

American Society of Interventional Pain Physicians®
"The Voice of Interventional Pain Management"
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The Honorable Chairman James Comer
Chairman, House Oversight Committee
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SUBJECT: Request of the American Society of Interventional Pain Physicians (ASIPP) for Congressional Oversight Regarding Non-Compliance of the Mandatory Ambulatory Specialty Model (ASM) with Executive Order 14303 ("Restoring Gold Standard Science"), the Information Quality Act, and Statutory Evaluation Mandates

Dear Honorable Chairman Comer:

On behalf of the American Society of Interventional Pain Physicians (ASIPP) and state societies of interventional pain physicians in all 50 states—representing thousands of interventional pain physicians, physiatrists, anesthesiologists, and spine specialists practicing across the United States—we thank you for your leadership of the House Committee on Oversight and Government Reform, which is charged with ensuring that federal agencies act with transparency, accountability, and fidelity to the law. We know you appreciate that federal healthcare policy must be anchored in rigorous, transparent, and uncompromised science.

We write to urgently bring to your attention severe empirical and structural deficiencies within the Center for Medicare and Medicaid Innovation's (CMMI) Ambulatory Specialty Model (ASM). While ostensibly framed as a mechanism to manage chronic condition expenditures, ASM's design directly violates the scientific integrity requirements established under Executive Order 14303 ("Restoring Gold Standard Science"), the Information Quality Act (IQA), and statutory evaluation standards under Section 1115A of the Social Security Act.

We respectfully urge you to use the Committee's oversight authority to press HHS and CMS to immediately stay the mandatory rollout of ASM for spine and low back pain episodes until this model is subjected to true Gold Standard scientific review and due process safeguards, and to examine whether the model's development complied with Executive Order 14303 and the Information Quality Act.

I. Direct Non-Compliance with Executive Order 14303 ("Restoring Gold Standard Science") status

Executive Order 14303 establishes nine binding tenets of Gold Standard Science for all federal agencies. The methodology underpinning ASM and its Low Back Pain Episode-Based Cost Measure (EBCM) deviates fundamentally from these administrative requirements across multiple core dimensions:

1. Suppression of Error and Uncertainty (Tenet 3): ASM mandates punitive fee-for-service payment adjustments spanning -9% to +9% (expanding to $\pm 12\%$) tied directly to individual National Provider Identifiers (NPIs). Shockingly, CMS establishes an attribution threshold of as few as 20 episodes. In a cohort size of 20, basic statistical epidemiology dictates that a single random, non-preventable outlier—

such as an unrelated myocardial infarction, fracture, or emergency tertiary hospitalization occurring within the 90-day post-trigger window—moves a physician from the median straight to the lowest penalty decile. Imposing massive administrative fee recoupments without publishing standard error bands or confidence intervals treats stochastic background noise as physician inefficiency.

2. Opaque, Non-Reproducible Algorithms (Tenets 1 & 2): Gold Standard Science requires full reproducibility and open analytic code. Participating interventional specialists cannot prospectively verify, audit, or reproduce their risk-adjusted scores. Relying on closed administrative claims algorithms and a 12-to-18-month claims lag, CMS forces physicians into retrospective penalties based on 'black-box' models that no independent clinician can audit or replicate in real time.

3. Structural Confirmation Bias & Failure of Falsifiability (Tenets 5 & 6): The model incorporates an automatic 15% discount/withhold on positive adjustments, mathematically anchoring the model to extract net program savings regardless of clinical quality outcomes. Furthermore, the model assumes that lower spending equals higher clinical efficiency. It incorporates zero falsification controls to measure whether spending reductions stem from delayed diagnosis, barrier-induced rationing, functional deterioration, or the abandonment of complex, intractable pain patients.

4. Absence of Independent, Blinded Peer Review (Tenet 7): CMMI relies on internal, agency-directed contractor reports driven by statutory savings goals, rather than independent, blinded peer review in respected biomedical and health economics literature prior to forcing mandatory provider compliance across 40% of geographic CBSAs.

II. Destructive Construct Validity in Low Back Pain Episodes

As interventional specialists, our members treat complex, chronic, refractory spinal disorders. The Low Back Pain EBCM reflects profound clinical invalidity:

- **Conflation of Disparate Pathology:** The administrative ICD-10 grouping conflates self-limiting muscular axial back pain with severe, multi-operated, refractory neuropathic spinal disease. Treating these fundamentally distinct clinical entities under a homogenized spending benchmark severely penalizes physicians who take on difficult, tertiary referral cases.
- **Unfair Attribution Cascades:** When a specialist performs an indicated interventional procedure (e.g., epidural steroid injection, facet neurotomy, or neuromodulation trial), a 90-day spending window is triggered. Unrelated inpatient admissions, imaging, physical therapy, and downstream tertiary surgical consults flow directly into the proceduralist's total cost profile. This creates severe perverse incentives to 'cherry-pick' healthy patients and refuse care to complex, comorbid Medicare beneficiaries.

III. Individual NPI Portability and Practice Destabilization

Unlike ACO benchmarks or group MIPS reporting tied strictly to Taxpayer Identification Numbers (TINs), ASM attaches payment adjustments directly to the individual physician's NPI. This structure introduces unprecedented economic volatility:

- **Portability Liabilities:** Penalties earned due to small-sample statistical noise follow a physician if they change practices, join an Ambulatory Surgery Center (ASC), or relocate, creating massive contractual liabilities and poisoning physician recruitment and practice valuations.
- **Acceleration of Practice Consolidation:** Compounded by ongoing Physician Fee Schedule conversion factor cuts and escalating practice expenses, ASM will accelerate the bankruptcy of independent

interventional pain practices, forcing physicians into hospital employment—ironically driving Medicare spending significantly higher under hospital facility fees.

IV. Formal ASIPP Requests

Under your leadership, we ask that you press CMS to halt this bureaucratically flawed, statistically invalid model and restore genuine science to payment policy. Specifically, ASIPP respectfully requests that the Committee:

- 1. An Immediate Administrative Stay:** Call on HHS and CMS to suspend the mandatory rollout of the Ambulatory Specialty Model (ASM) for Low Back Pain episodes across all geographic Core-Based Statistical Areas (CBSAs).
- 2. Independent Academic Review:** Request that CMS refer the Low Back Pain EBCM and ASM risk-adjustment architecture to an independent, external scientific body (such as the National Academies of Sciences, Engineering, and Medicine) for a comprehensive audit under EO 14303 Gold Standard criteria, and consider asking the Government Accountability Office or the HHS Office of Inspector General to review ASM's development.
- 3. Disclosure of Empirical Code & Uncertainty Bounds:** Direct CMS to publish open-source risk-adjustment code and to include statistical confidence intervals and standard errors on all provider feedback reports before any payment multiplier can be applied.
- 4. Correction under the Information Quality Act (IQA):** ASIPP is submitting its concerns to CMS as a formal request for correction under HHS/CMS Information Quality Guidelines, seeking the immediate retraction and recalculation of statistically unvalidated specialty performance measures. We ask that the Committee monitor CMS's response and timeliness.
- 5. Briefing and Records:** Request a briefing from HHS and CMS leadership, and the production of the analyses and documents supporting ASM's 20-episode attribution threshold, its risk adjustment, and its Gold Standard Science and Information Quality Act reviews.

We stand ready to meet with you and your Committee staff, and to join CMS and CMMI leadership, to review the empirical data and collaborate on value-based models that genuinely protect patients and reward high-quality clinical care without compromising scientific truth.

Respectfully submitted,

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Distinguished researcher and author:

- *Ranked #1* globally for randomized controlled trials in chronic pain therapy (1989–2024). *Medicine* (2025) 104:39
- *Ranked #1* among the most cited studies on epidural steroid injections. *PM&R Sci* 2025:292–297
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To view some of Dr. Manchikanti's publications go to:

<https://pubmed.ncbi.nlm.nih.gov/?term=Manchikanti+L%5BAuthor%5D&sort=date>

“The most entrenched conflict of interest in medicine is a disinclination to reverse a previous opinion.”
Yudkin JS et al. Lancet 2011

“There is no limit to what a man or woman can do, or where he or she can go if he or she doesn’t mind who gets the credit.” *Ronald Reagan*-modified

(On behalf of the Board of Directors and the National Membership of the American Society of Interventional Pain Physicians)