

## IMPORTANT NEWS (Detailed)

### CY 2027 Medicare OPPS/ASC Proposed Rule (CMS-1850-P) Significant changes

#### What It Means for an Interventional Pain Practice in an ASC

Important context on the document reviewed: the uploaded file (Federal Register doc. 2026-13656, scheduled for publication July 7, 2026) is not a commercial payer fee schedule. It is CMS's proposed rule for the CY 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment system. It does not contain a code-by-code rate table — the proposed rates for every CPT/HCPCS code live in Addenda AA and BB, published separately on the CMS website. What the rule does contain is the payment policies, update factors, and estimated payment impacts that will determine 2027 Medicare rates — and, because commercial payers commonly benchmark ASC contracts to Medicare, it also shapes private reimbursement. These are proposals; the final rule (typically November 2026) may change figures, and comments are due roughly 60 days after publication.

#### 1. Interventional Pain Procedures

The rule's clearest signal for pain medicine is a widening split between device-based neuromodulation (paid substantially more) and injection-based procedures (drifting slightly down). CMS's own impact estimates for the highest-spend ASC procedures (Table 90 of the rule) include an unusually large concentration of IPM codes:

Code	Procedure	Proposed Changes from the 2026 Payment Rates
63685	SCS generator insertion/replacement	+14.8%
64555	PNS electrode implant	+9.8%
64561 / 64590	Sacral electrode / pulse generator	+8%
64628	Basivertebral nerve ablation	+6.5%
27279	Minimally invasive SI joint fusion	+7.1%
63650	Percutaneous SCS lead implant	+6.2%
62323	Interlaminar ESI, lumbar/sacral	-3.8%
64483	Transforaminal ESI, L/S first level	-3.8%
64493	Lumbar/sacral facet injection, first level	-3.8%
64635	Lumbar facet RF ablation, single joint	-4.3%

### **Lowest-paying movement: bread-and-butter injections**

Epidural steroid injections (interlaminar 62323, -3.8%; transforaminal 64483, -3.8%), facet joint injections (64493, -3.8%), and lumbar facet radiofrequency ablation (64635, -4.3%) all decline modestly despite the +2.4% system-wide update. These codes are effectively “below benchmark” relative to the overall update — their relative weights are being recalibrated downward, so injection revenue loses ground to inflation. Many injection codes are also constrained by the office-based payment cap (paid at the lesser of the ASC rate or the PFS non-facility amount), which structurally limits their ASC facility fees.

### **Highest-paying movement: neurostimulation**

Spinal cord stimulator generator placement (63685) is the third-largest ASC procedure in the entire Medicare program by spend (\$421M) and is proposed for a +15% increase — the largest gain of any high-volume ASC procedure except rotator cuff repair. SCS lead placement (63650), peripheral nerve stimulation (64555, +10%), and sacral/peripheral generator codes (64561, 64590, +8%) all rise as well. CMS attributes the +6% aggregate increases for the nervous-system and musculoskeletal specialty groups to the high share of device-intensive procedures, which benefit from updated device-cost data. Newer technologies also fare well: basivertebral nerve ablation (64628, +7%), minimally invasive SI joint fusion (27279, +7%), and percutaneous intradiscal allograft injection (0627T, +9%).

### **Prior authorization: growing in hospitals, still absent in ASCs**

CMS proposes to expand hospital outpatient department (HOPD) prior authorization to additional botulinum toxin injection codes commonly used in pain practice — 64616 (cervical dystonia), 64642–64647 (extremity/trunk chemodenervation for spasticity), 64611, 64617, and J0589 — effective July 1, 2027. This adds to the existing HOPD prior-auth list that already covers facet joint injections and facet RF ablation (64490–64494, 64633–64636), percutaneous SCS lead implantation (63650), and cervical fusion. Critically, these prior authorization requirements apply only to hospital outpatient departments, not to ASCs — a meaningful administrative and scheduling advantage for pain procedures performed in the ASC setting.

### **Non-opioid pain treatments**

The temporary separate (unpackaged) payment for qualifying non-opioid pain treatments under Section 4135 of the CAA 2023 — covering products such as liposomal bupivacaine and qualifying analgesia devices in both HOPD and ASC settings, capped at 18% of the associated procedure payment — continues through December 31, 2027, its final statutory year. Practices using these products should plan for the payment cliff in 2028 unless Congress extends it. Separately, CMS is reviewing device pass-through applications relevant to pain, including the Altius high-frequency nerve block system for chronic post-amputation pain.

## 2. Ambulatory Surgery Center Payment System Overview

### Conversion factor and update

CMS proposes a 2.4% ASC update for 2027 (3.2% hospital market basket minus a 0.8-point productivity adjustment), raising the ASC conversion factor from \$56.322 to \$57.766 for ASCs meeting ASC Quality Reporting (ASCQR) requirements. ASCs that fail quality reporting receive only a 0.4% update (\$56.638) — a 2-percentage-point penalty that makes ASCQR compliance worth roughly 2% of all Medicare revenue. Notably, CMS extended the use of the more generous hospital market basket (rather than CPI-U) as the ASC update factor for one more year, through CY 2027 — a policy the ASC industry has fought to keep. Total Medicare ASC spending is projected at \$9.9 billion, up \$520 million.

### Relationship to hospital rates

ASC rates remain tied to OPPS relative weights scaled by a proposed weight scalar of 0.809 — meaning ASCs are paid roughly 81 cents on the OPPS dollar for the average procedure (before the differing conversion factors). The proposed OPPS conversion factor rises sharply to \$102.004, inflated by an 8.44% boost to non-drug services that offsets the proposed 340B drug payment cut (ASP minus 33.4%); this hospital-side dynamic does not flow through to ASCs, so the facility-fee gap between HOPDs and ASCs widens on paper even as ASC rates rise in absolute terms.

### Most favorable procedure categories in the ASC

By specialty group, CMS estimates 2027 ASC payment changes of +6% for musculoskeletal (\$2.0B) and +6% for nervous system (\$1.6B) — the two groups that contain nearly all interventional pain procedures — versus +5% cardiovascular, +1% genitourinary, -1% eye, and -2% gastrointestinal, against a +2% total. Device-intensive procedures (SCS, PNS, SI fusion) are the engine of those gains: the device cost portion is protected in the ASC rate, and ASC complexity adjustments for certain code combinations continue.

### Covered procedures list and site-of-service migration

CMS proposes adding 618 procedures to the ASC Covered Procedures List, driven by the continuing phase-out of the Inpatient Only list (637 removals this cycle, largely non-pain clinical families; the big musculoskeletal wave came in CY 2026). The direction of travel is unmistakable: CMS is deliberately expanding what ASCs may perform, citing patient choice and lower cost-sharing. Beneficiaries pay a flat 20% coinsurance in ASCs on lower base rates, so patient out-of-pocket costs are consistently lower than in HOPDs — a marketing point when competing with hospital-based programs.

### Other payment policies to note

- Multiple-procedure discounting continues unchanged (standard 50% reduction on subsequent procedures).
- Office-based procedure caps still apply: codes performed predominantly in physician offices are paid at the lesser of the ASC rate or the PFS non-facility practice-expense amount — this is what suppresses ASC rates for many injection codes.

- ASCQR program changes are modest: removal of the colonoscopy follow-up interval measure and a request for information on stratifying the transfer/admission measure.

### 3. Bottom Line

For an interventional pain practice operating an ASC, this proposed rule is, on balance, favorable — and it rewards exactly the service-mix shift most pain ASCs are already pursuing. The +2.4% system update is respectable, but the real story is composition: neuromodulation and device-based procedures (SCS at +15% for generator placement, PNS at +8–10%, basivertebral ablation and SI fusion at +7%) receive some of the largest increases in the entire ASC program, while conventional injections and RF ablation (–2% to –3%) continue a slow erosion. A practice whose ASC volume is dominated by ESIs and facet work will see essentially flat-to-declining Medicare facility revenue in real terms; a practice with a strong implant program will see meaningful growth. The prior-authorization asymmetry compounds this: facet interventions, SCS trials, and now an expanded botulinum toxin list require prior authorization in hospital outpatient departments but not in ASCs, making the ASC both the faster and the better-paid site of service for Medicare pain procedures.

Strategic priorities suggested by the rule: first, protect ASCQR quality-reporting status — the 2-point penalty is the single largest controllable payment variable. Second, grow the neuromodulation line (SCS, PNS, sacral stimulation) and evaluate adding SI joint fusion and basivertebral nerve ablation if not already offered, since these carry the strongest payment trajectory and device-intensive protection. Third, plan for the December 31, 2027 expiration of separate non-opioid payment (Section 4135) if the practice relies on qualifying products. Fourth, watch the final rule for the injection-code declines — they compound annually and are worth a comment letter (comments are due approximately 60 days after the July 7, 2026 publication; specialty societies such as ASIPP and SIS typically coordinate comments).

Because this is Medicare rulemaking, nothing here is negotiable with CMS — but it is highly relevant to commercial contracting. Payers that benchmark ASC contracts as a percentage of Medicare will automatically import the injection-code cuts, so when renegotiating commercial ASC agreements consider: fixing rates to the current-year Medicare fee schedule (or a stated floor) rather than a floating “current Medicare” reference; carve-outs or fixed case rates for high-cost implants (SCS generators and leads) so device cost inflation is not absorbed into a percentage-of-Medicare rate; separate payment provisions for non-opioid pain products after the Medicare separate-pay provision sunsets; and explicit contract language exempting ASC claims from the payer’s hospital outpatient prior-authorization policies, mirroring the Medicare asymmetry. This document is a proposed rule; verify final figures against the CY 2027 final rule and Addenda AA/BB before making financial projections. This analysis is informational and is not legal or reimbursement advice.