On behalf of the Board of Directors of American Society of Interventional Pain Physicians, we have submitted the following letter to CMS on Physician Payment Reform regarding CMS1832P

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September 11, 2025

Robert F. Kennedy, Jr.
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Mehmet Oz, MD
CMS Administrator
Centers for Medicare & Medicaid Services, Department of
Health and Human Services, Attention: CMS
1832
P, P.O. Box 8016,
Baltimore, MD 21244
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Re: CMS1832P Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Honorable Secretary Kennedy and Administrator Dr. Oz:

On behalf of the American Society of Interventional Pain Physicians (ASIPP), representing 49 state societies and the Puerto Rico Society of Interventional Pain Physicians, we thank you for your efforts to support independent physician practices. We respectfully submit the following comments regarding CMS1832P. Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program.

We appreciate CMS's efforts to modernize Medicare, reduce unnecessary spending, and improve chronic disease management. We commend the stated commitment by HHS Secretary Robert F. Kennedy, Jr. and CMS Administrator Dr. Mehmet Oz to support independent practices. However, several provisions in the proposed rule risk undermining that very goal.

The proposed changes—particularly related to work RVUs, practice expense allocations, telehealth and Ambulatory Specialty Model (ASM) could disproportionately harm independent physicians, exacerbate healthcare consolidation, limit patient access, and accelerate physician burnout. These changes come amid persistent challenges: rising practice costs, inflationdriven wage pressures, declining reimbursement, and increasing regulatory burdens.

Since 2001, physician reimbursement has declined by 33% (adjusted for inflation), not including the 2% sequestration cuts and looming 4% PAYGO cuts based on Congressional Budget Office report. This proposed rule compounds that strain, especially for specialties like interventional pain management, ophthalmology, gastroenterology, and orthopedic surgery which largely operate in ambulatory settings.

We urge CMS to revise the rule, beginning with a clear distinction between independent physicians and hospitalbased physicians. This could be accomplished through the use of a modifier, which would help prevent the broad 7% to 10% payment cuts applied to all procedures performed outside the office, such as those in ambulatory surgery centers and hospital outpatient departments, cuts from which independent physicians receive none of the benefits or perceived advantages outlined in the rule.

We strongly advocate:

1. Elimination of proposed efficiency adjustment, which is inappropriate, and efficiency is rather decreasing than increasing.

2. Due to escalating costs, practice expense cuts applicable to independent physicians need to be addressed.
3. Ambulatory Specialty Model (ASM) appears to be without any evidence and inappropriate putting independent physicians at high risk for survival; consequently, this should be eliminated or conducted voluntary trial for five years.
4. Telehealth services must be made permanent.

1. EFFICIENCY ADJUSTMENT TO WORK RVUS

CMS proposes a 2.5% reduction in the Physician Fee Schedule for nontimebased services, citing efficiency gains from EMRs and AI. However, technological improvements have not reduced administrative burdens. Independent physicians face:

- Complex prior authorizations
- Evolving Medicare coverage policies
- Increased audit risk (affecting nearly 30% of interventional pain physicians)
- Expanding documentation and compliance requirements

Additional concerns include CMS continuing these devastating cuts every 3 years, making it unsustainable for independent practices to survive.

In fact, the data from interventional pain management practices and others shows that instead of gains in efficiency, there have been significant drawbacks and reductions in efficiency.

To appreciate practice expense costs for independent physicians, costs of EMRs, AI, and administrative burdens have to be taken into consideration. As described above, independent physicians contend with complex prior authorizations, evolving Medicare coverage policies, growing audit risk with increased documentation and demands from all payer sources. It is difficult to survive for independent physicians and provide highquality care at a time expenses are skyrocketing and cuts are escalating. Nonphysician healthcare providers are striking for wage increases tied to inflation, rising practice costs, increased stress and causing burnout. The viability of private practices becomes questionable with declining morale of workforce. Medical inflation has consistently outpaced general inflation, with healthcare costs increasing by 121.3% compared to 86.1% rise in consumer goods and services.Costs of practice have increased 56% based on

[1] Rakshit S, et al. How does medical inflation compare to inflation in the rest of the economy? KFF, May 17, 2024. Accessed 10/23/2024.
https://www.kff.org/health costs/issue brief/how does medical inflation compare to inflation in the rest of the economy/#:~:text=Inflation%20in%20medical%20care%20prices%20and%20overall%20health,grew%20much%20more%20rapidly%20than%20in%20the%20past.

Medicare Trustees Reports from 2001 to 2025, while reimbursement for physicians have[1] decreased 33% and 41% for interventional pain physicians with supply costs soaring by 78% as shown in Figs. 1 and 2. One major source of the problem is that hospitals receive annual inflationbased updates while physicians do not. As shown in Fig. 2, Medicare updates to hospitals total roughly 80%, or 2.5% per year on average, since 2001, while physician payments remained essentially flat and decreased based on the inflation index.

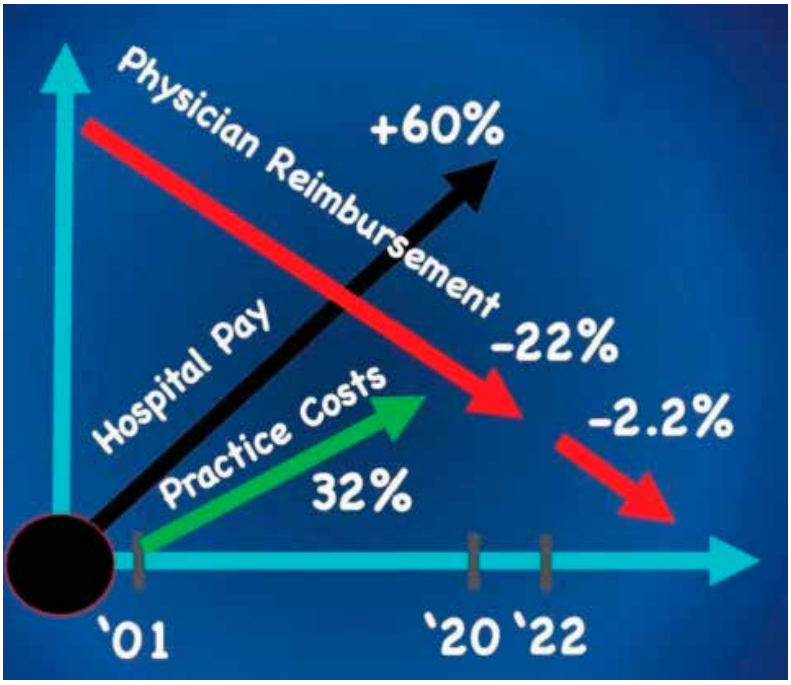

Fig. 1. *Comparison of declining physician reimbursement compared to practice costs and hospital reimbursement.*

Source: Green HA. The only four products of healthcare manufacture and produced with American patients. LinkedIn, January 14, 2023. https://www.linkedin.com/pulse/fourproductshealthcaremanufacturedproducedhowardagreenmd/

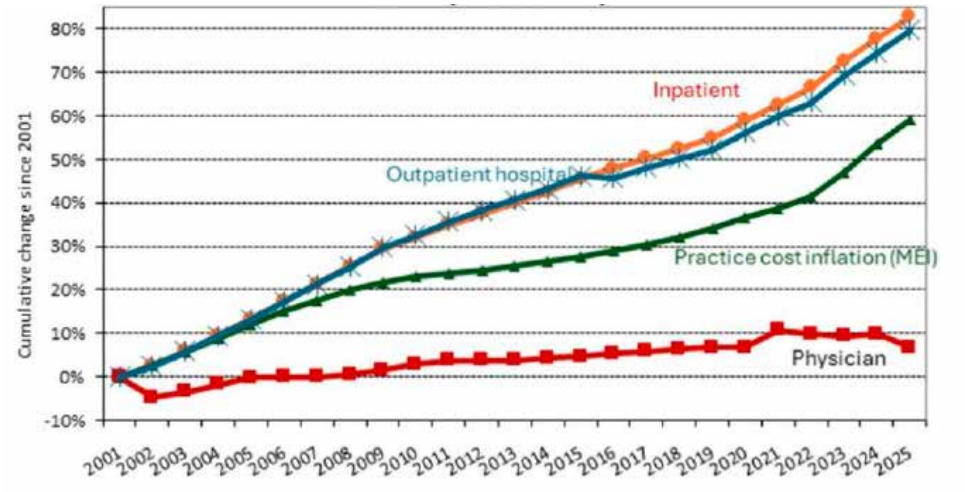

Fig. 2. *Medicare updates compared to inflation in practice costs (20012025).*

Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office

Consequently, we urge CMS to consider a separate modifier or reimbursement methodology for independent physicians in ASCs to avoid penalizing those who deliver costeffective outpatient care.

This adjustment fails to account for rising overhead and historic underpayment. We urge CMS to rescind the proposed efficiency adjustment and protect already strained practices.

For interventional pain physicians, these cuts have been particularly severe, as shown in Table 1. Physician payment rates declined by 41% from 2001 to 2025 and are projected to reach a 45% reduction with the new changes. However, there is some positive news—office payment rates have increased in 2026, reducing the overall loss from 42% (2001 to 2025) to 35% (2001 to 2026).[2]

Table 1. *Physician reimbursement rates for 2001, 2025, and 2026 (proposed), with percentage change compared to 2001.*

CPT	Description	Physician Payment Rates (In Facility)					Office Payment Rates				
		2001*	2025	Change	2026 (P)	Change	2001*	2025	Change	2026 (P)	Change
27096	Sacroiliac joint, arthrography	$139.88	$80.88	42%	$73.90	47%	$869.74	$159.16	82%	$176.68	80%
62310 or 62321	Cervical or thoracic interlaminar epidural	$169.65	$103.84	39%	$96.40	43%	$389.17	$251.04	35%	$278.80	28%
62311 or 62323	Lumbar or caudal interlaminar epidural injection	$138.50	$96.08	31%	$90.02	35%	$381.55	$246.83	35%	$275.77	28%
63650	Implant microelectrodes (Trial)	$794.26	$403.73	49%	$378.22	52%					
63685	Implant pulse generator	$922.38	$332.56	64%	$320.10	65%					
64470 or 64490	Cervical/thoracic facet joint injections	$171.05	$102.23	40%	$95.06	44%	$409.26	$186.34	54%	$206.91	49%
64475 64493	Lumbosacral facet joint nerve	$130.19	$88.32	32%	$81.62	37%	$364.93	$172.10	53%	$191.46	48%
64479	Cervical/thoracic transforaminal epidural injections	$204.96	$126.81	38%	$117.23	43%	$441.98	$256.21	42%	$287.19	35%
64483	Lumbosacral transforaminal epidural injections	$177.27	$107.73	39%	$100.43	43%	$411.32	$236.16	43%	$267.04	35%
64622 or 64633	Cervical/thoracic radiofrequency thermolysis	$291.54	$186.66	36%	$174.67	40%	$486.11	$420.55	13%	$468.92	4%
64626 or 64635	Lumbar/sacral radiofrequency thermolysis	$303.30	$186.28	39%	$174.33	43%	$515.89	$416.99	19%	$462.20	10%
	Average			41%		45%			42%		35%

* 2001 inflation adjusted payment rate: **$1.00 in 2001 is equivalent to $1.81 in 2025**
Change – Percentage of change from 2001

2. PRACTICE EXPENSE RVU ALLOCATION DETRIMENTAL TO INDEPENDENT PHYSICIANS

CMS proposes changes to how indirect practice expenses are allocated in facility settings. These adjustments would significantly reduce payment for procedures performed in Ambulatory Surgery Centers (ASCs), which are often owned and operated by independent physicians. Unlike hospitalemployed providers, independent physicians bear the full cost of care—regardless of site of service.

[2] Manchikanti L, Sanapati MR, Pampati V, et al. Physician payment reform in interventional pain management: Balancing cost, quality, access and survival of independent practices. *Pain Physician* 2025; in press.

As shown in Tables 1 and 2, interventional pain management procedures are subject to disproportionate cuts:

Table 2. *Changes in reimbursement for interventional procedures for independent physicians.*

Changes from 2025	InOffice procedure	Physicians pay in ASC or Hospital
Epidurals with fluoro	+ 11%	– 6.3% to 7.2%
Transforaminal epidural	+ 12%	– 6.8% to 7.6%
Facet– joint injections	+ 10.5%	– 7.0% to 7.6%
Radiofrequency neurotomy	+ 10%	– 6.4%
Spinal cord stimulation trial (63650)	+ 12.7%	– 6.3%
Spinal cord stimulation implant (63685)		– 3.7%

+ = increase

– = decrease

Payment reductions—averaging 33% for overall physician services, and often higher for surgical and procedural specialties—have been reported for interventional pain management, orthopedics, ophthalmology, gastroenterology, and oropharyngeal services. Interventional pain management have experienced more extreme cuts than some of the other specialties with 41% for physician payments from 2001 to 2025 leading up to 45% reductions from 2001 to 2026.[2] Consequently, the practice expense RVU allocation will impose an additional 4% to 6% reduction, compounded by a 2.5% efficiency adjustment, leading to total cuts of 7% to 9%.

It is also important to note that, contrary to the assumption that 80% of physicians are employed by hospitals, the actual figure is closer to 55%. As of 2022, and despite subsequent changes in 2023 and 2024, approximately half of physicians are still independent, not the 20% often cited.

As shown in the enclosed publication and supporting references, nearly 40% to 50% of physicians remain independent.Of these, an estimated 30% provide services in ambulatory surgery centers and hospitals. Major specialties delivering these services outside of their offices include ophthalmology, interventional pain management, gastroenterology, orthopedic surgery, otolaryngology, and others. These specialties account for a substantial share of total surgical volume and nearly all ambulatory surgical procedures.[3]

Unfortunately, while CMS proposes cuts for practice expenses of hospitalbased physicians with an impression that the majority of the physicians are hospitalbased, it applies to all independent physicians, which at the present time, are over 40% when they provide services in an ASC or hospital setting. It is difficult for independent physicians to provide high quality care at a time when nonphysician healthcare providers are striking for wage increases tied to inflation, rising practice costs, increased stress and causing burnout. The viability of private practices becomes questionable with declining morale of the workforce.[4,5]

[3] Popover JL, Jones T, Kalathia C, et al. Physician employment in America: Private practices dominate despite increased hospital employment. *JSLS* 2025; 29:e2025.00012.

[4] Manchikanti L, Hubbell III PJ, Pasupuleti R, Conn A, Sanapati M. Non partisan proposal for reforming physician payment system and preserving telehealth services. *Pain Physician* 2025; 28:E329 E335.

[5] Manchikanti L, Sanapati MR, Hubbell III PJ, et al. Escalating growth of spending on Medicare Advantage (MA) plans: Save Medicare from insolvency and balance the budget. *Pain Physician* 2025; in press.

ASIPP has published and submitted to Congress a nonpartisan proposal for reforming physician payment system in preserving telehealth services . The proposal is based on escalating Medicare Advantage costs nearly $100 billion annually, and additional funding through annual premiums of $198 billion from all Medicare beneficiaries, amounting to roughly $13 billion per year. Further, Medicare Advantage insurers have been basically abusing the system with extensive copays, deductibles, and denials without following Medicare coverage policies. CMS announced on January 10, 2025, that Medicare Advantage plans will receive a 4.3% payment increase for 2026, totaling $21 billion. To add fuel to the fire, CMS on April 7, 2025, issued a final rule of increasing on average by 5.06% from 2025 to 2026. Table 3 shows the proposal we have submitted.

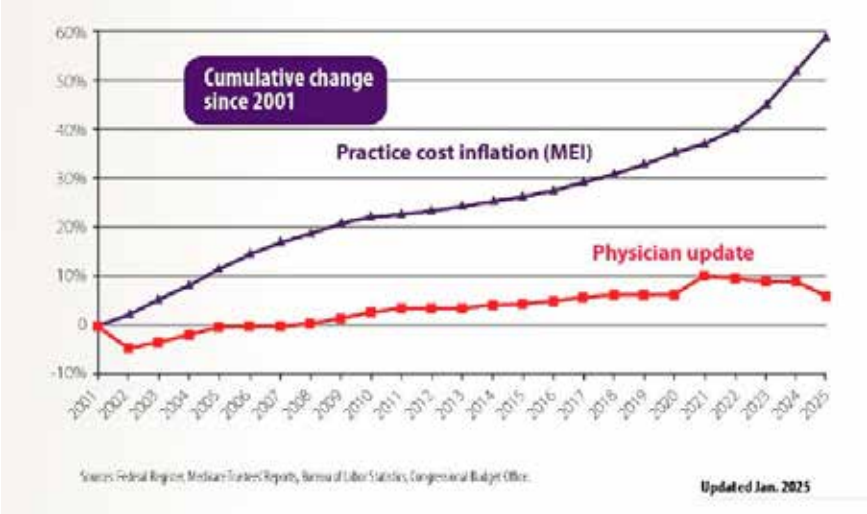

Fig. 3. *Medicare updates compared to inflation in practice costs (20012025).*

Source: American Medical Association https://www.amaassn.org/system/files/2025medicareupdatesinflationchart.pdf

Table 3. *A nonpartisan proposal for budget reconciliation over 10 years.*

SAVINGS
Savings from Medicare Advantage Plans: $1.2 trillion
Costs of Physician Priorities
• Reforming Physician Payment System: $240 billion • Elimination of Sequestration Cuts: $62 billion • Extension of telehealth services: $20 billion **Total Costs of Proposed Policy Changes: $322 billion**
Proposal for Physician Payment Reform
Savings from Medicare Advantage Plans: $1.2 trillion **Total Savings: $1.2 trillion** Physician Reform Costs: $322 billion **Net Savings: $878 billion**

3. Ambulatory Specialty Model (ASM)

CMS has proposed the Ambulatory Specialty Model (ASM) to hold specialists financially accountable for managing chronic conditions in Original Medicare, focusing on low back pain and congestive heart failure. The model begins January 1, 2027, and runs through 2031, with payment adjustments starting in 2029.

Specialists—including anesthesiology, pain management, neurosurgery, orthopedics, and PM&R—would face payment adjustments from –9% to +9%, based on performance in disease management, adherence to clinical guidelines, and care coordination. However, CMS plans to use a "redistribution percentage" of 85%, ensuring Medicare savings by reducing total physician payments, unlike MIPS or the Hospital VBP program.

Concerns include:

- Exclusion of primary care, chiropractic, and physical therapy providers from low back pain management.
- Unclear definitions of roles (e.g., anesthesia services outside specialist control).
- A "tournament" payment structure that penalizes most physicians, even with quality improvements.
- Higher penalties than MIPS and hospital programs, with mandatory participation for 25% of specialists.

We believe that ASM is inappropriate, lacks supporting evidence, and should be voluntary rather than mandatory.

4. TELEHEALTH CONTINUITY

We support the bill introduced by Reps. Buddy Carter (RGA) and Debbie Dingell (DMI). CMS's continued efforts to expand telehealth; however, the proposed rule does not guarantee telehealth flexibilities beyond 2025. A longterm commitment to telehealth is essential, especially for chronic pain patients in rural or underserved areas. We request CMS explicitly extend telehealth coverage through 2026 and beyond.

RECOMMENDATIONS

To protect patient access and preserve the viability of independent practices, we respectfully request that CMS:

1. Rescind the 2.5% efficiency adjustment to work RVUs. Drop the plan for continued devastating cuts every 3 years.
2. Develop separate reimbursement methodology and identify with a modifier for independent physicians in facility settings.
3. Ensure permanent access to telehealth services beyond 2025.
4. Differentiate payment policies for hospitalemployed vs. independent physicians.
5. ASIPP proposes that CMS preferably withdraw ASM implementation until evidence is developed and appropriateness criteria are utilized

These revisions are critical to maintain access to highquality care, reduce longterm costs, and prevent further consolidation in healthcare—where costs can increase by 200% to 300%.

BACKGROUND

Established in 1998, ASIPP is a nonprofit professional organization that currently boasts a membership of over 4,500 interventional pain physicians and other practitioners. Its mission is to promote safe, appropriate, fiscally neutral and effective pain management services for patients nationwide who grapple with chronic and acute pain. The United States is home to approximately 8,500 proficient physicians with the requisite training and qualifications in interventional pain management. ASIPP is composed of 48 state societies of Interventional Pain Physicians, encompassing Puerto Rico, and includes the affiliated Texas Pain Society.

Interventional pain management is defined by the National Uniform Claims Committee (NUCC) as, "the discipline of medicine devoted to the diagnosis and treatment of pain related disorders principally with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment" http://www.cms.hhs.gov/transmittals/Downloads/r1779b3.pdf

The Medicare Payment Advisory Commission (MedPAC) defined interventional pain management 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 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". https://permanent.fdlp.gov/lps21261/dec2001PainManagement.pdf

We appreciate your leadership and commitment to improving Medicare. Please do not hesitate to contact us for further input or clarification.

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