ASRA PAIN MEDICINE
American Society of Regional Anesthesia and Pain Medicine
Advancing Evidence-Based Pain Management

September 12, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1832-P; Medicare Program; 2026 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies; (July 16, 2025)

Dear Administrator Oz:

The American Society of Regional Anesthesia and Pain Medicine (ASRA Pain Medicine) is a voluntary organization representing physicians specializing in chronic and acute pain medicine nationally and internationally. In particular, we are highly dedicated to using evidence-based medical therapies to treat patients with chronic and acute pain when appropriate. Our membership of approximately 5,000 practitioners includes solo practitioners, small group practice members, and practitioners in large private and academic healthcare systems. We strongly support the efforts of the Centers for Medicare and Medicaid Services (CMS) to improve the quality of care and patient outcomes.

ASRA Pain Medicine is writing today to provide comments on the following topics from the above-highlighted proposed rule:

- CY 2026 Medicare Conversion Factor (CF) Update and G2211
- Valuation of New CPT Codes for Percutaneous Interlaminar Lumbar Decompression (CPT Codes 62XX0 and 62XX1)
- Methodology for Establishing Work RVUs – Efficiency Adjustment
- Updates to Practice Expense Methodology – Site of Service Payment Differential
- G-code for Intraoperative Cryoablation Therapy for Post-Operative Pain Management
- Ambulatory Specialty Model (ASM) – Low Back Pain

<u>CY 2025 Medicare Conversion Factor (CF) Update and G211</u>
ASRA Pain Medicine requests CMS to revisit the utilization assumptions for HCPCS code G2211.

As required by law, CMS has proposed two different conversion factors (CFs) for CY 2026: $33.42 for non-qualifying Alternative Payment Model (APM) participants and $33.59 for qualifying APM participants. These proposed figures represent a projected increase from the current $32.35 conversion factor for both groups, primarily due to a legislative update from the One Big Beautiful Bill Act and

statutory updates from the Medicare Access and CHIP Reauthorization Act (MACRA). This update also includes a positive relative budget neutrality adjustment of 0.55%. ASRA Pain Medicine was pleased to see a positive update proposed for the Medicare CF for the first time in five years.

Under the Medicare statute, CMS must annually adjust the Medicare CF to maintain budget neutrality, meaning that increases in payment for one service must be offset by corresponding decreases elsewhere, so that overall Medicare spending does not rise solely due to changes in Work Relative Value Units (RVUs). In 2024, Medicare began paying for HCPCS code G2211, which was developed to be reported along with Office/Outpatient E/M visits when there is a longitudinal relationship between the physician and patient, and the physician serves as the continuing focal point for medical services that are part of ongoing care related to a patient's single, serious condition or a complex condition. Medicare estimated significant utilization for G2211, triggering budget neutrality adjustments that negatively impacted the CY 2024 Medicare CF. Claims data now show that CMS significantly overestimated the utilization of the code.

An analysis of CY 2024 claims data by the American Medical Association (AMA) identified an overestimate of expected utilization of G2211. In the CY 2024 PFS, the Biden Administration projected that G2211 would be billed with 38% of all office/outpatient E/M visits reported in 2024. However, instead of accounting for 38% of all office visits, an AMA review of the first three quarters of 2024 Medicare claims data found that G2211 was reported with only 10.5% of office visits. Considering the utilization trends for 2024, the AMA forecasted an overall utilization of 11.2% for CY 2024. This analysis shows a $1 billion difference between CMS's projected and the actual utilization of G2211.

The 2024 utilization data published with the proposed rule further supports the earlier AMA analysis. The agency's own utilization data shows that HCPCS code G2211 was billed 11.2% of the time with an office visit code. This is far below the CMS assumption at 38%.

2024 G2211 Medicare Utilization

G2211, 2024 Medicare Utilization	24,654,894
99202-99215, 2024 Medicare Utilization	219,332,635
G2211 Percent in 2024	11.2%
CMS Assumption Used for Budget Neutrality Adjustment	38%

Because G2211 was implemented in a budget-neutral manner and was expected to increase Medicare spending significantly, it resulted in a steep, unwarranted cut to the Medicare conversion factor.

ASRA Pain Medicine strongly urges CMS to correct the utilization estimate for G2211 based on actual claims data from 2024 by making a prospective budget neutrality adjustment to the 2026 conversion factor in the forthcoming Medicare Physician Fee Schedule (PFS) Final Rule for CY 2026.

Valuation of New CPT Codes for Percutaneous Interlaminar Lumbar Decompression (CPT Codes 62XX0 and 62XX1)

ASRA Pain Medicine urges CMS to finalize its proposed recommendations for CPT codes 62XX0 and 62XX1.

In September 2024, the CPT Editorial Panel created two new Category I codes to replace the existing Category III code 0275T. CPT codes 62XX0 (*Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; one insterspace, lumbar*) and 62XX1 (*Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (that is, CT or fluoroscopy), bilateral; additional interspace(s), lumbar (List separately in addition to code for primary procedure*)) were surveyed for the January 2025 RUC meeting. The two new codes describe percutaneous interlaminar lumbar decompression (PLID).

CMS proposes the RUC-recommended work RVUs for both CPT code 62XX0 (8.00) and CPT code 62XX1 (4.25) without refinement.

Work RVU Recommendations for Percutaneous Interlaminar Lumbar Decompression (CPT Codes 62XX0 and 62XX1)

CPT Code	RUC Work RVU Recommendation	2026 CMS Proposed Work RVU
62XX0	8.00	8.00
62XX1	4.25	4.25

CMS is also proposing the RUC-recommended direct practice expense (PE) inputs without refinement for both CPT codes 62XX0 and 62XX1.

ASRA Pain Medicine appreciates that CMS is proposing to accept the RUC work RVU and PE inputs for CPT codes 62XX0 and 62XX1. The society urges CMS to finalize the proposed work RVU and PE inputs in the CY 2026 PFS Final Rule.

Methodology for Establishing Work RVUs – Proposed Efficiency Adjustment

ASRA Pain Medicine urges CMS not to finalize the proposal to implement the efficiency adjustment. It is a flawed methodology that will disrupt the existing relativity within the fee schedule. ASRA Pain Medicine believes that there are alternative methods to achieve the goals identified by the agency.

For CY 2026, CMS proposes a -2.5% reduction in the work RVUs and intra-service physician time for non-time-based services. This payment cut, which the agency refers to as an efficiency adjustment, sums up the Medicare Economic Index (MEI) productivity adjustments from the past five years. Its purpose is to reflect efficiencies gained as services become more routine (although CMS plans to apply the adjustment to new services) and to correct potential overpayment from outdated service valuations. If finalized, CMS proposes to implement this adjustment every three years, with the next planned for 2029. The adjustment would not affect time-based services such as evaluation and management (E/M)

visits, care management, behavioral health, telehealth, and maternity codes. It is expected to reduce payments by approximately 1% for most specialties. According to Table 92 (*Impact Table*) from the proposed rule, only specialties likely to see at least a 1% increase include clinical psychology, clinical social work, geriatric medicine, and psychiatry—areas where providers perform a higher proportion of E/M and other services excluded from this policy.

Methodological Flaws with the Proposed Policy

ASRA Pain Medicine supports the agency's efforts to improve payment accuracy. We also agree that, over time, efficiency may develop due to familiarity with the service, technological advancements, changes in the patient population, or other factors. While we share the agency's overall goal, ASRA Pain Medicine has significant concerns about the proposed approach. We believe the policy relies on an arbitrary and flawed methodology that undermines the core of the Resource-Based Relative Value System (RBRVS) – specifically, the relativity of services on the PFS.

- Across-the-board cuts: The proposed policy impacts 7,267 services on the Medicare PFS and applies a uniform 2.5% reduction to all services. ASRA Pain Medicine contends that applying the same adjustment to all codes, regardless of when they were last updated, is a flawed strategy. This approach is problematic because it assumes that, regardless of the specialty, service, procedure length, or other factors, the same level of efficiency is achieved and on a similar timeline. ASRA Pain Medicine believes this to be an incorrect assumption. Additionally, an across-the-board cut presumes that technology consistently reduces the complexity of the work and reduces the time it takes to perform the procedure. However, in some cases, technology can introduce more data, increasing physicians' workload and cognitive effort. For instance, artificial intelligence software might generate significantly more images, thereby increasing the physician's workload. We do not believe the assumptions behind the efficiency adjustment are supported by objective data from a national surgical registry. A recent study of surgical procedures found that operative times have stayed the same or increased from 2019 to 2023. Patient complexity also correspondingly increased.[1] Additionally, trends in the Medicare population find increases in diabetes, obesity, and other comorbidities that increase the complexity of their treatment and often increase surgical times. ***ASRA Pain Medicine does not support applying across-the-board cuts to work RVUs or intra-service time.***

- Risk to relativity: The Medicare PFS, regulated by Section 184 of the Social Security Act, is based on the RBRVS, which mandates that services reflect the relative resource costs involved in providing the service. This creates relativity among services on the Medicare PFS. The across-the-board cuts are inconsistent with the statutorily mandated relativity required by law. The efficiency adjustment deviates from the statute that provides for a review of services to determine their resource use and undermines the relativity that is the bedrock of RBRVS. ***ASRA***

[1] Childers, Christopher P MD, PhDa,b; Foe, Lauren M MPHc; Mujumdar, Vinita JDc; Mabry, Charles D. MD, FACSd; Selzer, Don J MD, MS, FACSe; Senkowski, Christopher K MD, FACSf; Ko, Clifford Y MD, MS, MSHS, FACS, FASCRSg,h,i; Tsai, Thomas C MD, MPH, FACSc,j,k. Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023. Journal of the American College of Surgeons ():10.1097/XCS.0000000000001588, August 13, 2025. | DOI: 10.1097/XCS.0000000000001588

Pain Medicine does not support the across-the-board efficiency adjustment because it is inconsistent with the law that regulates the Medicare PFS.

- Calculation of the cut: CMS proposes applying a 2.5 percent efficiency adjustment factor to the work relative values and physician intra-service time, explaining that this adjustment is based on the annual private non-farm productivity adjustment used in the MEI. CMS states that it applies this productivity adjustment to inpatient and outpatient hospital payments, but those entities receive an MEI update to account for inflation. Physicians do not get an MEI update, so penalizing them with a productivity adjustment is not comparable to hospital payments. ***ASRA Pain Medicine does not support using the MEI to estimate the efficiency adjustment.***

- Ongoing nature of the adjustment: CMS proposes to implement the adjustment every three years. ASRA Pain Medicine believes that applying an automatic, uniform reduction every three years is not sensible. An argument can be made for a one-time efficiency adjustment or periodic reviews to assess the appropriateness of the current valuation. There are diminishing returns with continuous efficiency reductions—you can only become so efficient. Practically, after a certain point, there will be no work RVU or time available to reduce from a code's value. ***ASRA Pain Medicine does not support the continuous, regular application of across-the-board cuts to work RVUs and intra-service time.***

- Inclusion of new codes: CMS proposes applying the efficiency adjustment to all codes, including new codes for CY 2026 that were surveyed for the January 2025 RUC meeting. ***ASRA Pain Medicine does not support the concept of an across-the-board cut and believes it is especially problematic when applied to recently reviewed codes.***

Efficiency Adjustments Through the RUC Process

The RVS Update Committee (RUC) was founded in 1991 by the AMA and medical specialty societies to support the implementation of the newly established RBRVS system. Using surveys and expert input, the RUC provides recommendations to CMS on physician work RVUs, physician time, and direct PE inputs. Over time, the RUC has adapted its processes to address the evolving needs and challenges of the healthcare payment system. They have collaborated with CMS to resolve issues identified by the agency or other stakeholders. The RUC serves as a key source of data for the agency and shares an interest with CMS in ensuring the RBRVS remains accurate and reasonable for all physicians and healthcare professionals. ***ASRA Pain Medicine encourages CMS to work with the RUC to address concerns raised in the proposed rule regarding the planned efficiency adjustment.***

The CPT book contains thousands of codes. Some are used infrequently, while others are more commonly used. Some have low work RVUs assigned, and others have high work RVUs. A significant concern raised by CMS was the frequency of code reviews and resurveys. The RUC has established processes focused on reviewing CPT codes that significantly impact fee schedule spending. It also has procedures to identify codes that may be potentially misvalued.

- New technology list/screen: The RUC identifies codes as new technology during their initial review. Codes marked as New Technology are reviewed every three years to decide if they

should be resurveyed or need other actions. The RUC has surveyed 60 codes with new survey data from the New Technology Screen.

- Other RUC screens: The RUC has several additional screens that address the efficiency concerns raised by CMS in the proposed rule. The RUC's Relativity Assessment Workgroup (RAW) uses multiple screens to conduct an initial review of codes to determine if a RUC survey, referral to the CPT Editorial Panel for code revision, or other actions are necessary. These screens include a high volume growth screen, site of service anomalies screen (services that have shifted from inpatient to outpatient), services originally surveyed by one specialty now performed by a different specialty, services performed together 75 percent of the time or more, and Harvard-Valued or CMS/Other source data (The RUC reviews services that were valued over 33 years ago in the Harvard Studies that have reached certain Medicare utilization thresholds).

ASRA Pain Medicine believes that with the large number of CPT codes, conducting targeted reviews as the RUC does is a truly more effective process to identify efficiencies and establish accurate payments than an across-the-board cut of work RVUs.

Examples of Code where Efficiencies Were Identified Through a RUC Screen

- Transversus Abdominis Plane (TAP) Block Code 64486
- Injection Anesthetic Agent Code 64415

We want to provide two specific examples that illustrate how the current RUC processes have identified efficiencies and downwardly adjusted work and PE RVUs. This targeted review of frequently performed services effectively captures the efficiency goals articulated by the agency in the proposed rule.

TAP Block Code 64486: CPT code 64486 (*Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)*) was established in 2015. It describes an anesthetic agent in the abdominal wall. The code was resurveyed for the 2025 fee schedule cycle. It was reviewed because six new codes for reporting thoracic, lower region, and abdominal fascial plane blocks in post-operative pain management were established and surveyed for the 2025 fee schedule cycle. The RUC considered CPT code 64486 related, and they wanted to maintain relativity within the family.

- 2015 PFS: TAP blocks were first introduced as a new acute pain modality in 2001. Prior to the establishment of a specific code, CPT code 64450 (*Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch*) was reported as a workaround. When 64450 was reported, imaging was billed separately. In 2013, the work RVU value of 64450 was reduced from 1.27 to 0.75. The reduction in the work RVU was the result of a RUC survey of the code, which, before the 2013 survey, was a Harvard-valued code.
- 2015 PFS Cyle: CPT code 64486 was established. Imaging was bundled.
- 2025 PFS Cycle: The code was resurveyed, and the value of the code was reduced.

TAP Block Code 64486

Service	2001-2012 Work RVU (64450 + 76942*)	2013-2014 Work RVU (64450 + 76942*)	2015-2024 Work RVU (64486)	2025 Work RVU (64486)	Work RVU Change (2019-2025)	% Change (2019-2025)
Transversus Abdominis Plane (TAP) Block	1.94 (1.27 + 0.67)	1.42 (0.75 + 0.67)	1.27	1.20	-0.74	-38.14%

* 76942 (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*)

As the table above illustrates, the multiple RUC surveys resulted in a reduction in work RVUs.

Injection Anesthetic Agent Code 64415: In recent years, CPT code 64415 has been reviewed by the CPT Editorial Panel twice and has been surveyed by the RUC twice. The last CPT/RUC review was initiated because the code was identified through the screen titled, "Services performed together 75 percent or more of the time or more." Medicare claims data indicated that image guidance was frequently performed with code 64415. The CPT Editorial Panel bundled imaging guidance into the code descriptor, and the RUC surveyed the code with imaging bundled. Both surveys resulted in a reduction in the total work RVUs assigned to the code.

- May 2018: CPT Editorial Panel revises code descriptor and guidelines for the code.
- October 2018: The code was surveyed (2020 Fee Schedule cycle).
- May 2021: CPT Editorial Panel revises code descriptor for 64415 and bundles imaging into the code.
- October 2021: RUC surveys 64415 with imaging bundles into the code (2023 Fee Schedule cycle).

Through these multiple reviews, the code descriptors have been updated to reflect how the service is currently performed, and the valuation has been adjusted to account for the resources used to deliver the service. The revised code descriptors and guidelines more accurately represent the evolution of the service over time. The multiple surveys capture the time and intensity of the procedure, capturing any efficiencies gained over time. This is reflected in the decreased work RVUs for the procedure, which are summarized in the following table.

Injection Anesthetic Agent Code 64415 (brachial plexus)

Service	2019 Work RVUs (64415 + 76942)	2020 Work RVUs (64415 + 76942)	2023 Work RVUs*	Work RVU Change (2019-2023)	% Change (2019-2023)
Injection Anesthetic Agent - Brachial plexus	2.15 (1.48 + 0.67)	2.02 (1.35 + 0.67)	1.50	-0.65	30.23%

* In 2023, imaging is bundled into the injection code

The change in work RVUs from 2019 to 2023 was 0.65 work RVUs, or a reduction of 30.23%.

We have provided two examples of the RUC and CPT processes, capturing efficiency and other changes over time. While these are just two examples, this trend is repeated across the fee schedule, utilizing evidence-based, targeted screens that have been developed and implemented by the RUC.

ASRA Pain Medicine urges CMS not to finalize the efficiency adjustment. We encourage CMS to collaborate with the RUC and other medical specialty societies to explore alternatives for capturing efficiencies gained as services become more routine.

Updates to Practice Expense Methodology – Site of Service Payment Differential
ASRA Pain Medicine opposes the agency's proposal to revise the indirect PE methodology. We do not believe it captures the true costs incurred by practices in the facility setting.

PE RVUs, along with work RVUs and professional liability RVUs, are the three components that determine physician payment. PE consists of direct PE (clinical staff, medical supplies, and equipment) and indirect PE, which covers the overhead costs of running a practice, including maintaining an office. CMS is proposing a change to the indirect PE methodology. The current approach assumes facility-based physicians maintain an office. Because of trends showing more employed physicians and fewer independent ones, CMS no longer considers this assumption accurate. CMS proposes to revise the allocation of indirect PE based on the site of service, which will significantly reduce PE RVUs for services in facility settings such as hospitals and ambulatory surgical centers. The proposal lowers the work RVU input—an important factor in the indirect component of the facility PE RVU formula—to 50 percent of the amount used for non-facility PE RVU calculations. This is a notable change because the work RVU in the PE formula acts as a proxy for estimating the amount of time indirect resources are used when providing a service.

This policy change would significantly affect payments, with total PFS payments in the facility setting decreasing by 7%, while non-facility-based payments would increase by 4%. Table 92 in the proposed rule shows that for interventional Pain Management specialists, the impact on facility PE RVUs is -8%, and on non-facility PE RVUs, it is +7%. ASRA Pain Medicine supports the agency's efforts to establish accurate payment rates that reflect the true costs of providing medical procedures. We agree that addressing the site-of-service payment differential is important, especially for non-facility, or office-based physicians competing with higher-paying sites, such as hospital outpatient settings. ***However, ASRA Pain Medicine opposes this proposal because we believe the assumption that clinicians billing for services in the facility setting do not incur indirect expenses is incorrect.***

CMS proposes that there are few or no indirect PE costs when a facility provides services. In considering the experience of ASRA Pain Medicine members, the society has found that this is not true. Two types of physicians bill for services in a facility setting: independent/private practice clinicians who perform procedures in the facility setting and physicians who the facility employs. Both sets of physicians incur costs.

Independent/private practice clinicians have an office staff that handles patient scheduling, billing and coding, prior authorization, pre-procedure, and post-procedure tasks when services are provided in a facility. Employed physicians may face varying indirect costs depending on their employment contract. They might still need to pay for office space and/or coding and billing staff. Recently, due to the increased burden of prior authorization, many have hired additional staff to manage these requests.

Billing for Professional Services Under Medicare Part B and Overhead Costs

Employment Status	Site of Service (Place of Service Code(s))	Type of PE RVUs Applied to Payment	Overhead Costs (Y/N)
Independent/Private Practice	Office (11)	Non-Facility	**Yes** • Maintains own office • Pays for all overhead costs
	Facility (e.g., 19, 21, 22, 24)	Facility	**Yes** • Maintains own office • While facility covers some overhead costs, the billing professional typically maintains their own office and covers overhead costs and may use their own staff for scheduling, billing and other services
Employed by Facility	Facility (e.g., 19, 21, 22, 24)	Facility	**Varies Significantly** • Employment contracts very significantly • Some physicians employed by a facility cover a portion of the costs of maintaining an office. • Types of costs include everything from paying a fee for their own office, covering costs for coding/billing professionals, hiring own staff to manage prior authorization requests

ASRA Pain Medicine also wishes to express our concerns that the agency's proposal to reduce indirect practice expense when a service is performed in a facility setting could have unintended consequences across the healthcare market. We fear it could further incentivize consolidation by harming private practice physicians who provide services in hospital outpatient departments or ambulatory surgical centers.

The relationship between physician employment status (independent or employed) and the location where services are provided is complex. For employed physicians, there is also significant variation in the potential costs they may face. Currently, this proposal could negatively impact both independent

and employed physicians, and ASRA Pain Medicine strongly urges the agency not to move forward with it. ***As an alternative, ASRA Pain Medicine recommends that CMS:***

- ***Engage with the hospital and academic hospital community to better understand the costs incurred by their employed physicians.***
- ***Collaborate with the AMA to identify data that can be used to capture indirect PE costs more effectively. This could potentially be extracted from the 2024 Physician Practice Information survey conducted by the AMA.***
- ***Until more data is gathered and an alternative method is identified to estimate these costs, the PE methodology should not be revised.***

G-code for Intraoperative Cryoablation Therapy for Post-Operative Pain Management

CMS is seeking comments on whether there is a need to develop a G-code that describes intraoperative cryoablation therapy for post-operative pain management. CMS received a request from an interested party who described it as a supplemental procedure alongside the primary procedure. It provides pain relief for 60 days and could reduce the need for opioids. The therapy works by freezing nerves near the surgical site without causing permanent damage, temporarily blocking pain signals during the patient's recovery period. The interested party stated that this procedure requires an additional 20-30 minutes of intraoperative time for the surgeon beyond the primary surgical procedure.

ASRA Pain Medicine supports exploring alternatives to opioids and advocates for a multimodal approach to managing intraoperative pain without relying solely on opioids. This method combines various drugs and non-pharmacological techniques, providing effective pain relief by targeting multiple pain pathways at once. One advantage of a multimodal approach is that it can lead to fewer side effects compared to using a single medication.

Although ASRA Pain Medicine supports alternatives to opioids for managing intraoperative pain, currently, the society does not endorse creating a G-code for cryoablation therapy for postoperative pain management. Despite a growing body of evidence, its current application remains limited, and we believe it would be premature to establish a G-code specifically for cryoablation therapy in intraoperative pain management.

We would also note that a category III code, CPT 0441T (*Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve*), currently exists that describes cryoablation of lower extremity distal/peripheral nerves. This would allow for tracking or serve as a way to reimburse if the agency chose to do so.

Ambulatory Specialty Model (ASM) – Low Back Pain

ASRA Pain Medicine values the opportunity for pain medicine specialists to take part in an advanced payment model. We have outlined several concerns with the proposal and encourage the agency to consider these issues as it continues developing the model.

CMS proposes a mandatory payment model for clinicians who care for patients with low back pain. The model will run from January 1, 2027, to December 31, 2031, and will apply to providers in selected geographic areas. Participants will face payment adjustments ranging from -9% to +9% in the first two

years of the model, based on their performance on quality, cost, improvement activities, and interoperability measures. Participants will be exempt from the Merit-based Incentive Payment System (MIPS). The model will use a two-sided risk arrangement, where participants are subject to financial gains or losses. Depending on their performance relative to peers, a participant could receive a higher rate (positive payment adjustment), the standard rate (neutral payment adjustment), or a lower rate (negative payment adjustment) on their future Medicare Part B claims for covered services. Selection will be based on claims under the Medicare PFS, with participants required to bill under a specified specialty type (anesthesiology, interventional pain management, neurosurgery, orthopedic surgery, pain management, and physical medicine and rehabilitation), meet the Episode Based Cost Measure (EBCM) episode volume threshold (20 episodes) relevant to an ASM targeted chronic condition (low back pain), and be located in one of the designated mandatory geographic areas.

ASRA Pain Medicine appreciates the opportunity for our members to participate in a value-based care program. We have significant concerns with several aspects of the model design, which we have summarized.

- ***ASRA Pain Medicine does not support the mandatory nature of the program***. Providers who meet the model criteria should be able to choose whether to participate in the model.

- ASRA Pain Medicine has concerns with the time lag on episode attribution. Eligibility to participate each year is based on the number of episodes attributed to the physician during the year that was two years earlier (*e.g.,* participation in 2027 is based on the number of episodes attributed in 2025). ***Physicians should be able to opt out of participation in the ASM if they can show that the number of patients with low back pain they are treating has decreased significantly since the attribution year.***

- ***A physician will be notified of whether they are a participant in an ASM less than six months before the beginning of the Performance Year. ASRA Pain Medicine is concerned that this is not enough lead time to prepare to participate in the model. Physicians should be notified earlier.*** This could be done if fewer than a year's worth of claims or a non-calendar year is used to determine participation, so that the physician could be notified earlier.

- Unlike MIPS, due to the model design, physicians would have no way to know in advance how well they would need to score to receive a payment increase or avoid a payment reduction. ***Specific performance thresholds for negative and positive adjustments to payment should be defined in advance.***

- Every physician should be able to avoid a payment penalty and ideally receive a payment increase if they achieve or exceed a predefined performance threshold that is known to be achievable. The current model design does not allow for this to happen. The model requires a reduction in aggregate Part B payments to the participating physicians through a redistribution percentage.[2] This required savings means that if all ASM participants received the highest

[2] A "redistribution percentage" of 85% will be used in calculating the payment changes that will ensure there is a 1.35% net reduction in aggregate Part B payments to the participating physicians in 2029 and 2030 (15%

possible score, they would receive a reduction in payment. ***The redistribution percentage should be eliminated. Savings in value-based care should be achieved through reducing avoidable services to patients, not by cutting physician fees.***

- In later years of the program, maximum penalties will exceed the MIPS maximum penalty of 9%.[3] Congress set the MIPS penalties. ***ASRA Pain Medicine believes it is inappropriate for the ASM penalties to exceed the MIPS penalties.***

- For scoring purposes, all participants will be compared to each other. ASRA Pain Medicine is concerned that, due to the wide range of diagnosis codes included as low back pain, as well as the range of specialties eligible to participate in the program, the pool of participants could be very diverse. ***ASRA Pain Medicine believes that physicians caring for similar patients should be compared to each other.***

- Physicians participating in ASM would be required to have at least one "executed collaborative care arrangement (CCA)" with "a primary care practice with which the ASM participant shares ASM beneficiaries." The CCA is required to include elements such as data sharing, protocols for co-management of patients and transitions of care, referral processes, and documentation of care coordination activities. ASRA Pain Medicine generally supports the idea that excellent care requires specialists to collaborate with their patients' primary care physicians; however, this is not always helpful or possible. Additionally, it is a reality that some patients do not have a primary care physician. ***Physicians in an ASM should not be required to have "executed" arrangements with primary care practices to meet the improvement activities category, or any other types of coordination arrangements with primary care physicians.***

- CMS proposes to use EBCM to evaluate physician performance. Use of cost measures in MIPS has been problematic. ***We urge the agency to consider the previous issues related to EBCMs as they consider their implementation in the ASM.*** Some issues to consider are how spending is attributed to the correct physician (Are Patient Relationship Codes a better option?), how to best categorize the spending captured by the EBCM (e.g., spending on avoidable services that can be controlled by the physician and all other expenditures), and allowing physicians to exclude patients that may have significant social or economic barriers.

- Cost measures have a reliability score. The Measure Justification Form for the Low Back Pain Episode Cost Measure indicates that when the measure was tested for NPI-TINs with 20 or more attributed patients, the reliability of the measure was below 0.7 for 37% of the NPI-TINs, and the reliability was below 0.4 for over 4% of NPI-TINs. This is an unacceptably low reliability for a measure used to determine payment penalties. ***Physicians should not be scored on the cost measure unless they have at least 50 attributed episodes, or the number of episodes where the reliability of the measure is at least 0.8, whichever is greater.***

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of the maximum 9% penalty). The net reduction will increase to 1.5% in 2031, 1.65% in 2032, and 1.8% in 2033.

[3] A physician's payments could be reduced or increased by up to 9% in 2029 and 2030, 10% in 2031, 11% in 2032, and 12% in 2033.

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ASRA Pain Medicine appreciates your consideration of our comments on the CY 2026 PFS Proposed Rule. We look forward to working with CMS to achieve our shared goals of advancing high-quality care and improving health outcomes for Medicare beneficiaries. As part of this vital work, we will continue our commitment to promote evidence-based, non-opioid pain management techniques in treating acute and chronic pain and the safe use of opioids according to evidence-based guidelines in patients for whom it is medically appropriate. If you have any questions about these comments or other issues of concern, please do not hesitate to contact Elizabeth Smith at 412-471-2718 x102 or esmith@asra.com.

Sincerely,

Steven P. Cohen, MD
President, ASRA Pain Medicine