ASRA PAIN MEDICINE

American Society of Regional Anesthesia and Pain Medicine

Advancing Evidence-Based Pain Management

September 14, 2026

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-1848-P; Medicare Program; CY 2027 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies; (July 16, 2026)

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 2027 Proposed Medicare Physician Conversion Factor
- Practice Expense (PE) Methodology Reform
- Updates to Practice Expense Methodology – Site of Service Payment Differential
- Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods
- Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS Code G2211)
- Telehealth Flexibilities and Modifiers
- Transition Timeline from Traditional MIPS to MVP
- Ambulatory Specialty Model (ASM) – Low Back Pain

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CY 2027 Proposed Medicare Physician Conversion Factor

ASRA Pain Medicine is gravely concerned that the CY 2027 proposed conversion factors would reduce Medicare physician payment at a time when physician practices face sustained increases in practice costs.

CMS proposes a CY 2027 qualifying Alternative Payment Model (APM) conversion factor of $33.1693, a 1.19% decrease from CY 2026, and a non-qualifying APM conversion factor of $32.8409, a 1.68% decrease from CY 2026. These reductions are driven in significant part by the expiration of the temporary 2.5% payment increase enacted for CY 2026. While this payment increase was welcomed for CY 2026, it was never a permanent solution to the long-standing structural inadequacy of Medicare physician payment.

According to an AMA analysis, Medicare physician payments declined 33% from 2001 to 2025 when adjusted for inflation.[1] Further, CMS projects physician practice costs will grow by 2.5% as measured by the Medicare Economic Index (MEI). This increase in practice costs coupled with a decrease in the conversion factor under the MPFS, results in a negative impact for pain medicine physicians in 2027 and raises a potential long-term concern for adequate access to care for Medicare beneficiaries struggling with chronic pain.

> ***ASRA Pain Medicine urges CMS to collaborate with Congress to develop a long-term solution to the persistent challenges within the PFS, including the absence of a meaningful payment update that reflects actual practice costs.***

Practice Expense (PE) Methodology Reform

CMS continues its multi-year effort to reform the Practice Expense (PE) methodology by proposing to allocate indirect PE using both physician work RVUs and clinical labor RVUs for most physician services, rather than limiting this methodology primarily to services technical, professional, and global components. CMS also proposes eliminating the Indirect Practice Cost Index (IPCI) and replacing it with a Practice Expense stabilization adjustment intended to mitigate significant year-to-year payment fluctuations that may result from these methodological changes. The impact of these interrelated changes is expected to vary substantially across individual CPT codes and service categories, making code-specific analysis essential before the long-term effects can be fully understood.

[1] https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf Accessed: 8/20/2026

ASRA Pain Medicine therefore urges CMS to delay implementation of the proposed changes until CMS provides the information necessary to adequately evaluate and provide comment on the impact on Pain Medicine physicians.

ASRA Pain Medicine supports a PE methodology that accurately reflects the current resources required to furnish services in all sites of service and practice arrangements. While there may be merit in applying the same allocation methodology for all physician fee schedule services, CMS does not provide a rationale in the proposed rule for excluding the 010- and 090-day global period codes. Further, code and specialty level impacts are not available for this specific proposed change to the PE methodology.

ASRA Pain Medicine also generally supports the concept of a stabilization adjustment, however the proposed rule does not include sufficient detail regarding its methodology, duration, or operational implementation. Although the proposed stabilization adjustment may reduce abrupt payment shifts during the transition to the new methodology, it should not be viewed as a substitute for ensuring that PE inputs accurately reflect the resources required to furnish contemporary pain medicine services.

Updates to Practice Expense Methodology – Site of Service Payment Differential

CMS is requesting stakeholder input regarding the growth of hospital-employed physicians and its effect on Medicare spending, site-of-service selection, care delivery, and beneficiary access. CMS is exploring whether existing payment policies encourage migration of services to higher-cost settings and whether future payment reforms may be appropriate. We support the CMS decision to consider additional information and potentially reconsider its current approach.

Effective January 1, 2026, CMS implemented a significant refinement to the PE methodology, allocating only half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting (eg, hospital, ambulatory surgical center) compared to those allocated to services furnished in the non-facility setting. For Pain Management specialties, the estimated impact on facility PE RVUs was -8%, and on non-facility PE RVUs, it was +7%. 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 continues to oppose this methodology as it does not fully take into account the indirect costs incurred by physicians who provide services in the facility setting.***

Physicians who bill for services in a facility setting include independent/private practice clinicians who perform procedures in the facility setting and physicians who the facility employs. As CMS has previously recognized, both sets of physicians incur costs. We remain unclear how CMS arrived at the 50% figure currently used to reduce the indirect practice expense for services

furnished in a facility. A broad reduction in indirect PE may not accurately reflect the resources physicians incur while providing services in the facility setting.

In the proposed rule, CMS suggests a new HCPCS modifier for employed physicians would be a reasonable way to identify and reduce facility PE from the services they perform in the facility setting. ***ASRA Pain Medicine does not support the use of a modifier to address potential site-of-service differences as physicians may be employed by a variety of entities with equally various impacts on indirect PE.***

The table below illustrates the variability in indirect cost for both independent and employed physicians:

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, preauthorization process, 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 continued concern 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. We urge CMS to consider payment policies that weigh value through patient outcomes, quality, access, complexity, care coordination, and total cost of care rather than focusing solely on physician employment arrangements or site of service.

> ***Based on these concerns, ASRA Pain Medicine strongly encourages CMS to repeal its 2026 implementation of the 50 percent work adjustment to the indirect practice expense methodology for January 1, 2027 until such time a data driven policy is proposed.***

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

ASRA Pain Medicine opposes the CMS proposal to reduce payment by 50% when a separately identifiable Office/Outpatient (O/O) Evaluation and Management (E/M) visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, or 90-day global procedure. Likewise, we oppose extending this policy to inpatient E/M and other services.

In the proposed rule, CMS asserts there is a "likely" overlap and duplication of payment between the E/M services included in global service and the E/M service reported using the 25 modifier. However, CMS does not provide data to support that an overlap exists nor the financial impact of the suggested overlap.

The CPT description for modifier 25 states: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a

significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed." This definition clearly indicates that the E/M service reported with modifier 25 does not include any pre/post work already valued in the procedure. We encourage any concerns of inappropriate use of the modifier be addressed through means other than an across-the-board policy and payment reduction. Furthermore, as the costs of travel and other daily necessities continue to rise, patients increasingly seek to consolidate appointments to reduce the financial and logistical burden of multiple trips. This is especially significant for patients in rural and underserved areas, who may travel several hours to access care. Requiring an additional visit on a separate day would impose an unnecessary burden on these patients and may create an additional barrier to timely access to care.

CMS states its proposal to reduce the lesser valued service by 50% is consistent with its current MPPR which accounts for the overlap in pre- and post-service work. This overstates any potential overlap in E/M and procedural services. This is especially profound for 0-day global services which do not include any post-procedure E/M visits. Although pre- and post-service RVUs vary by procedure, the overlap, particularly for 0-day and 10-day global services, does not approximate the proposed 50% reduction. The vast majority of procedures performed by Pain Management Specialties are 0-day and 10-day global procedures and many are reported in an outpatient setting.

The typical work for these procedures includes reviewing the procedure and expected outcome(s) with patient and/or family, obtaining informed consent, verifying all necessary instruments and supplies are readily available and assisting with patient positioning, preparing, and draping. These services are considered in the valuation for 0 and 10-day global services. Not included is the work of an E/M service to evaluate the patient's presenting problem, review of the patient's history or the consideration of other diagnostic or treatment options.

CMS acknowledges in the proposed rule, that the RUC already accounts for overlap in procedures typically done on the same day as an E/M service in its recommendations to CMS. CMS generally accepts the majority of the RUC recommendations including procedural services typically reported with an E/M service. Therefore, the proposed policy disregards the way CMS has already set the relative values of procedures typically billed with E/M services. Thus, the proposed reduction counts any overlap in services twice.

> ***ASRA Pain Medicine strongly opposes the application of a uniform payment reduction when an E/M and a procedural code are reported on the same day for both outpatient and inpatient services. Rather we encourage CMS to identify specific instances of overlap and submit them for review under the established misvalued code and RUC valuation processes currently in place.***

Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS Code G2211)

ASRA Pain Medicine is concerned with the CMS proposal to replace the current E/M visit complexity add-on code G2211 with E/M payment modifiers referred to as MOD1 and MOD2 which would increase payment for applicable E/M services by 16% and 32% respectively. While the increase in payment would benefit our members reporting higher levels of E/M services in conjunction with G2211, we believe a change in reporting methods could negatively impact the reporting of this additional care by many of our members.

G2211 was initiated in 2024 with utilization substantially less than CMS expected. Pain management practices are in the early phases of understanding and adoption of this code. The replacement of code G2211 with modifiers would further hinder the understanding and reporting of visit complexity during a time when Pain Management Specialists are learning to appropriately report the add-on code for the longitudinal care provided to beneficiaries with chronic pain. The deletion of code G2211 would require extensive re-education of physicians and their practices.

In addition to potentially reducing the reporting of the complexity factor, the proposed change to delete G2211 increases the administration burden for physicians and their practices to educate their physicians and adopt a new reporting mechanism.

Finally, we are also concerned with the payment differential between MOD1 and MOD 2. Payment under the PFS should reflect the physician work and practice resources required to furnish the service. The time, intensity, clinical judgment, and care-coordination responsibilities involved in managing a beneficiary's complex chronic pain condition do not decrease when the physician practices outside an ACO.

> ***We urge CMS to consider the potential negative impacts on practices providing longitudinal care for complex patients with chronic pain conditions by introducing a new reporting mechanism thus creating confusion and an increased administrative burden. We therefore oppose the deletion of code G2211 and its replacement with MOD1 and MOD 2 modifiers.***

Telehealth Flexibilities and Modifiers

ASRA Pain Medicine supports the proposal to allow teaching physicians to bill and have a virtual presence when either the teaching physician or resident is in the same physical location as the beneficiary. We thank CMS for considering this change from the current requirement for a three-way telehealth visit. This flexibility will expand the ability to provide quality care while continuing appropriate resident supervision. We note that the Accreditation Council for Graduate Medical Education (ACGME) has guidelines and strict limits concerning supervision via

interactive telecommunications technology that ensure maintaining levels of patient care and teaching physician direction. We support these efforts to ensure patient safety and appropriate resident education when utilizing audio/video real-time supervision.

> ***We urge CMS physicians to provide virtual presence in all settings when either the teaching physician or resident is in the same physical location as the beneficiary.***

ASRA Pain Medicine understands that section 6209(g) of the CAA, 2026, requires CMS to establish modifiers for telehealth services in certain instances, effective January 1, 2027. In the CY 2027 Medicare Physician Fee Schedule (PFS) proposed rule, CMS introduced new informational modifiers BB and BC designed to track and distinguish between telehealth services furnished using third-party virtual platform arrangements and those furnished "incident to."

While these modifiers do not impact payment amounts, our society is concerned with the impact on the administrative burden for Pain Management Specialists and the potential liability for failure to report appropriately. ASRA Pain Medicine is also concerned that the operational details of these modifiers were not included in the proposed rule and a timeline for such guidance has not been provided. This uncertainty not only adds to the administrative burden to physician practices but also to the concern for potential liability if the modifiers are not appropriately applied.

> ***We urge CMS to consider the administrative burden of introducing these modifiers as it develops its operational policies. We further encourage CMS to provide clear guidance on the use of these modifiers in advance of the implementation.***

<u>Transition Timeline from Traditional Merit-Based Incentive Payment System (MIPS) to MIPS Value Pathways (MVP)</u>

CMS proposes to sunset traditional MIPS reporting after the CY 2028 performance period and, beginning with the CY 2029 performance period, to make MVPs the only MIPS reporting option for eligible clinicians and groups who do not participate in a MIPS Alternative Payment Model (APM). Although the transition to MVPs has been expected, the current proposal has a more aggressive timeline. This means that Pain Management Specialists currently participating in the MIPS reporting option would have only two performance years to identify and transition to an MVP most relevant to their practice.

ASRA Pain Medicine supports a quality reporting system that includes meaningful clinical measures, appropriate financial impacts and that minimizes the administrative burden for Pain Medicine Specialists. However, the proposed timeline for transition would place significant burdens on practices to build workflows to collect the required data while also incorporating

changes in MIPS reporting measures. A particular burden is placed on multispecialty practices which face strict requirements to form and manage separate reporting subgroups.

> ***ASRA Pain Medicine urges CMS to establish a deadline for transition to MVPs that recognizes the advanced notice needed for practices to make a successful and compliant transition.***

Ambulatory Specialty Model (ASM) – Low Back Pain

In the CY 2026 PFS final rule, CMS finalized ASM as 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.

In the July 16, 2026, proposed rule, CMS suggests changes to definitions and other language to increase clarity and understanding of the program requirements. **ASRA Pain Medicine appreciates CMS's attempt to clarify aspects of the model, however we continue to have fundamental concerns about the payment model design as noted in our previous comments.**

Our concerns are outlined below:

ASRA Pain Medicine strongly opposes the mandatory nature of the program. Clinicians should be able to determine their participation like that allowed under MIPS.

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**.

Savings in value-based care should be achieved through reducing avoidable services to patients, not by cutting physician fees. **The redistribution percentage should be eliminated.** The model design continues to use a "redistribution percentage" of 85 percent which guarantees that the majority of participating physicians will receive a reduction in their Medicare payments regardless of how well they perform on the measures.

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. We are concerned with the downside risk of the model which

unlike other models in which downside risk is phased in over time, physicians in an ASM could see their payments cut by up to 9 percent during the first year of the program.

Proposed New Measures

In this Proposed Rule, CMS seeks comments on the inclusion of MRI Lumber Spine for Low Back Pain as a new quality measure in 2027. **We are concerned that the timeline does not provide sufficient opportunity for participants to understand the measure methodology, the proposed attribution system and the potential scoring and financial impact of the measure.**

ASRA Pain Medicine is particularly concerned with the proposed use of a multiple-particpant attribution method for this measure. We assert that performance measures should accurately reflect the clinical decisions for which participants are reasonably accountable. The proposed attribution method combined with the proposed 365-day lookback period, will result in clinicians being assessed based on imaging decisions they did not order or meaningfully influence. **ASRA Pain Medicine supports attribution to the ASM participant with primary responsibility for managing the patient's low back pain rather than attributing the same imaging event to multiple participants.**

ASRA Pain Medicine appreciates CMS's adoption of the Functional Outcome Assessment (MIPS 182) that may better align with existing clinical workflows. ***ASRA Pain Medicine supports replacing Functional Status Change for Patients with Low Back Impairment (MIPS 220) with Functional Outcome Assessment (MIPS 182).***

> ***ASRA Pain Medicine urges CMS to delay implementation of ASM Low Back Pain for one year. If implementation proceeds as scheduled, a transition period with reduced financial accountability should be applied while participants gain experience with the model.***
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> ***CMS should delay implementation of the MRI Lumbar Spine for Low Back Pain measure until complete measure specifications and attribution methodology are publicly available and participants have had an adequate opportunity to evaluate their implications.***

ASRA Pain Medicine appreciates your consideration of our comments on the CY 2027 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