Re: Requesting support to CMS to revise proposed physician payment rule to separate the cuts applied for hospital-based physicians from independent physicians

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_:

I sincerely thank you for your continued support of independent physician practices. I respectfully request your support in urging the Centers for Medicare & Medicaid Services (CMS) to revise its proposed Physician Payment Rule to distinguish reimbursement cuts applied to hospital-based physicians from those applied to independent physicians.

On July 14, 2025, CMS introduced sweeping reforms aimed at reducing wasteful spending, improving quality measures, and enhancing chronic disease management for Medicare beneficiaries. I commend the statements made by HHS Secretary Robert F. Kennedy, Jr. and CMS Administrator Dr. Mehmet Oz, who emphasized the importance of modernizing Medicare and protecting independent practices from systemic financial pressures that have favored large healthcare systems.

While I commend and support the overall concept and some aspects of the proposed rule, I are deeply concerned about its unintended consequences. The proposed changes threaten the viability of independent physician practices and may exacerbate ongoing trends in healthcare consolidation, diminish access to high-quality care, and further erode physician morale. These reforms come at a time when practice costs are soaring, non-physician staff are demanding inflation-aligned wage increases, physician burnout is on the rise, and reimbursement rates have continued to decline.

Since 2001, physicians have experienced a cumulative 33% reduction in Medicare reimbursement, even before accounting for the annual 2% sequestration cuts and increasing regulatory demands and looming 4% PAYGO cuts based on Congressional Budget Office report. The current proposal compounds these pressures, particularly for specialties like interventional pain management, ophthalmology, gastroenterology, and orthopedic surgery that often operate in ambulatory settings.

I would like to outline three key concerns:

**1. Efficiency Adjustment to Work RVUs**

CMS proposes a 2.5% reduction to the Physician Fee Schedule for non-time-based services, citing efficiency improvements in modern practice. While I support efforts to promote efficiency, I strongly oppose penalizing physicians by reducing work RVUs based on perceived gains in productivity. 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 nearly 30% of interventional pain physicians under audit at any time), and increased documentation and compliance demands from all payer sources.

Additional concerns include CMS continuing these devastating cuts every 3 years, making it unsustainable for independent practices to survive. Importantly, these reductions do not account for inflation or the cumulative 33% payment reduction since 2001. Additionally, ongoing sequestration cuts (2% annually through 2031) and potential 4% PAYGO cuts compound financial strain. I urge Congress to direct CMS to rescind the proposed efficiency adjustment to the work RVUs.

For interventional pain physicians, these cuts have been particularly severe. 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) (Manchikanti L, et al. Physician payment reform in interventional pain management: Balancing cost, quality, access and survival of independent practices. *Pain Physician* 2025; in press). 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%.

**2. Practice Expense RVU Allocation Detrimental to Independent Physicians**

CMS is proposing revisions to how indirect practice expenses are allocated in facility-based settings. These changes could significantly reduce payments for services performed in Ambulatory Surgery Centers (ASCs)—most of which are owned and operated by independent physicians. ASCs often function as practical extensions of physicians’ offices, especially for interventional pain procedures. Unlike hospital-employed physicians, independent practitioners bear the full cost burden regardless of site of service—whether in-office, ASC, or hospital.

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 (Manchikanti L, 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 Table 1, interventional pain management procedures face cuts ranging from 7% to 10%.

**ASIPP strongly urges CMS to adopt a distinguishing modifier or separate reimbursement methodology for independent physicians**, to prevent undue financial harm to practices that are not part of hospital systems but must still shoulder equivalent or greater costs.

**Table 1.** *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% |

**+** = increase; **–** = decrease

**3. Telehealth Continuity**

While I appreciate CMS’s proposed rules to expand telehealth capabilities, the current proposal does not explicitly extend telehealth flexibilities into 2026. Clear commitment to long-term telehealth access is vital to ensure continuity of care, particularly for chronic pain patients in rural or underserved areas.

I sincerely thank you for your continued support and respectfully request your advocacy in addressing several critical concerns. Specifically, I urge you to support the reversal of the proposed 2.5% efficiency adjustment to work RVUs and drop the plan for continued devastating cuts every 3, promote equitable treatment of independent physicians in practice expense allocations, ensure the permanent extension of telehealth access beyond 2025, and encourage CMS to distinguish reimbursement reductions between hospital-employed and independent physicians. Your support in these areas is vital to preserving access to high-quality, cost-effective care and protecting the viability of independent medical practices.

These revisions are essential to protect the independent physician community—the very group CMS aims to support—while preserving patient access and preventing further consolidation in healthcare, which continues to drive up costs by 200% to 300%.