in practice expense, is based on the flawed assumption that physicians performing procedures in ASCs or hospital outpatient settings do not continue to bear substantial independent practice expenses and are essentially

Table 2. Comparison of practice expense hourly rates across selected pain-related specialties under the finalized AMA PPIS rates.

Specialty Name	Old Baseline (Pre-PPIS Crosswalk)	AMA PPIS Finalized Rate (CMS Baseline)	Key Cost Impact Context
Interventional Pain Management	$59.04 / hr	$156.79 / hr	Largest Beneficiary: A nearly 165% increase driven by the high technical overhead of office-based fluoroscopy and sterile surgical equipment.
Pain Medicine	$59.04 / hr	$122.42 / hr	Reflects a blend of cognitive evaluation/management (E/M) overhead alongside specialized clinic procedure spaces.
Physical Medicine & Rehabilitation (PM&R)	Crosswalked	$102.50 / hr	Reflects dedicated floor space needs for therapy equipment, electrodiagnostic testing (EMG), and clinical support staff.
Anesthesiology	$19.76 / hr	$29.36 / hr	Lowest Hourly Overhead: Most anesthesia services are performed inside a hospital OR or ASC (facility setting), where the facility absorbs the operational overhead.

treated as hospital-employed physicians for purposes of PE allocation. ASIPP has advocated for the adoption of a modifier to distinctly identify independent physicians performing procedures in ASCs and hospital outpatient settings. This modifier would address the current payment losses of approximately 8-11% by providing a 10% increase in physician payments for these services (23,24).

The Cumulative Divergence Between Payment and Cost

All Physicians

The MEI was created in 1975 specifically to measure changes in physician practice costs and to inform annual Medicare payment updates (25). Since the Medicare Access and CHIP Reauthorization Act (MACRA) took effect in 2015, however, the MEI has not directly determined the annual payment update. Statutory updates are fixed by law at 0.75% for qualifying alternative payment model (APM) participants and 0.25% for all other physicians, rates established through statute rather than directly linked to measured increases in practice costs (25,26).

Between 2001 and 2025, the cost of operating a medical practice increased 59% as measured by the MEI, while Medicare physician payment remained approximately flat in nominal terms. When adjusted for practice cost inflation, Medicare physician payment declined approximately 33% over this period (26,27). However, the CMS projected MEI growth of 2.7% for CY 2026, substantially exceeds the statutory payment update (17).

Sequestration: A Separate and Additive Reduction

The 33% decline compares fee-schedule updates with practice cost inflation. It does not incorporate the Medicare sequester, which is separate from the fee schedule and not reflected in the conversion factor. Sequestration represents an across-the-board 2% reduction applied to Medicare payments, including payments under commercial Medicare plans, for each claim (28,29).

Sequestration took effect on April 1, 2013 under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012. It was suspended from May 1, 2020 through March 31, 2022 under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, as amended; reinstated at 1% from April through June 2022; and restored to the full 2% beginning July 1, 2022. Sequestration of Medicare benefit payments is currently extended through fiscal year 2032 (29). Table 2 summarizes this history.

Applied across the full period, sequestration further increases the cumulative inflation-adjusted losses beyond the approximately 33% decline in physician payment. Its significance is structural rather than merely numerical: it has reduced payment on nearly every Medicare claim for 13 of the past 25 years, compounds with other payment reductions, and remains invisible in the primary metric, the conversion factor, by which physician payment adequacy is conventionally evaluated.

Interventional Pain Management

Specialty-level experience diverges substantially from the national average. Manchikanti and colleagues estimate that interventional pain physicians experienced reimbursement reductions of approximately 41% between 2001 and 2025, approximately eight percentage points greater than the all-specialty decline (3-5). Figure 1 displays the three trajectories together.

Several mechanisms plausibly contribute to this decline. Interventional techniques are predominantly non-time-based procedural codes and have therefore been exposed to successive work RVU revaluations and, most recently, to the CY 2026 efficiency adjustment, from which time-based and evaluation and management (E/M) services are exempt (16,17). Fluoroscopic guidance has also been progressively bundled into the

Table 2. *Medicare sequestration applicable to physician payment, 2013 to 2032.*

Period	Reduction	Statutory basis and notes
April 2013 – April 2020	2%	Budget Control Act of 2011 and American Taxpayer Relief Act of 2012; first across-the-board Medicare payment reduction
May 2020 – March 2022	Suspended	CARES Act, as amended, during the COVID-19 public health emergency
April – June 2022	1%	Phased reinstatement
July 2022 – present	2%	Fully restored; sequestration of Medicare benefit payments extended through FY 2032
Effective revenue impact	2%	The 2% applies to Medicare's and Advantage Plans

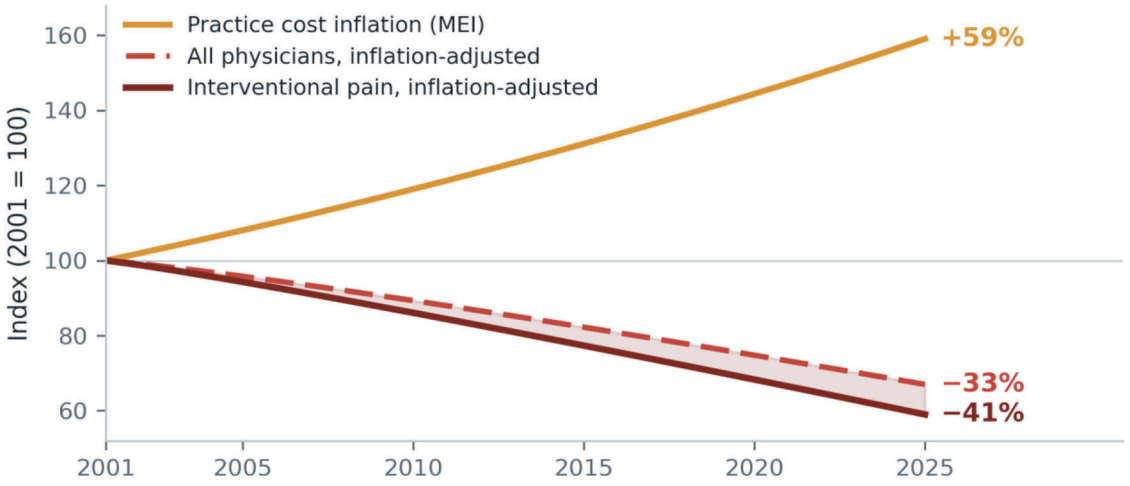


Fig. 1. *Cumulative practice cost inflation and inflation-adjusted Medicare payment, 2001 to 2025. Practice costs measured by the Medicare Economic Index rose 59% over the period. Inflation-adjusted Medicare physician payment declined approximately 33% across all specialties and approximately 41% in interventional pain management. Endpoint values are drawn from published analyses; intermediate-year values are smoothed and should not be read as year-specific estimates. Neither payment series incorporates sequestration.*

base procedure codes, eliminating separately reportable services without commensurate increases in the base code values (30). Further, because indirect PE is allocated in proportion to work RVUs, reductions in procedural work RVUs have also resulted in corresponding reductions in indirect PE, compounding the overall payment decline.

The CY 2026 Final Rule: A Rule That Cut In Both Directions

The CY 2026 PFS final rule took effect January 1, 2026 (16,17). For CY 2026, 2 conversion factors apply for the first time: $33.5675 for qualifying APM participants and $33.4009 for all others, representing increases of 3.77% and 3.26%, respectively, compared with the CY 2025 conversion factor of $32.3465 as shown in Fig. 2 (16,17). These increases were derived from three components: the statutory MACRA update of 0.75% or 0.25%; a budget-neutrality adjustment of approximately 0.49%; and a one-time 2.5% increase enacted through budget reconciliation legislation (3,17). The one-time 2.5% increase expires after CY 2026 and does not extend into CY 2027.

The Efficiency Adjustment

CMS finalized a negative 2.5% efficiency adjustment applied to the work relative value unit and corresponding intraservice physician time for non-time-based services, derived from a 5-year lookback at the productivity adjustment incorporated into the MEI. The adjustment exempts E/M services, care management, behavioral health, new codes, time-based codes, services on the Medicare Telehealth Services List, and maternity codes with an MMM global period. CMS intends to reapply the adjustment every 3 years (16,17).

CMS justified the adjustment on the premise that procedural services benefit from technological advances and standardized workflows that reduce physician time and resource utilization over time (17). Interventional pain procedures fall directly within the scope of this adjustment. However, the empirical basis for this assumption is questionable. Documentation requirements, prior-authorization processes, LCD-driven appropriateness requirements, and audit-related responsibilities have all expanded substantially over the relevant period, with little evidence that per-procedure resource utilization in small independent practices has declined to the extent assumed by CMS (3). ASIPP formally requested elimination of the adjustment on this basis (3,32-37).

The growing burden of medical documentation, particularly with the widespread adoption of EHRs, has

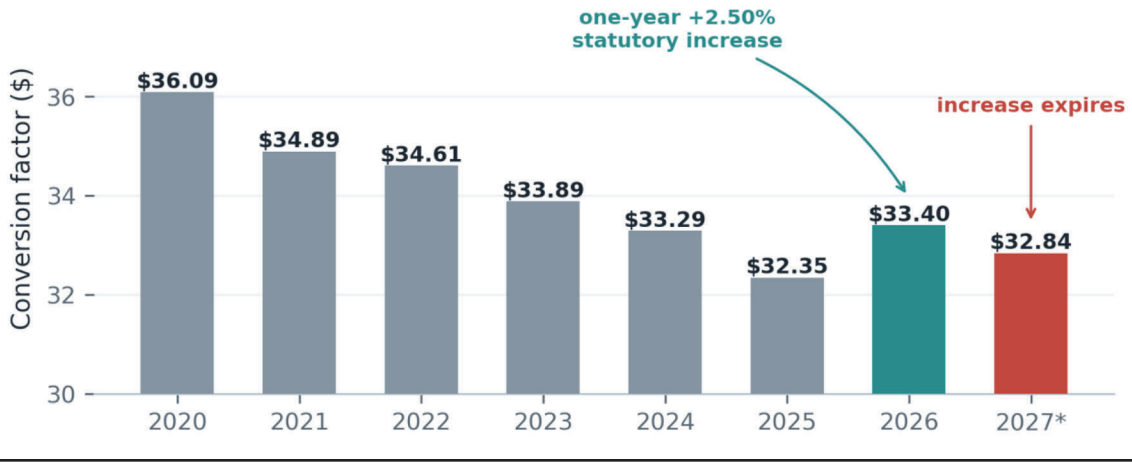


Fig. 2. *Medicare Physician Fee Schedule conversion factor, 2020 to 2027 (non-qualifying APM factor shown for 2026 and 2027). The CY 2026 increase derives substantially from a one-time 2.50% statutory increase enacted through budget reconciliation legislation, which does not extend into CY 2027. *CY 2027 value is proposed. APM, alternative payment model.*

contributed to physician burnout and decreased job satisfaction (39,40). The complexity of medical documentation, combined with time-consuming data entry and variable physician proficiency with electronic systems, has substantially reduced the time and attention available for direct patient care (41,42). The recent emergence of artificial intelligence (AI) in healthcare has been promoted as a potential solution to reduce documentation burden and improve clinical workflow efficiency (39,43). However, enthusiasm for AI often overlooks limited physician adoption, variable effectiveness, and the substantial costs associated with these technologies, which may approach $10,000-15,000 per physician annually. Recent literature also suggests that AI may provide only modest efficiency gains and, in some circumstances, may create additional work through the need for review and correction of generated documentation.

AI-assisted documentation also presents risks of omissions and hallucinations, creating a need for physician verification of generated content. In addition, a substantial training and adoption gap remains. A 2026 *JAMA* study (44) reported that only 32% of physicians used the AI tool in more than half of their visits. Infrastructure limitations represent another significant barrier. One health system report indicated that although 93% of health networks had implemented or developed third-party AI tools, 63% were still developing the fundamental IT and data infrastructure necessary to adequately support them.

Recent large-scale studies of medical documentation demonstrate a more nuanced reality. AI-assisted documentation tools may provide modest measurable efficiency gains, but they do not eliminate the administrative burden. A large multisite longitudinal *JAMA* study published in April 2026 (44), conducted by researchers at UCSF and Mass General Brigham, evaluated 8,581 ambulatory clinicians across 5 academic health systems. Adoption of an AI scribe was associated, on average, with 16 fewer minutes of documentation time and 13.4 fewer minutes of total EHR time during an 8-hour shift. Benefits were strongly associated with the frequency of use. Clinicians who used the AI scribe in 50% or more of patient visits saved approximately 27 minutes of documentation time per day. Importantly, however, after-hours EHR work did not decrease significantly overall. Instead, clinicians appeared to reallocate some of the time saved to other clinical responsibilities, including answering inbox messages, reviewing laboratory results, and modestly increasing patient visit volume.

A second study, a UCLA Health randomized clinical trial published in November 2025 (45), demonstrated a modest reduction in documentation time for individual notes of approximately 41 seconds, from 4.5 minutes to 3.8 minutes. The study also reported modest improvements in validated measures of physician burnout, cognitive workload, and work exhaustion. However, the time savings per note remained incremental rather than transformative.

Another study published in the New England Journal of Medicine in December 2025 (46) demonstrated that consultation duration did not decrease. Instead, physicians spent approximately the same amount of time with patients but appeared to shift their attention away from the computer screen and toward direct patient interaction.

Consequently, these studies demonstrate modest benefits in documentation efficiency but do not establish the substantial reductions in physician work or resource utilization that would support assumptions of broad procedural efficiency gains. These technologies also introduce additional costs that may approach $10,000-15,000 per physician annually. More importantly, 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 demonstrated stable or increasing intraservice times rather than systematic reductions. Childers et al (47), analyzing 1.7 million operations, reported increasing operative times across most evaluated procedures, while Society of Thoracic Surgeons data (48) 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 indicate that efficiency has not improved and that administrative demands have increased (3-5,48-52). In interventional pain management, efficiency may have declined by 30-40% as physicians and practices attempt to comply with continually changing documentation requirements associated with medical policies, LCDs, prior authorization, audits, and other regulations. Thus, penalizing physicians for presumed productivity gains that have not been adequately demonstrated, while administrative burden continues to increase, remains, in ASIPP's view, methodologically unsupported. For CY 2027, no additional efficiency reduction is proposed, but the CY 2026 reduction remains incorporated into the work RVUs that form the basis for 2027 payment. Consequently, following extensive advocacy, ASIPP submitted a request for a modifier at the request of CMS (1,3-5,53,54).

The Indirect Practice Expense Reallocation

CMS reduced the indirect PE allocated per work relative value unit for facility services to 50% of the amount allocated for non-facility services, whereas previously the allocation was equal across both settings (17). The change is budget neutral in aggregate and therefore redistributive, shifting payment from services furnished in facility settings toward services furnished in office settings (Table 3).

The stated rationale is that paying both a physician and an institution for the same indirect costs may result in duplicative payment, a principle organized medicine has advanced for years. Its adoption represents substantive recognition that a physician who owns and maintains the practice, staff, EHR, and related infra-

Table 3. *Practice expense provisions of the CY 2026 Physician Fee Schedule final rule and their relevance to interventional pain management.*

Provision	What CMS finalized	Relevance to interventional pain management
Indirect PE reallocation	Indirect PE allocated per work RVU for facility services reduced to 50% of the non-facility amount; budget neutral in aggregate	Favorable for office-based services; adverse for services furnished in ASCs and hospital outpatient departments
Efficiency adjustment	−2.5% applied to work RVUs and corresponding intraservice time for non-time-based services; five-year MEI productivity lookback; reapplied every three years	Applies to interventional procedures; E/M, care management, behavioral health, new codes, and telehealth-list services are exempt
AMA PPI Survey	Declined for updating PE relative values and MEI weights	Leaves indirect PE anchored to specialty cost data from 2007 or earlier
Conversion factors	$33.5675 (QP) and $33.4009 (non-QP), increases of 3.77% and 3.26%	Includes a one-time 2.5% statutory increase that expires after CY 2026
ASC payment system	4% update to ASC facility payments	Accrues to the facility payment; does not offset the reduction in the physician professional fee
Ambulatory Specialty Model	Mandatory five-year model for low back pain and heart failure beginning January 1, 2027	Payment adjustments of −9% to +9% from 2029; approximately 85% redistribution percentage

structure bears costs that may not be incurred directly by a hospital-employed physician. Consequently, it would be inaccurate to characterize the CY 2026 policy as uniformly adverse for independent physicians. The fundamental problem lies in the classification CMS uses to operationalize this principle, which is based on site of service rather than on who actually bears the physician's indirect practice expenses.

Specialty Impact By Site Of Service

Because interventional pain management is practiced across office, ASC, and hospital settings, the CY 2026 rule produces sharply divergent payment effects within a single specialty and, frequently, within the same practice. ASIPP's analysis of the final rule estimates approximately a 10% increase for office-based procedures and 7% to 10% for office E/M services; approximately an 11% decrease for services furnished in hospital settings; and reductions of 8% to 11% for services furnished by independent physicians in ASCs (3). The ASC payment system itself received a 2.6% update, but that increase applies to the facility payment and does not offset the reduction in the physician's professional fee (3). Figure 3 and Table 4 present these estimated impacts.

Site-of-service Mismatch

The CY 2026 reallocation rests on a central premise: when a service is furnished in a facility, an institution separate from the physician incurs and is separately reimbursed for the indirect costs associated with the encounter. Where this premise holds, such as for a hospital-employed physician practicing in a HOPD, the policy is defensible and arguably overdue. Where the physician remains independent and continues to bear the costs of maintaining the practice, however, the policy produces the opposite effect.

Medicare Payment Advisory Commission (MedPAC) has defined interventional techniques as "minimally invasive procedures including, percutaneous precision needle placement, with placement of drugs in targeted areas or ablation of targeted nerves; and some surgical

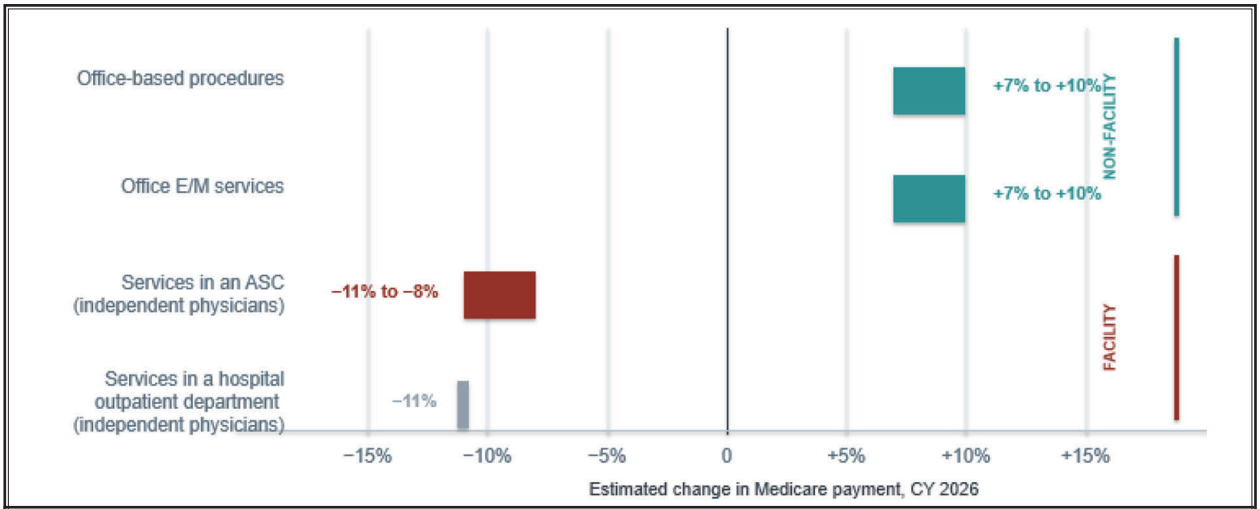


Fig. 3. *Estimated CY 2026 Medicare payment impact for interventional pain management by site of service. Estimates are specialty-level aggregate projections and do not reflect any individual practice's case mix or geographic adjustment. Independent physician-owned ambulatory surgery centers are classified as facility settings and receive the reduced indirect practice expense allocation. ASC, ambulatory surgery center; E/M, evaluation and management.*

Table 4. *Estimated CY 2026 Medicare payment impact for interventional pain management by site of service.*

Setting	Estimated impact	Who bears the indirect cost of the encounter
Office-based procedures (non-facility)	+10%	The physician practice
Office evaluation and management (non-facility)	+7% to +10%	The physician practice
Services in an ambulatory surgery center	−8% to −11%	
Services in a hospital outpatient department	approximately −11%	The hospital

techniques such as laser or endoscopic diskectomy, intrathecal infusion pumps and spinal cord stimulators, for the diagnosis and management of chronic, persistent or intractable pain" (55). Interventional techniques are performed across multiple settings, with ASCs accounting for approximately 30% of interventional techniques, HOPD settings accounting for 25%, and office settings accounting for over 45% (10-13). Of particular concern are independent physicians performing procedures in ASCs and HOPDs, who may experience revenue reductions of approximately 10%. In 2024, there were 6,394 Medicare certified ASC facilities across the United States, maintaining approximately 18,000 operating rooms. Of these ASCs, 52% are entirely physician-owned, 22% are physician-hospital joint ventures, 13% are physician-corporation partnerships, and 3% are physician-hospital-corporation combinations. Corporations, hospitals, and other alternative ownership arrangements account for approximately 10%. Further, 2,349, or 36.1%, of these facilities are dedicated to pain management, while pain management procedures are performed in approximately 36% of all facilities.

Thus, in interventional pain management, one-third of ASCs are owned and operated by the physician groups that practice in them (3). Such a center is not an institution that relieves the independent physician of practice overhead: centers including. Physician owners remain responsible for the lease, staff, sterilization services, imaging service agreements, accreditation and licensure costs, malpractice coverage, billing operations, and other administrative and operational expenses (Fig. 4). Classifying these physicians in the same facility category as hospital-employed physicians, and consequently reducing the indirect PE allocated to services they furnish, reduces payment to precisely the class of independent physicians who continue to bear the practice costs that the rule's stated rationale is intended to recognize.

The mismatch is not so much a drafting error as an artifact of a classification system designed for a different purpose. The facility/non-facility distinction was established to prevent duplicate payment across two separate payment systems, not to identify practice ownership or determine who bears the physician's indirect practice expenses. It therefore functions as a proxy for ownership and financial responsibility. For much of the fee schedule's history, this proxy may have been reasonably adequate. However, the substantial migration of procedural care into ambulatory settings has increasingly undermined its validity.

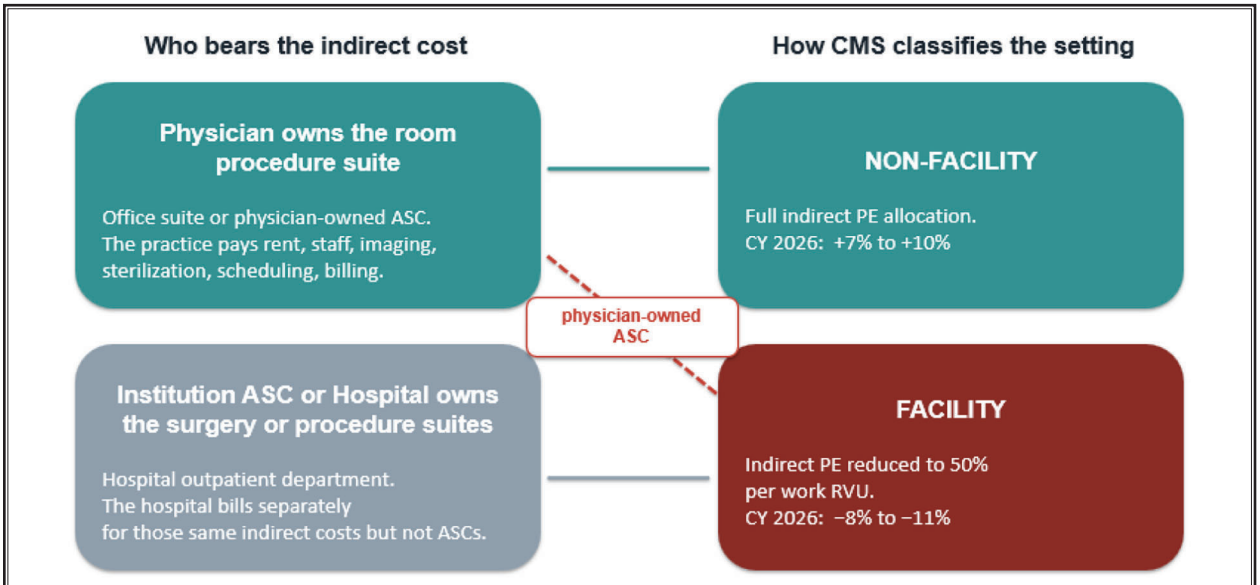


Fig. 4. *The site–setting mismatch. The CY 2026 indirect practice expense reallocation is premised on the assumption that a facility setting implies an institution, separate from the physician, that incurs and is separately paid for the indirect costs of the encounter. Where the ambulatory surgery center physician, that premise fails: the physician bears the indirect cost but the service is classified as facility and receives the reduced allocation. PE, practice expense; RVU, relative value unit; ASC, ambulatory surgery center.*

Two features compound the problem specifically for interventional pain management. First, a single practice commonly furnishes the same procedure in an office suite or an ASC depending on patient comorbidities, anticoagulation status, sedation requirements, anatomic complexity, and often with high co-pay and deductible considerations. Under CY 2026, the professional fee for the identical service may differ by approximately 20 percentage points depending on the site determined to be clinically appropriate. This creates a payment gradient that may run opposite to patient acuity: the higher-risk patient, appropriately treated in a more closely monitored setting, generates the lower professional payment. Second, ASC facility payments are themselves substantially lower than HOPD payments for the same procedures. Consequently, independent physicians experience the professional-side payment reduction without the higher facility-side payment available to hospitals. Compounding this is the fact that while the ASC does not provide or pay for the physician's practice management and indirect overhead, regardless of whether the physician is an owner or non-owner.

ASIPP has proposed a direct remedy: a modifier identifying services furnished by independent physicians, permitting indirect PE to be allocated according to independent practice status rather than site of service (23,24,31). Alternative approaches, including recognizing physician-owned ASCs as non-facility settings for purposes of indirect PE allocation or creating a distinct place-of-service code, could achieve similar objectives. We evaluate these approaches in Section 9.

The CY 2027 Proposed Rule

CMS issued the CY 2027 PFS proposed rule on July 14, 2026, with comments due September 14, 2026 (18). The proposed rule represents one of the most far-reaching restructurings of PE methodology to date and explicitly reopens the important question of site-of-service payment.

Conversion Factor

The proposed CY 2027 conversion factors are $33.1693 for qualifying APM participants and $32.8409 for all others, representing decreases of 1.19% and 1.68%, respectively (18). These reductions primarily reflect the expiration of the one-year statutory increase that supported the CY 2026 conversion factor. Absent additional legislation, current law results in a 2.50% reduction before application of other adjustments.

Practice Expense Methodology

CMS proposes to phase out the final step of the PE methodology that reconciles total PE RVUs by specialty to PE/HR data collected in 2007 or earlier, replacing it with a 'PE stabilizer' intended to mitigate short-term volatility without anchoring PE values to a fixed historical reference point (18). CMS describes this proposal as one component of a multi-year effort to move PE valuation away from AMA survey data toward more objective, routinely updated, and auditable cost data.

The overall direction is reasonable. Continued reliance on nearly two-decade-old specialty survey data is increasingly difficult to justify, and CMS appropriately recognizes that low response rates and methodological heterogeneity limit the reliability of these instruments. However, the principal risk for small specialties is distributional rather than conceptual. Any methodology replacing PE/HR anchoring will redistribute relative value across specialties, and specialties with fewer survey respondents and limited analytic resources may be poorly positioned to model, evaluate, and challenge the resulting payment effects before they are finalized.

The Site-Of-Service Comment Solicitation

Most consequentially for this discussion, CMS seeks comment on whether the site-of-service payment differential between facility and non-facility settings remains appropriate or whether an alternative approach should be used to account for indirect practice costs, particularly for physicians employed by a hospital, health system, or other entity (18). CMS also proposes to extend the CY 2026 site-of-service methodology to indirect PE for visits furnished during a Part A skilled nursing facility stay.

This solicitation represents one of the most important open issues in independent-practice payment policy and provides an unusual opportunity to address the limitations of the current methodology. CMS has directly raised the question that is central to this analysis. Any response should distinguish independent physicians from hospital-employed physicians and account for ASC ownership, the continuing indirect practice expenses borne by independent physicians, and the fact that independent physicians constitute more than 40% of physicians rather than approximately 20% as CMS hypothesized.

Other Provisions Relevant to Procedural Practice

- Same-day E/M with a global procedure. CMS pro-

poses paying the highest-valued service at 100% and each additional same-day procedure or E/M visit furnished by the same physician or practice at 50% (18). Interventional pain practices frequently evaluate and treat patients during the same encounter, a common and clinically appropriate pattern in this specialty. Practices should therefore model the potential impact of this proposal using their own encounter data.

- G2211 conversion to a modifier. The E/M complexity add-on would become a modifier increasing the associated base E/M payment by 16%, with a separate 32% modifier available only to Shared Savings Program and LEAD Model ACO participants (18).
- Global surgery data collection. CMS proposes to pause the data collection required by section 523 of MACRA while evaluating alternative approaches to valuing global surgical services (18).
- Sequester Cuts: The Medicare sequestration cut, which applies to Medicare and Medicare Advantage payments, will continue, resulting in an additional 2% reduction in revenue (4,5,9).

Utilization, Coverage, and Administrative Burden

Declining Utilization

Utilization of interventional techniques per 100,000 traditional Medicare beneficiaries declined cumulatively by 16.8% between 2019 and 2024, representing an average annual decrease of 3.6% (10-16). The steepest single-year decline occurred in 2020, when overall utilization of interventional techniques decreased by 18.7%. During the same period, utilization of epidural and adhesiolysis procedures declined by 19.0%, facet joint interventions and sacroiliac joint blocks by 17.5%, and disc procedures and other types of nerve blocks by 25.4% (14). Despite subsequent recovery from the initial impact of the pandemic, utilization did not return to pre-pandemic levels in the years that followed as shown in Fig. 5 and Table 5 (10-16).

Declining volume combined with declining unit payment creates a materially different financial problem than either factor alone. Fixed practice costs, including the lease, fluoroscopic equipment, and core staff, do not decline proportionately with procedural volume. Consequently, a reduction in procedures per beneficiary increases the fixed cost allocated to each remaining procedure at the same time that reimbursement for that procedure is declining. The causes of the utilization decline are multifactorial and are not solely economic; the pandemic, evolving evidence, coverage policies, and demographic changes all contribute (10). Regardless of the underlying cause, however, the financial consequence for a fixed-cost practice remains the same.

Local Coverage Determinations

Coverage policy for interventional techniques is established substantially through LCDs, which are issued by Medicare Administrative Contractors, adopted by many Medicare Advantage plans, and frequently incorporated into commercial medical policies (3). The facet joint intervention LCDs illustrate the volatility of these policies. Coverage effective May 2, 2021 was restricted in a manner that excluded therapeutic medial branch blocks; the policy was subsequently revised effective July 7, 2024 to include therapeutic facet joint nerve blocks along with intraarticular injections (32,33).

Further, the policy has been significantly tightened with respect to diagnostic blocks, subsequent radiofrequency neurotomy, and repeat procedures as shown in Fig. 6.

The epidural interventions policy was also issued in 2025 (34), substantially reducing the indications for epidural injections, limiting the frequency of procedures, and imposing heightened documentation requirements. In addition, the SI joint interventions policy was issued in 2023 (35). This policy not only increased documentation requirements but also established a non-coverage policy for sacroiliac joint nerve ablation. Finally, a peripheral nerve block policy was issued (36), which essentially eliminated coverage for numerous peripheral nerve blocks. However, following extensive opposition from physicians and patients (37), implementation of this policy has been placed on hold for now.

From a PE perspective, the relevant issue is not whether any particular coverage determination is appropriate, but that the compliance infrastructure required to meet these policies represents a real and growing indirect practice expense. Documentation templates, appropriateness attestations, appeal workflows, staff training, and continuous adaptation to changing coverage criteria require substantial physician and staff resources, yet these activities carry no relative value unit and generate no separately billable service. In addition, declining utilization patterns have been demonstrated across almost all interventional techniques except implantables (10-16).

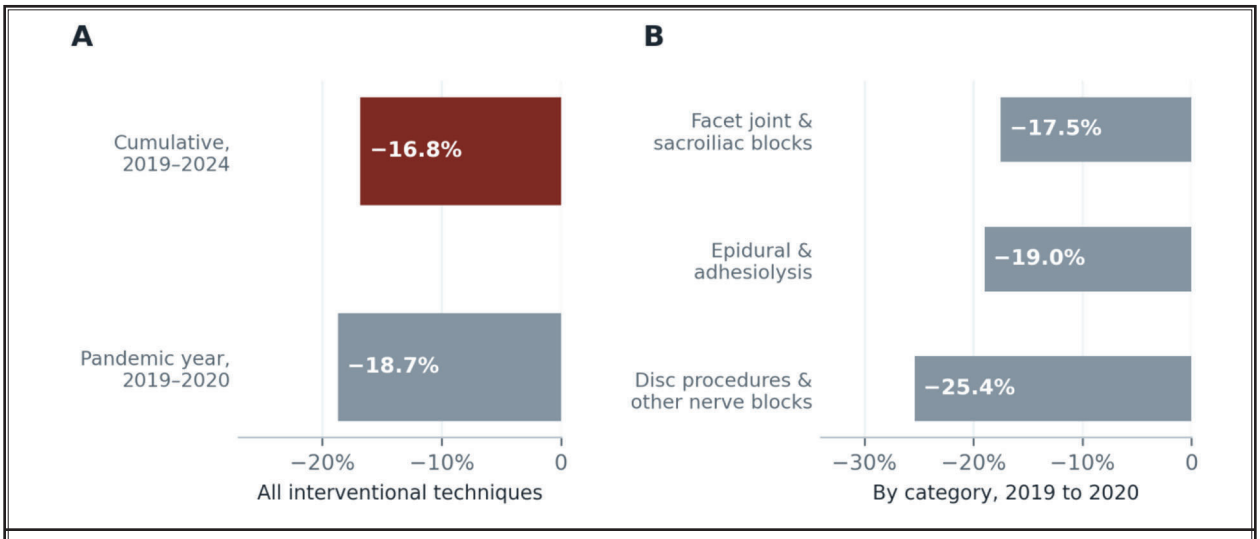


Fig. 5. *Utilization of interventional techniques per 100,000 traditional Medicare beneficiaries. (A) Cumulative change 2019 to 2024 and change during the 2020 pandemic year, all interventional techniques. (B) Change from 2019 to 2020 by procedure category. Only observed published data points are shown; intermediate years are not interpolated. Data describe traditional fee-for-service Medicare and exclude Medicare Advantage.*

Table 5. *Utilization of interventional techniques per 100,000 traditional Medicare beneficiaries.*

Measure	Change	Period
All interventional techniques, cumulative	−16.8% (−3.6% per year)	2019 to 2024
All interventional techniques, pandemic year	−18.7%	2019 to 2020
Epidural and adhesiolysis procedures	−13.1%	2019 to 2024
Facet joint interventions and sacroiliac joint blocks	−23.1%	2019 to 2024
Disc procedures and other types of nerve blocks	−26.9%	2019 to 2024

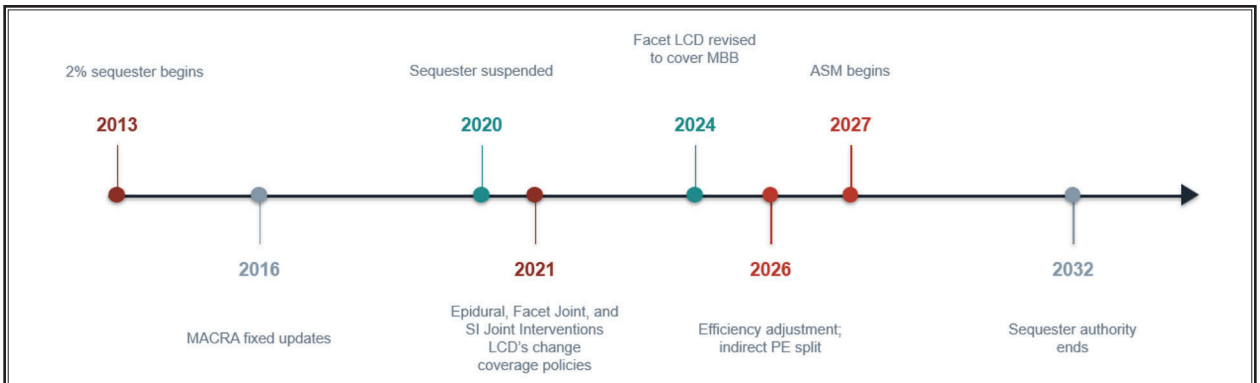


Fig. 6. *Timeline of Medicare policy changes affecting independent interventional pain practice, 2013 to 2032. LCD, local coverage determination; MBB, medial branch block; PE, practice expense; PE/HR, practice expense per hour; ASM, Ambulatory Specialty Model.*

Audit and Prior Authorization Burden

By ASIPP's estimate, approximately 30% of interventional pain physicians are under audit at any given time (3). Nationally, physicians report completing approximately 39 prior authorizations per physician per week, consuming roughly 13 hours of physician and

staff time, while 40% report employing staff who work exclusively on prior authorization (38). For a small practice, this burden may represent a full salaried position financed entirely from the indirect PE pool, a pool that CMS continues to allocate using survey data collected before prior authorization reached its current magnitude.

Table 6 summarizes the principal cost pressures affecting independent interventional pain practices. Figure 7 places several of these input-cost trends alongside the statutory PFS update, which is fixed by law at 0.25% for non-APM clinicians in CY 2027. The comparison is not strictly like-for-like because the input series are derived from different sources and time periods, and supply figures may reflect health-system purchasing. Nevertheless, the magnitude of the divergence is the central issue. A payment system whose annual statutory update remains substantially below its own

Table 6. *Selected practice cost pressures relevant to independent interventional pain practice, 2025 to 2026.*

Cost driver	Recent trend	Practice expense implication
Total overhead	Commonly 60% to 70% of practice revenue	A 2% payment reduction with 2% sequester cut, totaling 4% consumes a large share of the residual margin
Support staff	Salaries and benefits approximately 25% of revenue	Small practices compete for clinical and front-office staff against health systems and non-healthcare employers
Professional liability	Premiums rose for a seventh consecutive year in 2025; 39.9% of reported premiums increased across 36 states; 11 states saw at least one increase of 10% or more	Malpractice is approximately 4% of the RVU calculation and cannot absorb a double-digit premium year
Medical and surgical supplies	Approximately 8.2% average annual growth 2020 to 2025; 82% of health-system executives expect tariff-driven increases of up to 15%	Direct PE input files are refreshed on a multi-year cycle; increases are absorbed until revaluation
Imaging capital	Fluoroscopy C-arm purchase from approximately $150,000; rental from approximately $300 per day	A fixed cost that does not scale down as utilization per beneficiary declines
Administrative burden	Approximately 39 prior authorizations per physician per week, consuming approximately 13 hours; 40% of physicians employ dedicated prior-authorization staff; approximately 30% of interventional pain physicians under audit at any time	Pure indirect practice expense with no associated RVU and no billable code

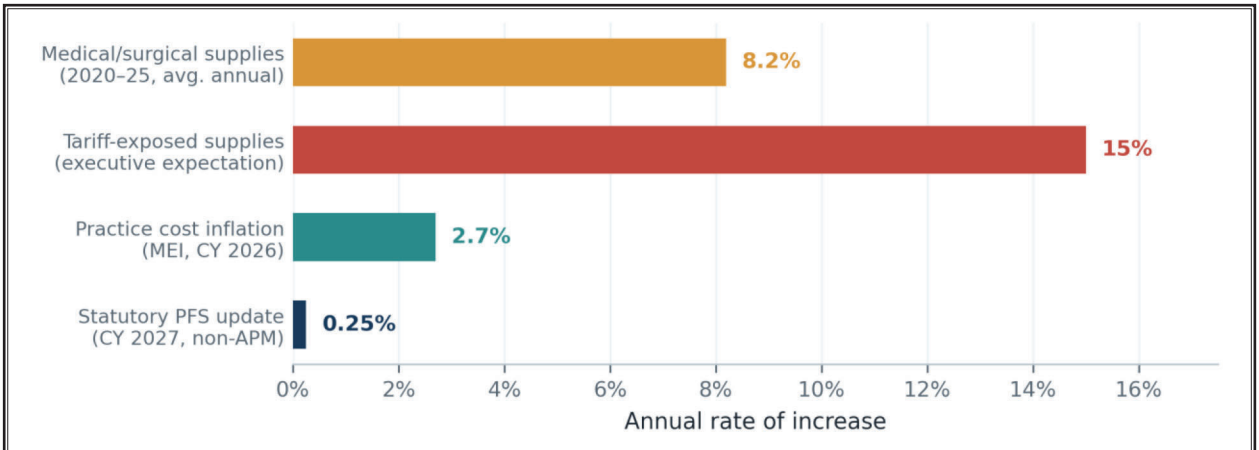


Fig. 7. *Selected practice input cost trends compared with the statutory Physician Fee Schedule update. Supply cost figures derive from health-system purchasing data and executive expectations under current tariff schedules and may not transfer directly to small-practice procurement. MEI, Medicare Economic Index; PFS, Physician Fee Schedule; APM, alternative payment model.*

measured practice cost index cannot, by design, adequately track increases in practice expense.

The Ambulatory Specialty Model

CMS is proceeding with the ASM, a mandatory five-year model beginning January 1, 2027 and continuing through 2031, with payment adjustments beginning in 2029 (5,22). The model targets low back pain and heart failure and applies to specialists including anesthesiology, pain management, neurosurgery, orthopedics, and physical medicine and rehabilitation, with payment adjustments ranging from –9% to +9% based on performance (3-5,22).

Two design features warrant particular attention. First, the model is mandatory rather than voluntary for included clinicians. Second, CMS intends to apply a redistribution percentage of approximately 85%, meaning that, unlike the Merit-based Incentive Payment System (MIPS), the model is not fully budget neutral among participants but is structured to generate net program savings through reductions in aggregate physician payments (3-5,22). ASIPP has requested that the model be eliminated or converted to a voluntary five-year trial (31). For a specialty that has already experienced an approximately 41% decline in real payment, the introduction of a mandatory model with substantial downside risk focused on its highest-volume condition represents a significant additional financial burden.

Consolidation as the Terminal Outcome

Sustained underpayment of PE does not necessarily result in immediate practice closure. More often, it drives the sale or acquisition of independent practices. When the fee schedule reimburses physicians at levels that do not adequately cover the costs of owning and operating the practice infrastructure, the economically rational response may be to relinquish ownership and transition to employment or corporate affiliation.

As of January 1, 2026, 82% of practicing physicians in the United States were employed by hospitals or corporate entities, leaving only 18% in physician-owned practices (56). The proportion of practices under hospital or corporate ownership increased from 29.8% in January 2018 to 63.9% in January 2026, representing an increase of 114.4% (56). During 2024 and 2025 alone, hospitals and corporate entities added approximately 48,100 physicians and acquired approximately 13,900 practices. Of the practices acquired, approximately 8,000 were acquired by corporate entities, including health insurers, private equity firms, and pharmacy chains (56).

Consolidation is not solely a response to increasing cost pressures; it is also driven by a payment differential that financially rewards consolidation. HOPDs have been paid approximately 247% more than physician offices for the same services on a volume-weighted basis, with payments two to four times higher for many identical outpatient procedures (57). Consequently, an acquired physician practice may generate substantially greater revenue for the same services when they are billed through a hospital system. This payment differential creates precisely the type of arbitrage that site-neutral payment policies are intended to address. CMS has begun narrowing this gap. The CY 2026 Hospital Outpatient Prospective Payment System (OPPS) rule extended site-neutral payment to drug administration services furnished in excepted off-campus HOPDs, with estimated first-year savings of $290 million. However, the policy remains limited relative to the magnitude and scope of the existing payment differential (58).

The ASC sector has experienced similar consolidation pressures from private equity and health systems (59). For interventional pain, the practical consequence is particularly significant: the independent physician-owned ASC, which the CY 2026 rule classifies as a facility and consequently subjects to reduced physician PE payment, is simultaneously an attractive acquisition target for corporate and health system buyers. Thus, the current payment structure places financial pressure on the independent physician-owned ASC while making the same facility increasingly attractive for acquisition, further challenging the long-term sustainability of independent practice as shown in Fig. 8.

Policy Options

The problems identified above operate at different levels of the payment system and therefore require different policy remedies. Table 7 summarizes the principal options, each of which is discussed below.

Align Indirect Practice Expense with Physician Employment

The most targeted remedy is to allocate indirect PE according to whether the physician is independent or hospital-employed. Two implementation approaches are available. A modifier identifying services furnished by independent physicians, as ASIPP has proposed, would require no change to existing place-of-service coding (31). Alternatively, recognizing physician-owned ASCs as non-facility settings for purposes of indirect PE allocation may

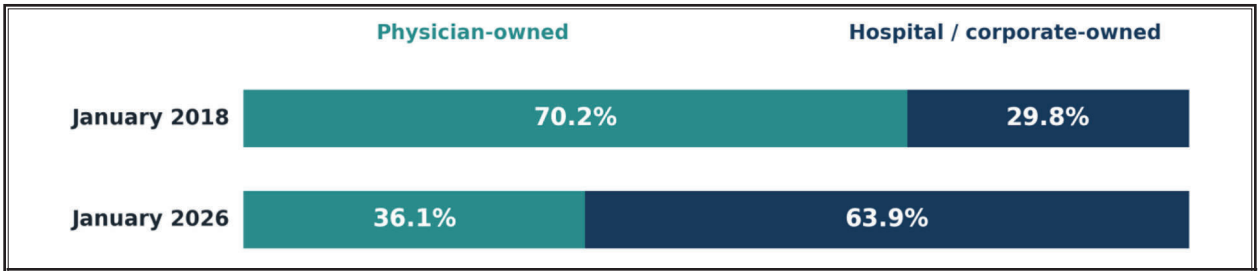


Fig. 8. *Share of United States physician practices by ownership, January 2018 and January 2026. The share of practices under hospital or corporate ownership rose from 29.8% to 63.9%, an increase of 114.4%.*

Table 7. *Policy options for aligning practice expense payment with the indirect costs actually borne by independent physicians.*

Option	Mechanism	Assessment
Independent-practice modifier	A modifier identifying services furnished by independent physicians, allowing indirect PE to follow ownership rather than site of service submitted by ASIPP	Most targeted; requires no place-of-service recoding; needs ownership verification and anti-abuse provisions
Non-facility treatment of ASCs	Treat ASCs as non-facility for indirect PE allocation	Conceptually cleanest; no additional expenses for CMS, as ASCs are Medicare certified
MEI-based annual update	Tie the annual PFS update to measured practice cost inflation, as for other provider categories	Foundational; without it, allocation reform redistributes a shrinking pool
Budget-neutrality threshold reform	Raise the $20 million threshold, unchanged since 1992, to approximately $54.3 million and index to cumulative MEI growth	Precondition for any targeted increase that is not financed by an across-the-board cut
Evidence requirement for efficiency adjustment	Require service-level evidence of efficiency gain before applying the adjustment	More likely to succeed than outright elimination; preserves CMS's underlying authority
Voluntary Ambulatory Specialty Model	Convert the mandatory model to a voluntary five-year trial	Generates the evidence base the model currently lacks; reduces asymmetric downside
Site-neutral payment expansion	Narrow the approximately 247% volume-weighted HOPD premium	The only option addressing the incentive for consolidation rather than its consequences

provide a more direct approach, but would require CMS to establish criteria for identifying and verifying Medicare certified ASCs and physician ownership.

Restore an Inflation-Based Annual Update

No allocation reform can be durable within a fee schedule whose aggregate annual updates are fixed by statute at levels below measured practice cost growth. Linking the annual update to the MEI, as Medicare already does for hospitals, skilled nursing facilities, and nearly every other provider category, represents a foundational reform (25,26). MedPAC has recommended linking physician payment updates to a portion of the MEI, such as MEI minus one percentage point (27). Without an inflation-based update, reforms to PE allocation merely redistribute an increasingly inadequate payment pool.

Modernize the Budget-Neutrality Threshold

If CMS projects that pricing changes will alter aggregate spending by more than $20 million in a year, it must offset the excess through adjustments to the conversion factor. This threshold was established in 1992 and has never been indexed for inflation; adjusted for inflation, it would be approximately $54 million today (60). Legislation has been introduced to increase the threshold to $54.3 million and index it to cumulative MEI growth every five years (60). Because the existing threshold can convert targeted payment increases into broader conversion factor reductions, modernization is

an important component of payment reform that seeks to avoid repeated zero-sum redistribution.

Reconsider the Efficiency Adjustment for Procedural Services

The efficiency adjustment applies a uniform productivity assumption across a heterogeneous group of services. Where measurable efficiency gains are documented, appropriate revaluation may be justified. However, when efficiency gains are inferred from an economy-wide productivity measure and applied to image-guided procedures performed by small practices facing increasing documentation, prior authorization, and compliance burdens, the assumption should be demonstrated rather than presumed. A more defensible approach than a uniform adjustment would require service-level evidence of actual efficiency gains before applying a reduction and would exempt services whose direct PE inputs have not been revalued within a defined period.

Convert the Ambulatory Specialty Model to a Voluntary Trial or Eliminate it

A mandatory model with an 85% redistribution percentage creates substantial downside risk for a specialty already experiencing significant payment reductions and increasing practice expenses. Converting the model to a voluntary trial would allow CMS to develop an evidence base regarding its clinical, operational, and financial effects before imposing mandatory participation. Alternatively, the model should be eliminated if its effectiveness and fairness cannot be adequately demonstrated (22).

Expand Site-Neutral Payment

Narrowing the HOPD payment premium would directly reduce the financial incentive for acquisition and consolidation. Among the reforms discussed here, expanded site-neutral payment most directly addresses the underlying payment differential that encourages consolidation rather than merely addressing its downstream consequences. This approach has also received bipartisan policy support (57,58).

Limitations

This is a narrative health policy review rather than a systematic review. Studies and documents were selected based on their relevance to the policy issues examined rather than through a prespecified systematic search protocol; consequently, the possibility of selection bias cannot be excluded.

Payment impact estimates require particular caution. Specialty-level projections published by CMS and specialty societies are aggregate estimates based on an assumed distribution of services. Individual practices may differ substantially from these assumptions. Actual payment impact depends on case mix, the proportion of services furnished in each setting, payer mix, geographic practice cost indices, and participation in alternative payment models. The estimates presented in Fig. 2 and Table 4 are derived from a specialty-society analysis (3) and should therefore be interpreted as directional estimates rather than forecasts for any individual practice.

The –41% estimate for interventional pain reimbursement (3,4) and the 33% all-specialty estimate (26,27) are derived from separate analyses using different methodologies and are not strictly comparable. They are presented together to illustrate the relative magnitude of payment erosion rather than to support a precise arithmetic comparison. Neither estimate incorporates sequestration, which is addressed separately. The cumulative index trajectories presented in Fig. 1 are anchored to published endpoints; intermediate-year values are smoothed and should not be interpreted as year-specific estimates.

Several cost inputs, notably medical and surgical supply cost growth and tariff exposure, are derived from health-system purchasing data rather than physician-office purchasing and therefore may not directly reflect procurement costs experienced by small independent practices. Utilization data are limited to traditional fee-for-service Medicare and exclude Medicare Advantage, which now covers a majority of Medicare beneficiaries; utilization trends in that population may differ materially.

Finally, all CY 2027 provisions discussed are proposed and remain subject to modification in the final rule. Accordingly, statements regarding their potential effects are conditional on the provisions being finalized as proposed.

Conclusion

PE represents nearly half of what Medicare pays for a physician service, and for the independent interventional pain physician, it is the component that may determine whether the practice remains financially viable. The CY 2026 final rule advanced an appropriate principle: a physician who bears indirect practice costs should be reimbursed for those costs. However, CMS implemented this principle through a facility/

non-facility classification that does not identify who actually bears the indirect costs. For a specialty in which the procedural practice and related infrastructure are frequently owned and supported by the physician, the result is that the intended benefit of the policy is withheld from a substantial proportion of the independent physicians it was designed to support.

CMS has now asked, in the CY 2027 proposed rule, whether the facility/non-facility differential remains appropriate. This is the appropriate question, and the specialty is particularly well positioned to respond with evidence rather than objection alone, including ASC ownership data, documentation of indirect practice costs, and the observed CY 2026 payment impact on independent physicians practicing in ambulatory settings. An independent-practice modifier would more accurately identify who bears these costs and would therefore advance the stated rationale of the CY 2026 rule more faithfully than the current site-of-service methodology.

That reform, however, would only redistribute payment within a pool whose overall size remains constrained by a statutory update that is not linked to actual practice cost growth and by a budget-neutrality threshold that was established in 1992 and has never been adequately modernized. Allocation reform without an inflation-based annual update and modernization of the budget-neutrality threshold may improve the fairness of distribution, but it does not address the continuing inadequacy of the overall payment pool. All of these reforms are necessary components of durable physician payment reform, and none is sufficient alone.

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