Health Policy Perspective

Physician Payment Reform in Interventional Pain Management: Balancing Cost, Quality, Access, and Survival of Independent Practices

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On July 14, 2025, the Centers for Medicare and Medicaid Services (CMS) released the 2026 Physician Proposed Payment Rule aimed at reducing wasteful spending, enhancing quality measures, improving chronic disease management, and protecting independent practices from systemic financial pressures that have favored large healthcare systems and plagued independent practices. The goals are admirable, but the proposed measures with uniform reductions of 2.5% in physician payments based on efficiency adjustments apply across the board to all physicians. Further, practice expense (PE) reductions of 4% to 6%, meant to apply for hospital-based physicians will inadvertently apply to independent physicians constituting 43% of the physician workforce providing services in ambulatory surgery centers (ASCs), as well as hospitals. Thus, reductions of work relative value unit (wRVU) based on efficiency adjustment of 2.5% and PE reductions of 4% to 6%, with total reductions of 7% to 9%, compromise and limit patient care by putting additional pressure on independent physicians. Further, CMS' proposal to start Ambulatory Specialty Model (ASM) for low back pain with specialties of interventional pain management (IPM) and pain management involved. These specialties have no control over costs incurred as an overwhelming majority of patients are chronic pain patients and managed by family physicians, chiropractors, physical therapists, neurosurgeons, and others, resulting in 9% reductions, or increase in reimbursement over a period of 3 years with recurring changes of 3% each year.

The proposal includes a 3.8% conversion factor (CF) payment update and increased reimbursement for office-based services, including evaluation, management, and procedures. The changes will increase reimbursement by 8% to 10% for office-based services, but they also decrease reimbursement for all procedures performed outside offices by 7% to 9%.

These proposals arrive at a time when non-physician health care providers are striking for wage increase tied to inflation, and ironically, physicians have experienced repeated cuts in reimbursement with occasional stagnation, leading to 33% reduction from 2001 to 2025 in general, and 41% reductions in reimbursement for interventional pain physicians. In addition, there is an additional 2% sequester cut each year from 2011 to last until 2031, and there is a potential for 4% PAYGO cuts starting next year. Further, supply costs have increased 56% to 80% during these years. Further, despite technological advancements such as EMRs and AI, administrative burdens have intensified rather than improved. Independent physicians contend with complex prior authorizations, evolving Medicare coverage policies, growing audit risk with increased documentation and compliance demands from all payers' sources, 30% of interventional pain physicians under audit at any time. Our data on interventional pain physicians and published data on other physicians shows that efficiency has decreased and PEs have been skyrocketing.

Ironically, CMS has proposed on January 10, 2025, a 4.3% payment increase to Medicare Advantage Plans, amounting to $21 billion in 2026. 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. These proposals come amid growing concerns about Medicare Advantage over payments, including $44 billion due to favorable selection, $40 billion from risk adjustment discrepancies, and $15 billion for duplicative coverage of veterans who already receive benefits through the Veterans Administration (VA). In addition, according to the Medicare Payment Advisory Commission (MedPAC), traditional

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Medicare beneficiaries also face higher costs, contributing an additional $198 annually, totaling roughly $13 billion per year. All of these added together, CMS is spending on Medicare Advantage over $110 billion a year.

Thus, as independent practice continues to come under assault, the American Society of Interventional Pain Physicians (ASIPP) and other societies urge CMS to create a separate identifier for independent pain physicians to distinguish them from hospital-based physicians and prevent these cuts from harming independent practices. This separate but equal treatment of independent physician practices ultimately interferes with patient care.

Key words: Physician payment policy, physician fee schedule, independent physicians, Medicare, interventional pain management

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The Centers for Medicare and Medicaid Services (CMS) released the proposed 2026 Physician Payment Schedule and Quality Payment Program on July 14, 2025. The proposal seeks to reduce waste, strengthen quality measures, and improve chronic disease management for Medicare beneficiaries (1). It emphasizes advancing primary care through new quality metrics and introducing a new payment model for chronic disease care.

The U.S. Department of Health and Human Services (HHS) Secretary, Robert F. Kennedy, Jr., stated:

> "For the last four years, powerful interests have targeted independent medical practices. Thanks to Dr. Oz's leadership, this rule modernizes CMS payment systems, eliminates perverse incentives, and uses better data to improve chronic care while protecting hometown doctors."

CMS Administrator, Dr. Mehmet Oz, added:

> "We're modernizing Medicare, cutting waste, improving preventive access, rewarding results, and cracking down on abuse to protect Medicare for the next generation" (2).

Key proposals include:

1. 3.8% increase in the conversion factor (CF).
2. 2.5% reduction in wRVUs for non-time-based services, with proposal to continue imposing additional cuts every 3 years.
3. 7% to 10% increase in office-based reimbursement for evaluation, management, and procedural services.
4. 4% to 6% reduction in PE relative value units (RVUs) for services provided by hospital-employed physicians.
5. Overall, 7% to 9% reimbursement reduction for independent physicians working in ASCs and hospitals, including a 2.5% efficiency adjustment cut to wRVUs and a 50% PE RVU of hospital-based physicians applicable to independent physicians with reduction of 4% to 6%.
6. Creation of ASM involving low back pain and heart failure with pain physicians in the center with increasing risk. ASM would include anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation, without inclusion of primary care, chiropractic, physical therapy, and neurology. It involves penalty with cuts of 9% over a period of 3 years recurring every year with additional 3% risk with potential bonuses at the same level.
7. No formal telehealth extension, though several modifications are proposed.
8. The proposal does not include any safeguards against sequester cuts and PAYGO cuts.

Efficiency adjustment to work RVUs based on improvements in modern practices is more of a theoretical assumption, but not a practical reality. This is based on technological advances such as EMRs and AI. However, despite these advancements, administrative burdens have intensified rather than improved. Independent physicians contend with complex prior authorizations, evolving Medicare coverage policies, growing audit risk (with nearly 30% of interventional pain physicians under audit at any time), and increased documentation and compliance demands for all payer sources. Additional concerns include CMS continuing these cuts every 3 years with reassessment, making it unsustainable for independent practices to survive. In fact, multiple evaluations of utilization patterns of interventional techniques and surveys (3-8) and multiple other publications in various specialties (9-11). Interventional pain

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physicians have provided data with significant reductions ranging as high as 28%, while maintaining the same schedules and same level of staff (3-8).

A study by Childers et al (11) published in the Journal of the American College of Surgeons found that the proposed efficiency adjustment is not supported by empirical surgical time data, as analysis of intra-service times from 1.7 million surgeries across 249 CPT codes and 11 specialties showed that overall operative times increased by 3.1 percent from 2019 to 2023, with 90 percent of CPT codes having longer or similar operative times in 2023 compared to 2019.

To follow the above, the Society of Thoracic Surgeons (STS) (12)) reviewed the intra-service time data related to arterial and venous (33510-33523, 33533-33536) coronary artery bypass graft (CABG) procedures from the STS National Database from 2012 to 2022. This data compiled from 1,448,393 procedures shows that the intra-service times for arterial or venous CABG codes have substantially increased by 12%.

CMS's proposal to revise indirect PE RVU for physicians practicing in facility-based settings with reductions of 50%, will inadvertently affect independent physicians providing services in ASCs - most of which are owned and operated by independent physicians as an extension of their offices and hospital settings (1,2).

To appreciate PE 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 for independent physicians to survive and provide high-quality care at a time when expenses are skyrocketing and cuts are escalating. Non-physician 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. Costs of practice have increased 56% based on Medicare Trustees Reports from 2001 to 2025. Medical inflation has consistently outpaced general inflation, with healthcare costs increasing by 121.3% compared to 86.1% rise in consumer goods and services (13). At the same time, reimbursements for physicians have 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 inflation-based updates while physicians do not. As shown in Fig. 2, Medicare updates to hospitals

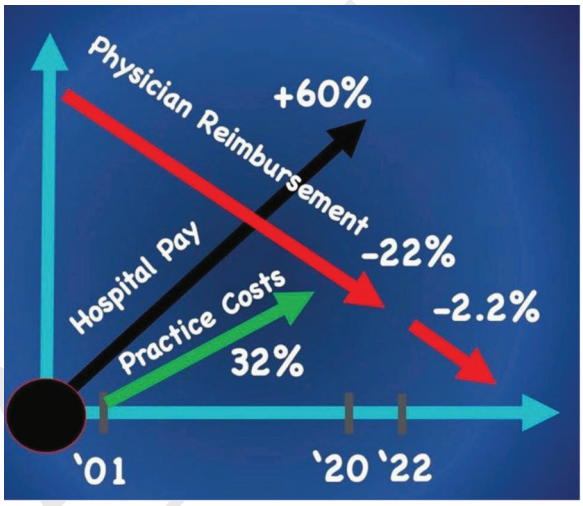


Fig. 1. *Comparison of declining physician reimbursement compared to practice costs and hospital reimbursement.*

Source: Green HA. The only 4 products of health care manufacture and produced with American patients. LinkedIn, January 14, 2023. https://www.linkedin.com/pulse/four-products-healthcare-manufactured-produced-howard-a-green-md/

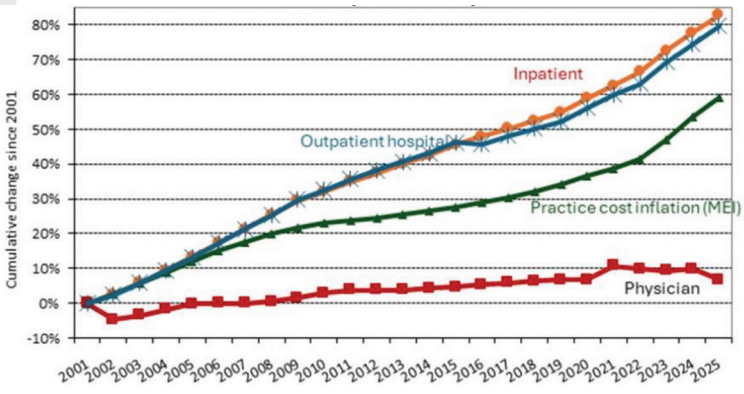


Fig. 2. *Medicare updates compared to inflation in practice costs (2001-2025).*

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

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.

Small private practices, despite being positioned to deliver cost-efficient, high-quality care, often receive lower reimbursement from payers compared to large health systems, creating sustainability challenges. While in-office procedures may see an 8% to 10% increase, equivalent reductions for ASC and hospital-based procedures will likely offset gains, resulting in a net overall loss.

In reference to 2025 fee schedule, on November 1, 2024, CMS issued a Final Rule for physician payment which included several significant changes (14). Among them was the elimination of telehealth services and a 2.8% reduction in payments for physician services – accounting to an estimated $20 billion per year. However, ironically, on January 10, 2025, CMS proposed a 4.3% payment increase to Medicare Advantage Plans, amounting to $21 billion in 2026 and approximately $210 billion over the following decade (15). To add fuel to the fire, CMS finalized 2026 payment policy update for Medicare Advantage and Part D programs with an increase on average of 5.06% from 2025 to 2026 (16). Details of these devastating cuts and unfair advantages of Medicare Advantage Plans are provided in previous publications (17,18). As described in, Non-partisan Proposal for Reforming Physician Payment System and Preserving Telehealth Services (17), apart from these increases, these proposals come amid growing concern about Medicare Advantage overpayments, including $44 billion due to favorable selection, $40 billion from risk adjustment discrepancies, and $15 billion for duplicative coverage of veterans who already receive benefits through the VA. According to MedPAC, traditional Medicare beneficiaries also face higher costs, contributing an additional $198 annually, totaling roughly $30 billion per year (19-27).

ASIPP proposed to identify independent physicians with a modifier and applying 2024 RVUs, without cuts, as if the services were performed in-office (28).

This article, therefore, will review current healthcare conditions, the state of independent medical practices, physician payment trends, interventional pain management, and the adverse effects if these proposed rules are finalized without changes.

State of Health Care

Healthcare spending in the United States was projected to grow by 7.5% in 2023, exceeding the nominal gross domestic product (GDP) growth rate of 6.1%, thereby increasing the share of the nation's economy devoted to healthcare spending to 17.6% (29-31). Forecasts indicate continued growth in national health expenditures (32). Overall, Medicare spending was $1,029.8 trillion in 2023, increasing to $1,115 trillion in 2024, and to $2,192 trillion in 2033. In addition, Medicaid also has been showing substantial growth patterns despite talk of cuts. Keehan et al (32) have shown Medicaid spending of $807.5 billion in 2022, increasing to $871.7 billion in 2023, and projected to increase to $925.6 billion in 2024, finally increasing to over a trillion in 2027 and $1,626.3 trillion in 2033. For private health insurance, spending has been $1,313.8 trillion in 2022, increasing to $1,616.8 trillion in 2024 and expected to increase $2.4 to $1.7 trillion in 2033, which is less than double. Table 1 shows national health expenditures and health insurance enrollment, aggregate and per enrollee amounts, and average annual growths of the expenditures and enrollment Per enrollee spending is shown to increase substantially for Medicare and Medicaid compared to private health insurance. Expenditures per enrollee ranged from $6,441 in 2022, $7,065 in 2023, $7,608 in 2024, and projected to increase to $11,483. In contrast, Medicare expenditures ranged from $14,933 in 2022, $15,808 in 2023, $16,860 in 2024, increasing to $28,109 in 2033. Further, Medicaid also showed higher per enrollee spending of $8,869 in 2022, $9,502 in 2023, $10,951 in 2024, and, finally, $18,189 in 2033.

Medicare Part B, which covers physician services, accounts for 20% of spending for Medicare fee-for-service (FFS) patients. In 2022, spending in this category increased by 2.7% to $952.5 billion (32). Keehan et al (32) provided national health expenditure projections from 2024 to 2033 showing that despite insurance coverage declines, health expenditures to grow as share of GDP. They showed that national health expenditures are projected to have grown 8.2% in 2024 and to increase to 7.1% in 2025, reflecting continued strong growth in the use of healthcare services and goods. During the period 2026 to 2027, health spending growth is expected to average 5.6%, partly because of decrease in the share of the population with health insurance, and partly because of an anticipated slowdown in utilization growth from recent highs. Each year for the full 2024 to 2033 projection period, national health care expenditure growth (averaging 5.8%), is expected to outpace that for the GDP, averaging 4.3%, and to result in health share of GDP that reaches 20.3% by 2033,

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Table 1. *National health expenditures (NHE) and health insurance enrollment, aggregate and per enrollee amounts, and average annual growth, by source of funds, selected calendar years 2022–33.*

			Projected			
Source of funds	**2022**	**2023**	**2024**	**2025**	**2027**	**2033**
EXPENDITURE, BILLIONS						
Private health insurance	$1,313.8	$1,464.6	$1,616.8	$1,740.1	$1,878.6	$2,421.7
Medicare	952.5	1,029.8	1,115.0	1,201.0	1,425.5	2,192.0
Medicaid	807.5	871.7	925.6	994.4	1,135.2	1,626.3
PER ENROLLEE SPENDING						
Private health insurance	$6,441	$7,065	$7,608	$8,104	$8,981	$11,483
Medicare	14,933	15,808	16,860	17,654	20,020	28,109
Medicaid	8,869	9,502	10,951	11,905	13,273	18,189
ENROLLMENT, MILLIONS						
Private health insurance	204.0	207.3	212.5	214.7	209.2	210.9
Medicare	63.8	65.1	66.1	68.0	71.2	78.0
Medicaid	91.0	91.7	84.5	83.5	85.5	89.4
Uninsured	26.6	24.9	26.6	26.8	31.2	30.9
Population	332.4	334.0	337.2	340.1	344.2	354.8
Insured share of total population	92.0%	92.5%	92.1%	92.1%	90.9%	91.3%
Average annual growth	2022[a]	2023	2024	2025	2026-27	2028-33
EXPENDITURE						
Private health insurance	4.5%	11.5%	10.4%	7.6%	3.9%	4.3%
Medicare	5.8	8.1	8.3	7.7	8.9	7.4
Medicaid	9.5	7.9	6.2	7.4	6.8	6.2
PER ENROLLEE SPENDING						
Private health insurance	4.1	9.7	7.7	6.5	5.3	4.2
Medicare	3.8	5.9	6.7	4.7	6.5	5.8
Medicaid	1.7	7.1	15.2	8.7	5.6	5.4
ENROLLMENT						
Private health insurance	0.3	1.6	2.5	1.0	-1.3	0.1
Medicare	1.9	2.1	1.5	29	2.3	1.5
Medicaid	7.7	0.8	-7.9	-1.2	1.2	0.7
Uninsured	-5.7	-6.3	6.8	0.8	7.9	-0.2
Population	0.3	0.5	1.0	0.9	0.6	0.5

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group. NOTES Definitions, sources, and methods for NHE categories can be found in CMS. National Health Expenditure Accounts: methodology paper. Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. Tables with data for all years of the projection period can be found at www.CMS.gov.

[a] Annual growth, 2020–22.

Adapted from: Keehan SP, Madison AJ, Poisal JA, et al. National health expenditure projections, 2024-33: Despite insurance coverage declines, health to grow as share of GDP. *Health Aff (Millwood)* 2025; 44:776-787 (32).

which is up from 17.6% in 2023. Per capita spending shown as 6% in 2022 is expected to increase. Per capita spending was $14,570 in 2023, increasing to $15,610 in 2024 and projected to increase to $24,200 in 2033 (32).

In line with rising national healthcare expenditures, U.S. spending on personal and public healthcare between 1996 and 2016 reached its highest level for back and neck pain in 2016, totaling $134.5 billion, a 53.5% increase from 2013, when spending was $87.6 billion (33).

Since the implementation of the Affordable Care Act (ACA), overall healthcare utilization has declined (3-8,34-42). Patients have faced increasing financial burdens from high deductibles, coinsurances, and copayments. Pain practices have experienced rising operational costs, including the need to hire staff to help patients navigate insurance plans, address complaints about escalating costs, and manage the administrative demands of more frequent and intensive audits (13,43-63). The COVID-19 pandemic accelerated the decline in utilization (3-8,64-75), creating severe disruptions

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as patients and employees quarantined, while shifting and sometimes contradictory requirements regarding screening, testing, vaccination, and treatment created uncertainty and additional barriers to care. Lockdowns and intermittent bans on elective procedures further compounded access issues.

The situation has been exacerbated by broader economic pressures, including unemployment, inflation, workforce changes, and supply chain disruptions (13,43-53). Patients are now often presented with more advanced disease, having deferred preventive screenings and necessary medical care in recent years, either to avoid perceived infection risks by staying home or due to diminished access to primary and secondary preventive services for the reasons outlined above.

Independent Medical Practices

One of the most pressing challenges facing healthcare today is the ongoing economic slowdown, which began with the COVID-19 pandemic and has been intensified by inflation, supply chain disruptions, rising energy costs, and other external economic pressures. Between 2021 and 2024, inflation rose by 19%, while physician payments declined by 33% compared to 2001, a reduction often justified as necessary to balance the budget amid growing service demands and the expansion of managed care (13,17,18,46,48). Since 2000, medical inflation has consistently outpaced general inflation, with healthcare costs increasing by 121.3% compared to an 86.1% rise in consumer goods and services. In June 2024, medical costs rose by 3.3%, slightly higher than the 3.0% increase in overall consumer prices (13).

Figure 3 illustrates the widening gap between declining physician reimbursement and the rising costs of running a practice, as well as comparatively higher reimbursement for other sectors of healthcare. Because physician payments are not indexed to inflation, inflation-adjusted reimbursement fell by 33% between 2001 and 2025 (17). This erosion in compensation is compounded by frequent redistributions mandated by budget neutrality adjustments and the absence of annual inflationary updates. Budget neutrality provisions, established under the Omnibus Budget Reconciliation Act (OBRA) of 1989, remain a problematic cornerstone of Medicare payment policy (76).

Physicians and other providers are also subject to the ongoing 2% sequestration cuts, which will remain in effect through 2031 under the Budget Control Act of 2011 (BCA) (77). Enacted initially to support the ACA, sequestration imposes automatic, across-the-board federal spending reductions when budget caps are exceeded. These cuts are not subject to presidential or congressional discretion and are applied equally to all non-exempt programs. The measure was designed to incentivize lawmakers to stay within fiscal limits or pass targeted cost-saving legislation. The Fiscal Responsibility Act (FRA) further included a sequestration mechanism that could be activated if Congress failed to complete appropriations for fiscal year 2024 (78). Although the White House Office of Management and Budget (OMB) have reported that sequestration will not be triggered for the current fiscal year because appropriations remain within limits, the mechanism remains active and continues to erode physician practice revenue. While physicians temporarily avoided a 4% cut under the Pay-As-You-Go (PAYGO) provisions, the risk remains (79). The Statutory PAYGO Act of 2010, signed into law by President Obama, mandates automatic reductions in federal spending when new legislation increases the deficit. If deficit-increasing bills are enacted without offsetting savings, automatic cuts are applied to programs such as Medicare, including payments to hospitals, physicians, and Medicare

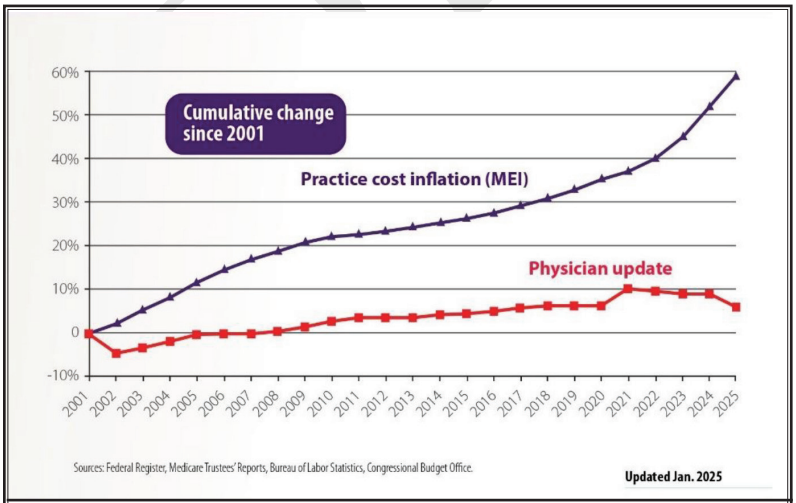


Fig. 3. *Medicare updates compared to inflation in practice costs (2001-2025).*

Source: American Medical Association (https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf)

Advantage plans. Projections from the Congressional Budget Office (CBO) suggest that such cuts could amount to $45 billion in Medicare funding in 2026, rising to $75 billion by 2034. In fact, the CBO report (80) warns of nearly $500 billion in potential Medicare cuts. Unlike sequestration, Congress can avert PAYGO cuts by legislative action before year-end, and in the past, it has done so through exclusions or delays. However, repeated deferrals carry a risk, as accumulated cuts could eventually reach 20%.

The survival of independent medical practices is closely tied to broader physician employment trends. Nearly 110,000 physicians left private practice for other employment opportunities between 2019 and 2021 (49,50,81,82). Even then, recent data published by Popover et al (83) indicate that private practices still account for a majority of physician employment despite growth in hospital-based physicians. This stands in contrast to CMS's assumption that hospitals employ 80% of physicians (1,2).

The landscape of physician employment has shifted significantly over the past three decades, with physician-owned practices steadily declining as corporate and hospital ownership has expanded (84). Data from Avalere Health indicates that by January 2022, 74% of physicians were employed by corporate or hospital entities, up from 62% in 2019, a trend accelerated by the COVID-19 pandemic (85). Large hospital systems have expanded their footprint, now encompassing 68% of all U.S. hospitals, which collectively account for 703,246 system-affiliated beds out of nearly 920,000 nationwide (86). This consolidation raises concerns about growing monopolization in healthcare.

Data on practice ownership remains less clear. Some estimates suggest that 44%–46% of all practices are physician-owned (87,88). Given that hospital or corporate entities own an estimated 131,463 practices, this would imply a total of 234,755 practices nationwide (85). However, other sources report 338,899 physician group practices, defined separately from solo physician practices, indicating potential discrepancies in how ownership is categorized (89).

Because of significant contradictions and a lack of cohesiveness in the data available from private sources, Popover et al (83) conducted a comprehensive evaluation using data from the U.S. Census Bureau's Statistics of U.S. Businesses (SUSB) and the Bureau of Labor Statistics' Occupational Employment and Wage Statistics (OEWS). Industry classifications were defined under the North American Industry Classification System (NAICS). In 2022, the United States had 760,000 physicians, representing a 22% increase over the past decade. Hospital employment rose by 33%, while private medical practices grew by 17%. At the time of the study in 2022, 55% of physicians worked in private practices, which was a 3% decrease from a decade earlier, and 27% were hospital-employed, an increase from 25% a decade earlier (Fig. 4). Government employment decreased from 14% in 2013 to 12%, while university employment remained stable at 3%. In 2020, there were 213,000 private medical practices, 73% of which were small practices. Over the past two decades, the number of large practices (≥ 50 employees) has increased, while small practices (< 50 employees) have declined by 16%.

Between 2013 and 2022, the cost of medical and surgical supplies increased by 82% (50). Further, to enhance the cost increases, medical inflation has consistently outpaced the general inflation, with healthcare costs increasing by 121.3% compared to 86.1% from 2000 to 2024 (13). Nearly 80% of physicians reported better leverage in payer negotiations as a key reason for selling their practices to hospital systems (51). Fraud investigations and regulatory scrutiny have also disproportionately affected physicians (4,10,43-45), contributing to increasing burnout, bankruptcies, and the closure of private practices. The latest data show that the proportion of physicians in private practice has declined steadily over the past decade, from 60% in 2012 to 42% in 2024. Notably, over 40% of physicians remain independent, providing services not only in their offices but also in ASCs and hospitals.

Factors influencing the shift in employment set-

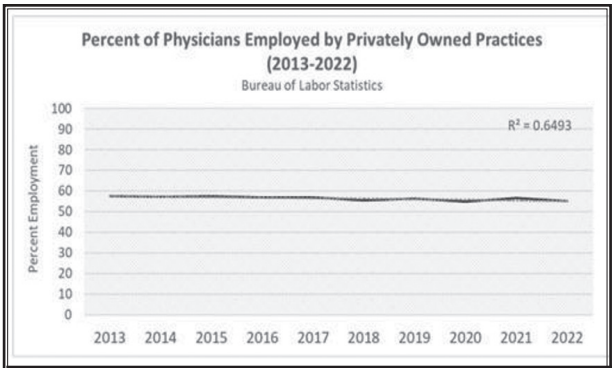


Fig. 4. *Percent of practitioners having a degree of MD (Doctor of Medicine) or DO (Doctor of Osteopathy) employed by private or group practices over 10 years. The statistical significance of the negative trendline is P < .005, 95% confidence interval.*

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tings include financial instability, regulatory burdens, access to resources, negotiating power, and physician preferences, particularly among recent graduates. Overall, these data indicate that CMS has an opportunity to establish reimbursement policies that support the survival of independent practices, improve cost-utility, and enhance quality of care while controlling service costs.

Independent practices are uniquely positioned to deliver efficient, high-quality care, yet they often receive less favorable reimbursement rates from payers compared to large, consolidated health systems, making fiscal sustainability challenging (9). Despite these challenges, consolidation continues to expand across health care (90), and persistent issues with Medicare Advantage plans and Medicaid reimbursement have been extensively documented (20).

It is essential to recognize that genuine cost savings and quality improvements often originate in small practices, where overhead is tightly managed and patients benefit from stronger physician–patient relationships. The CMS Bundled Payments for Care Improvement (BPCI) initiative further demonstrated that physician group practices saved the program more money than hospital participants, reinforcing the efficiency and value that small practices contribute to health care improvements (91,92).

Physician reimbursements are undergoing significant changes, and the present proposed rule disproportionately impacts IPM practices in that over 43% remain independent, with a substantial proportion practicing in ASCs, which often function as extensions of physician offices.

The core concern lies in the proposed reimbursement regulations. For independent physicians, who account for over 40% of total physician volume and practice in ASCs and hospitals, these changes threaten practice sustainability. Specialties such as interventional pain management (IPM) (40%), gastroenterology (70%), ophthalmology (90%), orthopedics (40%), and several others perform virtually all ambulatory surgical procedures and over 30% of surgeries in hospital settings, whether inpatient or outpatient.

Reimbursement for interventional techniques has already declined significantly. Wiest et al (93) found that from 2014 to 2023, inflation-adjusted Medicare reimbursement for interventional pain procedures decreased by an average of 3.63% annually, compared to only 0.87% annually for evaluation and management (E/M) services, a statistically significant difference ($P <$ 0.001) (Table 2). Similarly, Park et al (94) reported that between 2000 and 2023, inflation-adjusted Medicare reimbursement decreased by 61.31% for facility procedures and 60.40% for non-facility procedures. They concluded that while proposed changes marginally improve non-facility settings (i.e., office-based procedures), the detrimental impact on facility-based procedures in ASCs and hospitals will be severe for independent physicians. Figure 5 illustrates the substantial reductions in average adjusted reimbursement rates (in 2023 dollars) for interventional pain procedures compared to 2000.

Other specialties face similar declines. In orthopedics, Lum et al (9) demonstrated that by 2024, Medicare reimbursed surgeons less than one-third of the inflation-adjusted amount paid in 1995 for the same procedures. Data from one institution showed that a surgeon performing three primary hip or knee arthroplasties in one day generated approximately 58.8 wRVUs, while a day consisting of a mix of primary and revision procedures averaged 46.7 to 49.9 wRVUs. By comparison, a clinic day with roughly 30 patient visits (including new evaluations and some injections) generated 53.9 wRVUs. This disparity is amplified by the 90-day global period, during which all post-operative visits are bundled into the surgical fee, producing no additional revenue despite ongoing time and resource demands. Additionally, patient communication has surged, one medical center reported a 500% increase in messages over the past five years, yet there remains no reimbursement for this workload. As a result, even before further reductions in work RVUs, surgeons may increasingly question the financial sustainability of operative practice, particularly when office visits generate more revenue and stability (9,95).

Neurosurgery has followed a similar trend. Haglin et al (96) found that from 2000 to 2018, inflation-adjusted reimbursement for neurosurgical procedures declined by an average of 25.8%, equating to an annual decrease of 1.59% and a compound annual growth rate (CAGR) of -1.66%. Otolaryngology has also seen steep declines; Dominguez et al (97) reported that from 2000 to 2019, the average inflation-adjusted reimbursement for 20 standard procedures dropped by 37.63%. These sustained reimbursement cuts have far-reaching consequences for the physician workforce. Physicians dedicate their careers to delivering life-enhancing and often life-saving care, including complex surgeries, yet diminishing returns and mounting financial pressures erode morale. In private practice,

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Table 2. *Inflation-adjusted changes in physician reimbursement by CPT code, sorted from highest-to-lowest-grossing.*

CPT Code	Code Description	% Share	Average YPC (%)
Procedures	n/a	n/a	n/a
64635	Destroy lumbar or sacral facet joint nerves	29.0%	-4.76%
64483	Inject anesthetic/steroid into lumbar or sacral nerve	22.7%	-3.25%
63650	Implant neuroelectrodes	16.5%	-3.01%
64493	Inject lumbar or sacral facet joint	12.1%	-3.19%
27096	Inject sacroiliac joint	5.2%	-3.23%
64636	Destroy lumbar or sacral facet joint nerves	4.5%	-3.31%
64494	Inject lumbar or sacral facet joint	3.5%	-3.24%
64484	Inject anesthetic/steroid into lumbar or sacral nerve	2.5%	-3.24%
64495	Inject lumbar or sacral facet joint	2.2%	-3.24%
20610	Inject/aspirate joint or bursa	1.6%	-3.15%
Evaluation and Management (E/M)	n/a	n/a	n/a
99214	Established patient office visit, 30-39 minutes	44.8%	-0.43%
99213	Established patient office visit, 20-29 minutes	21.4%	0.00%
99204	New patient office visit, 45-59 minutes	20.3%	-2.58%
99205	New patient office visit, 60-74 minutes	3.7%	-2.03%
99215	Established patient office visit, 40-54 minutes	3.3%	0.05%
99203	New patient office visit, 30-44 minutes	2.9%	-1.90%
99232	Subsequent hospital care, 35 minutes	1.5%	-1.72%
99233	Subsequent hospital care, 50 minutes	1.0%	-1.25%
99309	Subsequent nursing facility care, 30 minutes	0.6%	-0.97%
99212	Established patient office visit, 10-19 minutes	0.4%	0.98%

CPT, current procedural terminology; YPC, yearly percentage change

already burdened by rising overhead and inflation, the strain is particularly acute. Combined with escalating administrative demands, these pressures are fueling a worsening burnout crisis in medicine (4,10,98). This, in turn, decreases the number of available treatment providers, decreases access to patient care, and causes prolonged delays. The narrow margins and every increasing copay, deductibles, and non-coverage policies with increased risk of non-payment and financial losses associated with providing medical care are restricting patient access to procedures.

Background on the Physician Fee Schedule (PFS)

Since 1992, Medicare has reimbursed physicians and other billing professionals under the Physician Fee Schedule (PFS) for services provided in offices, hospitals, ASCs, clinical laboratories, and patients' homes (99). Payments are also made to suppliers for technical services delivered in non-institutional settings.

In physician offices, Medicare provides a single pay-

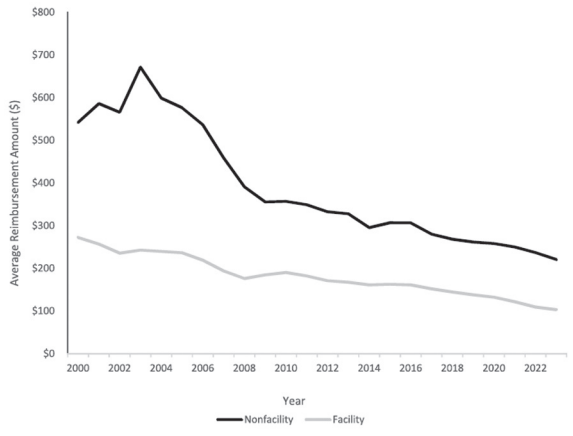


Fig. 5. *Average adjusted reimbursement rates in US dollars for top interventional pain procedures.*

Source: Park AM, Khurana A, Wang RR, Eltorai AEM. Medicare reimbursement for interventional pain procedures: 2000 to 2023. Interv Pain Med 2024; 3:100526 (94).

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ment rate intended to cover all resources required to deliver a service. In facility-based settings, such as hospital outpatient departments (HOPDs) or ASCs, payment rates reflect only the resources directly incurred by the practitioner. Approximately 30% of independent physicians perform procedures in ASCs, which are classified as facility settings. In fact, ASC is an extension of physician office, requiring licensure with higher operating costs, but facilitating to provide complex procedures.

Specific diagnostic tests and selected services receive separate payments for professional and technical components, which can be billed by either physicians or suppliers. Payment amounts are determined using RVUs for work, PE, and malpractice costs, adjusted by a CF and geographic indices, with updates mandated by statute.

Physician Payment Proposed Rule

Conversion Factor (CF) Update for 2026

Beginning in CY 2026, CMS proposes two separate CFs: one for qualifying Alternative Payment Model (APM) participants (QPs) and one for non-QPs. The CY 2026 update is +0.75% for QPs and +0.25% for non-QPs, in addition to a statutory one-year increase of +2.50% and an estimated +0.55% adjustment for proposed work RVU changes. The qualifying APM CF is $33.59, up $1.24 (+3.8%) from $32.35, while the non-qualifying APM CF is $33.42, up $1.07 (+3.3%) from $32.35. CMS also proposes updates to geographic practice cost indices (GPCIs), malpractice RVUs, and 2 anesthesia CFs. Proposed CFs are shown in Table 3 (100).

These CFs are further affected by a +0.55% budget neutrality adjustment resulting from misvalued code changes and a -2.5% efficiency adjustment to wRVUs and intra-service time for non-time-based services that CMS expects to gain efficiency over time. This efficiency adjustment impacts most surgical specialties, interventional pain management, radiology, and pathology, reducing overall payment.

These changes threaten patient access to high-quality care, the viability of private practices, and physician morale, while accelerating healthcare consolidation. They come amid staff demands for inflation-based wages, rising practice costs, escalating burnout, a 41% reduction in physician reimbursement from 2011 to 2025, ongoing 2% sequestration cuts, potential 4% PAYGO cuts, increasing regulatory requirements, and heavier workloads.

American Society of Interventional Pain Physicians (ASIPP) advocates for permanent baseline CF updates reflecting physician cost growth, projected at 2.7% per the MEI. ASIPP also supports MedPAC's June 2025 recommendation to repeal current law updates and tie annual updates to the MEI (101). The 2025 Medicare Trustees Report warned that, under current law, physician access for Medicare patients will become a significant long-term concern (102).

Efficiency Adjustment

CMS has historically relied on American Medical Association (AMA) Relative Value Scale Update Committee (RUC) survey data to estimate practitioner time, work intensity, and PE for PFS code valuation (100). Few codes are re-evaluated annually, and surveys often have low response rates and potential conflicts of interest, which may overstate time assumptions (103).

To address this, CMS proposes an efficiency adjust-

Table 3. *Proposed 2026 Medicare conversion factors (CFs).*

Proposed 2026 Medicare Conversion Factors (CFs)							
	2025 CFs	APM or Non APM Update Factor (1.0075 or 1.0025)	CY 2026 RVU Budget Neutrality Adjustment (1.0055)	CY 2026 2.50 Percent Increase (1.025)	Anesthesia Only PE and PLI Adjustment	Proposed 2026 CFs	Percentage Changes
APM QP	$32.3465	$32.5891	$32.7683	$33.5875	N/A	$33.587	3.84%
Non-APM QP	$32.3465	$32.4274	$32.6057	$33.4209	N/A	$33.4209	3.32%
Anesthesia APM QP	$20.3178	$20.4702	$20.5828	$21.0973	$20.6754	$20.6754	1.76%
Anesthesia Non-APM QP	$20.3178	$20.3686	$20.4806	$20.9926	$20.5728	$20.5728	1.26%

Source: American Medical Association. 2026 Medicare physician payment schedule and quality payment program proposed rule summary. Accessed 7/28/2025 (100).
https://www.ama-assn.org/system/files/2026-mpfs-proposed-rule-summary.pdf

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ment to wRVUs and intra-service time for non-time-based services expected to gain efficiency over time. This adjustment would exclude time-based codes such as E/M, care management, behavioral health, telehealth, and maternity codes (MMM). The adjustment equals the sum of the past five years of MEI productivity adjustments calculated by the Office of the Actuary (OACT), resulting in -2.5% for CY 2026. CMS also proposes prioritizing empiric time studies over low-response survey data to reduce historical distortions in the PFS.

As described earlier in the introduction, the efficiency adjustment is riddled with multiple flaws in their estimations and multiple studies have shown that in fact, efficiency is decreasing rather than increasing (3-11).

While promoting efficiency is essential, ASIPP believes it is inappropriate to penalize physicians by reducing wRVUs based on perceived, unproven gains in productivity without considering prior losses. Despite technological advances such as EMRs and AI, administrative burdens have intensified. Independent physicians face complex prior authorizations, evolving Medicare coverage policies, growing audit risks (nearly 30% of interventional pain physicians are under audit at any time), and increasing documentation and compliance demands from all payer sources.

Practice Expense (PE) Changes

The current PE methodology relies on the AMA's 2008 Physician Practice Information (PPI) Survey data. In 2024, the AMA updated the survey and submitted results to CMS in early 2025 for the CY 2026 PFS. Due to small sample sizes, low response rates, representativeness concerns, potential errors, and incomplete data, CMS is not proposing to use the PE/hr. or cost share data for 2026, but modeled potential payment impacts for comment and possible future use (1).

CMS proposes central PE methodology updates reportedly to reflect current practice better. The plan includes recognizing greater indirect costs for office-based versus facility settings, reflecting the decline in private practice and rise in hospital employment. CMS also proposes using auditable hospital data, such as Medicare OPPS, to set relative rates for some technical services, beginning with radiation treatment and remote monitoring in CY 2026, to improve transparency, predictability, and reduce reliance on limited surveys. It is important to note that hospital data itself may contain various inaccuracies raising significant questions about this unproven approach.

Unfortunately, while CMS proposes cuts for PEs of hospital-based physicians with an impression that the majority of the physicians are hospital-based, 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 non-physician 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 surgical workforce (17-19). ASIPP has published and submitted to Congress a non-partisan proposal for reforming physician payment system in preserving telehealth services (17). 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.

Ironically, while physicians face significant payment cuts continuing through 2025, CMS proposed on January 10, 2025, a 4.3% payment increase for Medicare Advantage Plans – totaling $21 billion in 2026. However, it appears that CMS has not touched these outrageous benefits and overpayments to Medicare Advantage Plans but further increased payments by 5.6% from 2025 to 2026.

The AMA provided extensive comments on PPI surveys (100). For interventional techniques, independent physicians performing services in ASCs and hospital settings are expected to experience significant effects (Table 4). Our calculations in Table 5 showing physician reimbursement rates from 2001 to 2025 and the proposed 2026 rules demonstrate concerning trends. IPM physicians have experienced a 41% decrease in inflation-adjusted reimbursement from 2001 to 2025, projected to worsen to 45% with the new fee schedule. For office-based procedures, there is a modest improvement in 2026, reducing cumulative losses from 2001 to 2025 from 42% to 35%.

ASIPP and multiple other specialty societies are concerned about the disproportionate impact on independent physicians in ASCs and HOPDs and request that CMS consider adopting a modifier to distinguish independent from hospital-employed physicians.

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Table 4. *Changes in reimbursement for interventional procedures for independent physicians.*

Changes from 2025	In-Office 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%

Telehealth Services Under the PFS

Without confirming a telehealth extension for 2026, CMS proposes several significant policy changes (1). Frequency limits on subsequent hospital and nursing facility visits, as well as critical care delivered via telehealth, would be permanently lifted. Virtual direct supervision would also be allowed permanently, while virtual teaching physician supervision of residents would be limited to non-metropolitan areas, ending in metropolitan regions. Coverage changes include adding five services to the 2026 Medicare Telehealth List. CMS does not propose adding Current Procedural Terminology (CPT)® codes for telemedicine E/M services; both audio-only and audio-video E/M services must con-

Table 5. *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

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tinue to use in-person CPT codes with the appropriate modifier.

Ambulatory Specialty Model (ASM)

CMS has proposed ASM treating low back pain and heart failure. The purpose of Ambulatory Specialty Model, or ASM, is to hold specialists who treat people with original Medicare financially accountable for upstream management of chronic conditions. The model would focus on low back pain and congestive heart failure, two areas of high original Medicare spending with significant potential for cost savings. Purportedly, timely, targeted care for these conditions can prevent avoidable hospitalizations and unnecessary surgeries. Specialists would be awarded for effective disease management, adhering to clinical guidelines for care, and coordinating with other providers involved in the management of their patients' care. ASM would begin on January 1, 2027, and run for 5 performance years through December 31, 2031. ASM's payment years run from January 1, 2029, through December 31, 2023.

CMS will use ASM participants as final scores across the 4 performance categories to determine if they receive positive, neutral, or negative payment adjustments on future Medicare Part B claims for covered services. In the first payment year, these adjustments would range from minus 9% to plus 9%. All participants would be subjected to this risk. The payment approach would ensure that total positive adjustments for high performers do not exceed the total negative adjustments for low performers. Model timeline is shown in Fig. 6.

Low back pain specialists include anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation.

Multiple issues in this model include in managing low back pain, all of them are specialists. There are no primary care, chiropractic, or physical therapy providers. It is not certain if anesthesiology includes providing anesthesia services, on which they do not have any control. Similarly, pain management and IPM do not have any control on any of the expenses, as these are almost tertiary referrals, sometimes just before and other times after surgery.

One of the issues is related to the CMS proposal using a "redistribution percentage" of 85% in calculating payment changes for physicians, which means that only 85% of any payment reductions would be used to increase payments for high-performing physicians. The redistribution percentage would guarantee Medicare savings from ASM by forcing a net reduction in Part B payments through the participating physicians. No such redistribution is used in MIPS, nor is one used in the Hospital Value-Based Purchasing (VBP) Program.

Medicare adjustment in ASM is considered as a tournament approach, meaning that physicians could be penalized even if they significantly improved quality. Thus, as proposed, ASM's financial model guarantees that most participating physicians will have their payments cut regardless of how well they perform on measures. Maximum penalties from 2031 to 2033 are larger than MIPS, and much larger than hospital space and hospital VBP program. ASM would mandate participation by specialists in 25% of the country. Redesigning the ASM as a voluntary model and would be more consistent with statutory authority to test experimental models. Further, this kind of tournament model has been discredited and is not used in other payment models. Finally, these criteria for participating physicians appear to be inappropriate and there is no evidence of effectiveness of this model.

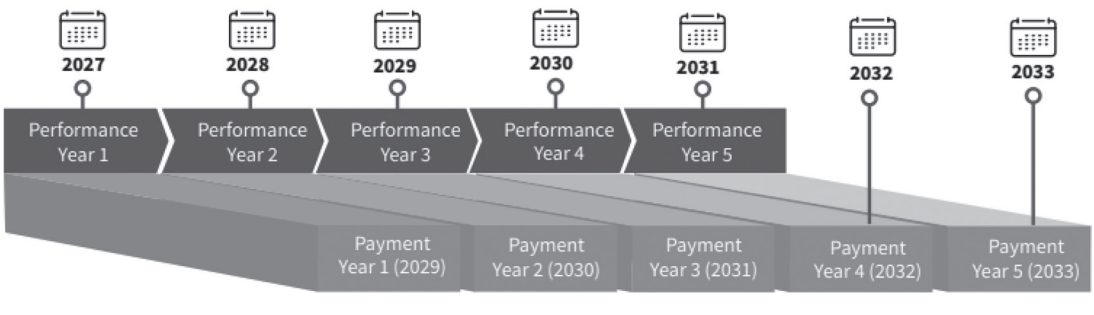


Fig. 6. *Model timeline for Ambulatory Specialty Model.*

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Solutions to Survival of Independent Practices

CMS has already acknowledged that safeguarding patient access to high-quality care requires the survival of independent practices. At this stage, however, the goal should extend beyond survival to true revival. CMS must therefore revisit its approach to physician payment and avoid sustaining a model that undervalues the contributions of independent physicians, particularly those providing complex surgical care in ASCs and hospital settings. Policymakers should recognize that systematically devaluing the services offered by independent physicians risks disincentivizing pain physicians, surgeons, gastroenterologists, ophthalmologists, and other specialists from delivering many of the most beneficial and cost-effective procedures in medicine.

Key Solutions

Addressing these challenges requires permanent stabilization of the CF with baseline updates aligned to the Medicare Economic Index (MEI), elimination of budget neutrality adjustments, removal of the 2% sequester cuts, and repeal of the potential 4% reduction associated with PAYGO rules (17).

Preservation of Appropriate Work RVU Values

The proposed 2.5% reduction in work RVUs is unjustified for physicians in any setting. Despite advances such as electronic medical records (EMRs) and artificial intelligence (AI), administrative demands have intensified rather than eased. Independent physicians must navigate complex prior authorization processes, shifting Medicare coverage policies, and heightened audit exposure. Nearly 30% of interventional pain physicians are under audit at any given time, along with escalating documentation and compliance requirements from both Medicare and commercial payers through local coverage determinations (LCDs) and medical policies. Additional concerns include CMS continuing these devastating cuts every 3 years, making it unsustainable for independent practices to survive.

Eliminate Practice Expense (PE) RVU Allocation for Independent Physicians and Separate Them from Hospital-Based Physicians

While office-based procedures, representing only 8% to 10% of cases, can be modestly advantageous for independent physicians, the majority of procedures are performed in ASCs and classified as facility-based. These face reimbursement cuts of 8% to 10%, and this is unsustainable.

Telehealth Continuity

Extending telehealth provisions through 2026 and beyond is essential to maintaining access and continuity of care in independent practice settings.

Ambulatory Specialty Model (ASM)

ASIPP proposes that CMS preferably withdraw ASM implementation until evidence is developed and appropriateness criteria are utilized. In addition, if CMS insists on implementing unproven and unjustified maneuvers, the ASM should be made voluntary with inclusion of primary care, chiropractic, physical therapy, and elimination of anesthesiology, pain management, and interventional pain management.

Non-partisan Proposal for Reforming Physician Payment System

ASIPP has proposed a health policy perspective describing a proposal for reforming physician payment system and preserving telehealth services (17). In addition, ASIPP has also published an article describing numerous issues, not only for cost, but also quality of Medicare Advantage Plans, which is disruptive for the survival of the Medicare program itself. ASIPP proposes a non-partisan proposal for budget reconciliation over a period of 10 years (Table 6). In this proposal, ASIPP shows savings derived from Medicare Advantage Plans of $120 billion a year, or $1.2 trillion over a period of 10 years. ASIPP also shows costs of physician priorities as reforming physician payment system with $24 billion, or $240 billion, over a period of 10 years, elimination of sequester cuts of $62 billion over 10 years, and extension of telehealth services of $20 billion over 10 years. ASIPP's recommendations are informed by extensive analysis from MedPAC, CMS, OIG-HHS, and the CBO.

The largest savings would come from reforms to Medicare Advantage. Estimated savings from specific changes include:

1. Canceling the proposed 4.3% payment increase for 2026: $21 billion per year / $210 billion over 10 years
2. Eliminating duplicative payments for VA-covered veterans: $15 billion per year / $150 billion over 10 years
3. Ending favorable selection practices: $44 billion per year / $440 billion over 10 years
4. Reforming risk adjustment methodologies: $40

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billion per year / $400 billion over 10 years.

Collectively, these reforms could generate $120 billion in annual savings, or $1.2 trillion over a decade, from Medicare Advantage alone.

By implementing targeted reforms, such as modernizing physician payment systems and eliminating the sequestration cuts, while upholding essential recommendations from MedPAC (19), the CBO (104), and OIG-HHS (105), and remaining aligned with the fiscal goals of the House Energy and Commerce Committee and the Trump administration, it is possible to achieve physician payment reform without reducing Medicaid and Medicare funding. This strategy is fiscally sound and remains feasible within the current budget reconciliation framework.

Table 6. *A non-partisan 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**

Conclusion

The proposed physician payment fee schedule presents both benefits and challenges for independent physicians. While it offers reimbursement increases for office-based services, including E/M and procedural services, it simultaneously imposes an 8% to 10% reduction on procedures performed in ASCs and hospitals. In addition, the proposal includes multiple other issues to be addressed. We have addressed another issue which can be devastating to pain physicians related to ASM.

Reducing regulatory burdens and administrative overhead, including minimizing excessive prior authorizations, inappropriate denials of care, and unnecessary fraud or abuse investigations, can help relieve financial pressure, mitigate physician burnout, and allow physicians to focus on patient care. Streamlining these processes would also help lower practice overhead and enhance the sustainability of independent practices, which in turn increases the supply of physicians and improves access to specific treatment options.

ASIPP has provided a 6-point formula with solutions to survival of independent practices with:

- Permanent stabilization of CFs with baseline updates
- Preservation of appropriate wRVU values
- Elimination of PE RVU allocation for independent physicians and separating them from hospital-based physicians
- Extension of telehealth services indefinitely
- Elimination of ASM due to lack of evidence of efficiency
- Implementing proposal for reforming physician payment system and controlling runaway expenses of Medicare Advantage Plans.

Conflict of Interest

Dr. Gupta receives payments for grants or contracts from Nevro Corp, Vertos Medical Inc., Biotronik Inc., Averitas Pharma, made to the institution for clinical research; receives payment or honoraria to the institution for lectures, presentations, speakers bureaus, manuscript writing, or educational events from Nevro Corp., Averitas Pharma, and Nalu Medical; and receives payments from Nevro Corp, Curonix, and Averitas Pharma made to the institution for participation on a Data Safety Monitoring Board or Advisory board. Dr. Abd-Elsayed is a consultant for Medtronic, Curonix, Avanos, and Averitas. Dr. Hirsch receives grants or contracts from the Neiman Health Policy Institute, is a Medtronic, Relievant, and Sanofi consultant, and is the Chair of CSMB of neurovascular studies for Balt: Rapid Medical.

Author Contributions

The review was designed by LM, MRS, and JAH.

All authors contributed to the preparation of the article, reviewed, and approved the content with the final version.

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