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81 Lakeview Drive, Paducah, KY 42001 · Phone: (270) 554-9412 · Fax: (270) 554-5394
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September 8, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-1848-P — Ambulatory Specialty Model (ASM): Request to Withdraw or Substantially Redesign the Model

Dear Administrator Oz:

On behalf of the American Society of Interventional Pain Physicians (ASIPP), representing 49 state societies and the Puerto Rico Society of Interventional Pain Physicians, and the Society of Interventional Pain Management Surgery Centers (SIPMS), we respectfully submit these comments regarding the Ambulatory Specialty Model (ASM).

ASIPP supports efforts to improve outcomes, quality, and efficiency for Medicare beneficiaries with low back pain. However, we are deeply concerned that the ASM, as presently designed, will threaten the survival of independent interventional pain practices, reduce beneficiary access to non-opioid pain care, and accelerate consolidation into higher-cost hospital systems.

The ASM should be withdrawn or substantially redesigned before mandatory implementation.

The model becomes mandatory January 1, 2027, placing participating interventional pain physicians into two-sided financial risk of up to ±9%, with no opt-out and without adequate historical benchmark data or a meaningful opportunity for practices to understand their performance before financial consequences begin. Critical elements—including attribution, risk adjustment, and the application of utilization and cost measures—must be sufficiently transparent and validated before physicians are held financially accountable.

This is particularly concerning for interventional pain management. Low back pain is not a single, uniform clinical condition. Independent interventional pain practices frequently care for Medicare beneficiaries with severe degenerative disease, prior spine surgery, multiple comorbidities, chronic opioid exposure, and other factors that substantially affect utilization, outcomes, and cost. Without appropriate attribution and risk adjustment, physicians who accept the most difficult patients may be penalized precisely because they care for patients with the greatest clinical needs.

The financial structure of the ASM creates an additional and fundamental concern. CMS proposes to redistribute only approximately 85% of the at-risk payment pool to participating clinicians while retaining approximately 15% as program savings. Consequently, the model is not budget neutral among participants. Average performance can produce a payment reduction by design rather than as a

consequence of poor performance. Even high-performing physicians collectively cannot recover the full amount placed at risk.

For independent practices, these reductions do not occur in isolation. Inflation-adjusted Medicare payment for interventional pain management has already declined approximately 41% from 2001 through 2025 and is approaching a 47% decline in 2027. In addition, the 2% Medicare sequester continues, while utilization of interventional techniques per 100,000 traditional Medicare beneficiaries declined 16.8% between 2019 and 2024. Adding mandatory downside risk of up to 9% could be the difference between remaining independent and being forced to sell or consolidate with a hospital or other large entity.

Such consolidation does not eliminate the need for these services. Instead, patients may receive the same care in more expensive settings, increasing Medicare expenditures while reducing access to community-based independent physicians.

There is also a substantial difference in the cost structure of services furnished in physician offices, independently owned ambulatory surgery centers (ASCs), and hospital outpatient departments. A cost methodology that fails to recognize these differences can unfairly penalize independent physicians and ASCs. ASM cost calculations therefore must appropriately account for the actual site of service and the fundamentally different economics of office-, ASC-, and hospital-based care.

ASIPP and SIPMS respectfully urge CMS to withdraw the ASM or substantially redesign it before implementation. At a minimum, CMS should:

1. **Convert the ASM to a voluntary model for an initial five-year period**, or provide a voluntary on-ramp before mandatory participation begins. A new payment model should first be tested, validated, and refined before physicians are compelled to assume substantial financial risk.

2. **Set the redistribution percentage at 100%** so the ASM is budget neutral among participants and functions as a true performance program rather than producing a guaranteed aggregate payment reduction.

3. **Exempt low-volume and small practices below a defined threshold**, consistent with the low-volume protections already recognized under the Quality Payment Program. Small independent practices should not be placed at disproportionate financial and administrative risk.

4. **Calculate costs appropriately based on the site of service**, including physician office, independently owned ASC, and hospital-based settings. Physicians should not be penalized because the model fails to recognize substantial differences in practice structure and facility costs.

5. **Publish complete attribution, risk-adjustment, cost, utilization, and measure specifications and provide a dry-run reporting period** with practice-level feedback before any payment adjustment is calculated. Physicians must be able to understand and validate how their patients, costs, utilization, quality scores, and financial risk are determined before being held accountable.

6. **Delay the first payment adjustment until at least two full performance years of validated data are available to participants.** Practices need sufficient experience and reliable data to identify problems, improve care, and correct methodological errors before financial penalties are imposed.

The ASM represents a major change in Medicare payment policy for interventional pain physicians. Implementing an untested mandatory model with substantial downside risk, incomplete transparency, and a built-in reduction in the amount redistributed to physicians places independent practices and Medicare beneficiary access at unnecessary risk.

We respectfully urge CMS to **withdraw the ASM as currently designed**. If CMS elects to proceed, the model should be substantially redesigned with the protections outlined above before mandatory participation or financial adjustments begin.

ASIPP and SIPMS stand ready to work with CMS and to provide practice-level data regarding patient complexity, referral patterns, site-of-service costs, utilization, and the operational impact of the ASM on independent practices. We would welcome the opportunity to meet with CMS and participate in any technical expert panel or stakeholder process addressing the model.

Thank you for your consideration and for your commitment to preserving Medicare beneficiaries' access to high-quality, evidence-based, non-opioid interventional pain care.

Respectfully submitted,

Laxmaiah Manchikanti, MD
Chairman of the Board and Chief Executive Officer,
ASIPP and SIPMS
Paducah, KY · drcm@asipp.org

Mahendra Sanapati, MD
Vice Chairman of the Board and COO, ASIPP
Vice President, SIPMS
Evansville, IN · msanapati@gmail.com

Annu Navani, MD
President, ASIPP
Walnut Creek, CA · annu@navani.net

Amol Soin, MD
President, SIPMS; Lifetime Director, ASIPP
Dayton, OH · drsoin@gmail.com