Health Policy Perspective

When Outcomes Become Currency: Reconsidering Value in Interventional Pain Management Under Emerging Episode-Based Payment Models

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The transition toward value-based care in the United States has introduced episode-based payment models that increasingly tie physician reimbursement to longitudinal costs and standardized outcomes.

The Centers for Medicare & Medicaid Services (CMS) Ambulatory Specialty Model (ASM), targeting chronic low back pain (cLBP), represents a pivotal extension of this framework into interventional pain management. While intended to reduce low-value utilization, such models risk redefining clinical success in ways that may not align with the heterogeneous and biopsychosocial nature of chronic pain. This perspective examines the potential for outcome-driven reimbursement to incentivize risk selection, marginalize clinically meaningful but non-durable functional gains, and exacerbate existing health disparities.

Based on available literature, we propose a "Value Plus" framework incorporating enhanced risk adjustment and patient-centered composite outcomes to better align economic incentives with the realities of chronic pain care.

In conclusion, in the field of interventional pain management, withdrawal of multiple conflicting models (ASM, WISER, etc.), and addition of a payment model including a value plus framework would better align incentives with the realities of delivering care to chronic pain patients.

Key words: Interventional pain management, reimbursement, Ambulatory Specialty Model, chronic pain, value-based care

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Value-based care initiatives have reshaped reimbursement across medicine, emphasizing cost containment, quality metrics, and accountability for outcomes. Episode-based payment models have demonstrated mixed success across procedural and medical specialties, often performing best in conditions with predictable trajectories and discrete interventions (1).

The introduction of the CMS Ambulatory Specialty Model (ASM) signals a critical shift: the individual interventionalist, rather than the institution, bears financial accountability for the total cost and outcomes of a longitudinal episode of care (2-6). While conceptually aligned with improving efficiency, applying such a model to chronic pain—a condition fundamentally shaped by biological, psychological, and social determinants—introduces a structural mismatch between clinical reality and economic modeling (7-11).

The "Durability Trap" in Pain Metrics

Interventional therapies, including epidural steroid injections and radiofrequency ablation, are commonly

evaluated using threshold-based definitions of success, often ≥ 50% pain reduction sustained over a defined period. However, chronic pain outcomes are inherently continuous, variable, and patient-specific.

Patients frequently experience:

- Partial but meaningful pain reduction
- Improved functional capacity or mobility
- Reduced reliance on opioid or adjunctive pharmacotherapy
- Enhanced sleep and participation in activities of daily living

IMMPACT recommendations emphasize that even modest changes in pain intensity (e.g., 10–20%) may represent clinically important differences for patients (12). Yet under rigid episode-based frameworks, such improvements may be insufficient to meet predefined thresholds.

This creates a "durability trap," wherein clinicians are incentivized to pursue only those interventions likely to produce sustained, measurable changes, while shorter-duration or functionally meaningful improvements are devalued. As a result, interventions that provide real-world benefit may be systematically categorized as low value.

Incentivized Patient Selection and the "Complexity Penalty"

When reimbursement is tied to outcomes, economic theory predicts the emergence of risk-selection behavior (13). In interventional pain management, this may manifest as preferential treatment of patients with localized pathology and predictable response patterns, alongside avoidance of patients with higher complexity.

Chronic pain is strongly influenced by psychosocial factors, including depression, anxiety, catastrophizing, and adverse social determinants of health (7,8,11). These variables are associated with poorer outcomes on standardized metrics, even when appropriate care is delivered.

This dynamic introduces a "complexity penalty," wherein:

- Patients with nociplastic or centralized pain
- Individuals with significant mental health comorbidity
- Patients with socioeconomic barriers to care

These factors are less likely to generate favorable outcome metrics and therefore become less desirable within risk-bearing models.

Evidence from broader healthcare systems demonstrates that value-based reimbursement can incentivize "cream-skimming," whereby lower-risk patients are preferentially selected to optimize performance metrics (2-5,14). In pain management, such behavior risks exacerbating disparities in access and outcomes for already vulnerable populations.

Reconsidering Value in Chronic Pain Care

The prevailing definition of value in healthcare, outcomes achieved per dollar spent, assumes that outcomes are readily measurable, comparable across populations, and reflective of meaningful clinical benefit (15). These assumptions are frequently violated in chronic pain.

Pain is a multidimensional experience, and meaningful improvement is often non-linear, intermittent, and context-dependent. Central sensitization and nociplastic mechanisms further complicate the relationship between intervention and outcome, often limiting the magnitude or durability of measurable change despite appropriate care (9).

A patient who experiences several weeks of improved function, reduced medication use, and enhanced quality of life may derive substantial benefit, even if standardized scores fail to demonstrate significant change within a fixed episode window. Narrow outcome definitions risk systematically undervaluing such improvements.

A Path Forward: The "Value Plus" Framework

To mitigate unintended consequences and better align reimbursement with clinical reality, we propose a "Value Plus" framework with three key components:

1. Precision Risk Adjustment
   Risk adjustment must extend beyond traditional medical comorbidities to incorporate validated psychosocial and socioeconomic variables. Instruments such as the Pain Catastrophizing Scale (PCS), along with structured assessment of social determinants of health, should be integrated as baseline modifiers to enable equitable comparison across patient populations.
2. Expanded Outcome Currency
   Value should be operationalized through a composite, patient-centered framework that captures multidimensional benefit, including:
   - Opioid sparing: Reduction in morphine milligram equivalents
   - Healthcare utilization: Decreased emergency

department visits, imaging, and downstream interventions
- Functional and vocational outcomes: Return to work, improved sleep, and participation in activities of daily living

Such composite measures better reflect real-world benefit than single-domain pain scores alone.

3. Dynamic Episode Windows
Chronic pain trajectories are inherently non-linear. Fixed episode windows may fail to capture the cumulative benefit of intermittent or "bridge" therapies. Flexible, longitudinal assessment frameworks are needed to reflect the episodic nature of chronic pain management.

Conclusion

The ASM represents an inflection point for interventional pain management (2-6). While it offers an opportunity to reduce low-value care and improve accountability, a narrow definition of value risks marginalizing clinically meaningful but less measurable improvements and incentivizing avoidance of complex patients.

A recalibration is required, one that acknowledges the multidimensional nature of pain, incorporates robust risk adjustment, and prioritizes patient-centered outcomes. If outcomes are to become the currency of modern healthcare, the framework by which they are measured must be sufficiently nuanced to avoid unintended harm.

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