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September 8, 2026

The Honorable Mehmet Oz, MD
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016, Baltimore, MD 21244-8016

RE: Protecting Medicare beneficiary access to non-opioid interventional pain care and elimination of independent practices — CY 2027 Payment Policies Under the Physician Fee Schedule (CMS-1848-P) Proposed Rule

Dear Administrator 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, and the Society of Interventional Pain Management Surgery Centers (SIPMS), we appreciate the opportunity to comment on the CY 2027 Physician Fee Schedule (CMS-1848-P) proposed rule. Interventional pain physicians furnish the image-guided, non-opioid procedures that keep Medicare beneficiaries with chronic pain functional and out of the operating room. Inflation-adjusted Medicare payment for these services has fallen approximately 41% from 2001 to 2025 and is approaching 47% in 2027, and utilization per 100,000 traditional Medicare beneficiaries declined 16.8% between 2019 and 2024. The CY 2027 rules would compound that decline. We write to raise five concerns that together threaten the survival of independent interventional pain practices and beneficiary access to office- and facility-based pain care.

1. The Ambulatory Specialty Model (ASM)

The most important aspect is make or break of survival of independent practices. The ASM becomes mandatory on January 1, 2027, sweeping interventional pain physicians into two-sided risk of up to ±9% with no opt-out, no historical benchmark data, and an "excess utilization" measure that remains undefined months before performance begins. Unlike MIPS, the model is not budget neutral: CMS redistributes only 85% of the at-risk pool to clinicians and retains 15% as guaranteed program savings, so average performance produces a payment reduction by design. Worst of all, Medicare Advantage and other payers will adopt reduced payment.

We ask CMS to: withdraw or substantially redesign the ASM, and at minimum to:

- Convert the ASM to a voluntary model for an initial five-year period, or provide a voluntary on-ramp before mandatory participation begins;
- Set the redistribution percentage at 100% so the model is budget neutral among participants and functions as a performance program rather than a payment reduction;
- Exempt low-volume and small practices below a defined threshold, consistent with the low-volume threshold already used in the Quality Payment Program;
- Calculate the cost based on office, ASC, or hospital-based practices;

- Publish attribution, risk adjustment, and measure specifications, and provide a dry-run reporting period with practice-level feedback reports before any payment adjustment is calculated; and
- Delay the first payment adjustment until at least two full performance years of validated data are available to participants.

2. A separate modifier identifying facility-based services furnished by independent physicians

Medicare pays physicians less for services furnished in a facility on the premise that a separate institution bears the overhead of the encounter based on miscalculation. That premise holds for a hospital outpatient department. It fails for an ambulatory surgery center. This resulted in almost a 10% cut when independent physicians (overall 40%, IPM 70%) work in ASCs or HOPDs. Establishing the modifier is within CMS's existing HCPCS authority, requires no statutory change, and commits the agency to no payment change — it simply creates the instrument. ASIPP has also developed draft statutory language adding a new subsection (s) to Section 1848 of the Social Security Act (42 U.S.C. 1395w-4) increasing professional payment for services billed with the modifier by 10 percent, with facility fees unaffected, budget neutrality preserved, and verification, audit authority, and civil monetary penalties for knowing misuse.

3. Compounding Reductions to Interventional Pain and Facility-Based Services

These proposals do not fall in isolation. Beyond the conversion-factor reduction discussed below, several elements of the CY 2027 Physician Fee Schedule rule compound the impact on interventional pain management services. First, CMS proposes to phase out the Indirect Practice Cost Index and reduce reliance on specialty-specific practice-expense-per-hour data. Because interventional pain procedures carry substantial imaging, supply, medication, and staffing costs, the new methodology risks understating the true cost of furnishing these services. Second, CMS continues to apply and extend the site-of-service payment differential finalized in the CY 2026 final rule, which lowers professional payment for services furnished in ambulatory surgical centers and hospital outpatient departments. Many interventional pain procedures are appropriately performed in those settings for patient-safety reasons; reducing professional payment there penalizes the higher-acuity, image-guided care that belongs there. Third, CMS proposes to pay only the higher-valued service at 100%, and each additional service at 50%, when a separately identifiable E/M visit is furnished on the same day as a 0-, 10-, or 90-day global procedure. Interventional pain physicians routinely furnish a distinct, medically necessary E/M service alongside a procedure, and this proposal undervalues that legitimate work.

We ask CMS to: publish an interventional-pain-specific impact analysis (including common epidural, facet, medial-branch, and radiofrequency ablation services); narrow the same-day E/M reduction so that distinct E/M services remain fairly valued; and ensure the practice-expense and site-of-service policies do not understate the cost of office- and facility-based interventional care.

4. A Conversion-Factor Reduction at a Time of Rising Practice Costs

For CY 2027, CMS proposes a qualifying-APM conversion factor of $33.17 (down about 1.19% from $33.57) and a non-qualifying conversion factor of $32.84 (down about 1.68% from $33.40). Despite modest statutory updates and a positive budget-neutrality adjustment, these are net cuts, driven principally by the expiration of the temporary 2.5% increase Congress provided for CY 2026 under Public Law 119-21. The reduction arrives as practice costs continue to outpace Medicare updates: physician payment has persistently lagged the Medicare Economic Index (MEI), while interventional pain practices absorb rising costs for clinical staff, supplies, imaging equipment, and compliance.

We ask CMS to: use all available authority to mitigate the reduction and to support a permanent, MEI-based annual update.

We respectfully urge CMS to adopt the changes above in the final rules. We would welcome the opportunity to meet with you or your staff, and we are glad to provide claims-level data or clinical input at any time. These changes would help preserve independent practices and maintain beneficiary access to non-opioid interventional pain care.

Thank you for your consideration.

Respectfully,

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