American Society *of* Interventional Pain Physicians®

"The Voice of Interventional Pain Management"

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Re: Medicare Physician Fee Schedule Damages Independent Practices

Thank you very much for your interest. We hope your efforts are progressing well. We need changes and answers, as the issues we are facing continue to grow more complex and the cuts are becoming increasingly significant.

Although the administration continues to state that it does not intend to increase payments to insurers, the recent proposed adjustment—from 4.3% under the Biden administration to 7.2%—appears to contradict this position. This change represents an additional $35 billion flowing to Medicare Advantage plans in 2026 compared to this year. For context, payment increases were 3.7% in 2025 and 3.3% in 2024.

It appears that our phone calls and letters are not eliciting an appropriate response. We hope you will call for a hearing and ask them these crucial and high impact questions.

1. **Modification of Practice Expenses of 6 to 11% Cuts for Independent Physicians by Adding a Modifier to Identify Independent Physicians**
2. **Reinstating Telehealth as Post COVID to Avoid Numerous Access Issues for Elderly, Rural, and Distant Population Seeing Their Physicians**
3. **Ambulatory Specialty Model (ASM) – Which is an Unproven Concept Leading to Major Access Issues and Cuts to be Removed as it also Conflicts with ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model and WISeR (Wasteful and Inappropriate Service Reduction) Model, and Elimination of Inconsistent ASM Specialty Model Program.**
4. **Reversal of Efficiency Cuts of 2.5% as There is No Efficiency as Studies Show that AI May Help if at All, 20 Seconds Per Note**

Following is a brief explanation:

1. **Modification of Practice Expenses of 6 to 11% Cuts for Independent Physicians by Adding a Modifier to Identify Independent Physicians**

   With respect to practice expense, CMS is implementing a 50% practice management cut based on the assumption that 80% of physicians are hospital-employed, and therefore only 20% would be affected. This assumption is inaccurate. Nearly 45% of physicians are independent, meaning these reductions will impact approximately 45% of physicians whenever services are performed in hospitals or ASCs.

National data show that:

1. 23 million surgeries take place in ambulatory surgery centers (ASCs)
    - 90% of these surgeries are performed by independent physicians
    - There are approximately 5,530 ASCs nationwide, accounting for more than 23 million procedures annually.
2. 31.5 million surgeries occur in hospital outpatient departments (40% of these are performed by independent physicians, 10 million on Medicare patients)
3. 51.4 million inpatient surgeries are performed each year (CDC)

Once Medicare sets these rates, other payers typically follow.

As a result, independent physicians will face an estimated 6% to 11% reduction in reimbursement for services performed in hospitals and ASCs. This will further destabilize independent practices, which are already under severe financial pressure due to declining reimbursement and rising costs for staffing, supplies, and operations.

We urgently hope action will be taken to address these issues.

2. Reinstating Telehealth as Post COVID to Avoid Numerous Access Issues for Elderly, Rural, and Distant Population Seeing Their Physicians

Regarding telehealth, we were previously under the impression that permanent coverage had been established in the fee schedule. We have now learned that telehealth extensions do not apply broadly, except for behavioral health. Fortunately, the continuing resolution has extended telehealth coverage through January, and we are hopeful it will remain in place through the end of the year. This matter needs to be resolved permanently, as telehealth costs are minimal when compared to the expenses associated with Medicare Advantage plans.

3. Ambulatory Specialty Model (ASM) – Which is an Unproven Concept Leading to Major Access Issues and Cuts to be Removed as it also Conflicts with ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model and WISeR (Wasteful and Inappropriate Service Reduction) Model, and Elimination of Inconsistent ASM Specialty Model Program.

The Ambulatory Specialty Model (ASM) program presents numerous conflicts and may be the most harmful of all, resulting in projected cuts of approximately 9%. It overlaps with and contradicts other programs, including:

- ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model
- WISeR (Wasteful and Inappropriate Service Reduction) Model

These programs are inconsistent with the ASM framework, which itself lacks evidence-based validation and has not been tested in real-world practice. We do understand that HR6361 will basically remove WISeR Model, we would like to see the same for ASM.

4. Reversal of Efficiency Cuts of 2.5% as There is No Efficiency as Studies Show that AI May Help if at All, 20 Seconds Per Note

The administration has taken the position that physician efficiency has increased due to AI and has therefore implemented a permanent 2.5% cut to physician work value. Based on how the policy is presented, it appears that an additional 2.5% reduction may follow.

However, a recently published randomized controlled trial demonstrated that AI scribes saved UCLA physicians only 20 seconds per note — a result that is far from transformative (Lukac et al., "Ambient AI scribes in clinical practice: A randomized trial," *NEJM AI* 2025; 2:12). This was a well-designed randomized controlled trial using an intention-to-treat analysis, meaning outcomes were averaged across all randomized clinicians, including those who rarely or never used the AI scribe and therefore could not benefit from it. Moreover, the vast majority of physicians (including 90% of independent physicians and most hospital-based physicians) are not using AI at all, yet CMS has applied this cut broadly across the entire physician workforce.

A brief explanation has been provided above for all of the issues. Detailed explanations have been provided in the enclosed comment letters and articles.

1. Comment letter to CMS, Robert F. Kennedy, Jr., and Mehmet Oz, MD, from Laxmaiah Manchikanti, MD, Mahendra Sanapti, MD, and the American Society of Interventional Pain Physicians (ASIPP) Re: CMS-1832-P 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. September 11, 2025.
2. Manchikanti L, et al. Physician Payment Reform in Interventional Pain Management: Balancing Cost, Quality, Access, and Survival of Independent Practices. *Pain Physician* 2025; 28:377-396
3. Manchikanti L, et al. Escalating growth of spending on Medicare Advantage plans: Save Medicare from insolvency and balance the budget. *Pain Physician* 2025; 28:359-376
4. Manchikanti L, et al. Non-partisan proposal for reforming physician payment system and preserving telehealth services. *Pain Physician* 2025; 28:E329-E335

Thank you very much for your assistance. Please feel free to contact us if you have any questions.

Thank you,

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