

Health Policy Review

Implications of the CMS Ambulatory Specialty Model for Low Back Pain for Interventional Pain Management: The Good, The Bad, And The Ugly

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Since the enactment of the Affordable Care Act (ACA) in 2010, the Centers for Medicare & Medicaid Services (CMS) have embraced value-based care as the organizing principle of national payment reforms. Yet, after more than a decade, the value-based movement has, at best, generated modest returns and at worst increased costs on patients and negatively impacted access. Pursuant to its authority under the ACA, CMS proposed the Ambulatory Specialty Model (ASM) in the CY 2026 Physician Fee Schedule rulemaking and subsequently finalized the model, establishing the agency's first mandatory alternative payment model focused on ambulatory specialty care. ASM targets 2 high-cost, high-prevalence chronic conditions, heart failure, and low back pain (LBP) and will require eligible physicians in selected geographic regions to accept 2-sided financial risk beginning with performance year 1 in January 2027.

This article summarizes the design of ASM, details how physicians are selected into the model and how payment adjustments are calculated (including how procedure mix and site of service, office versus ambulatory surgery center or hospital outpatient, affect episode-based cost scoring), enumerates the required quality measures and patient-reported outcome measures (PROMs), describes the Collaborative Care Arrangement requirements, compares ASM against traditional Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APM) such as Accountable Care Organizations (ACOs), weighs whether ASM functions as a carrot-and-stick or aversion-based policy and whether it represents innovation or limitation, and addresses whether performance is compared across specialty types (e.g., neurosurgery versus pain medicine). It then examines specific implications for interventional pain management (IPM) practices, situates IPM within the broader multispecialty landscape of LBP care, and closes with a practical action list and CMS reference links for IPM groups preparing for mandatory participation.

Key Words: Chronic low back pain, interventional pain management, Ambulatory Specialty Model, Merit-based Incentive Payment System, Advanced Alternative Payment Models, patient-reported outcome measures

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The Patient Protection and Affordable Care Act (ACA), commonly called Obamacare, radically altered the United States healthcare system. While it successfully expanded coverage to millions of previously uninsured citizens, it also introduced numerous structural complications (1). Some of

the challenges included skyrocketing deductibles, premium increases, shrinking provider networks, subsidy cliff risks, complex enrollment requirements, and enactment of multiple policies. Since the enactment of ACA, Centers for Medicare & Medicaid Services (CMS) has fully embraced value-based care as

the organizing principle of national payment reforms, despite continuing failures, extensive costs, and very little demonstrated benefit. After more than a decade of experimentation, the value-based movement has, at best, generated modest returns and, at worst, increased costs for the program and providers, while adversely affecting patient care. Extensive evaluations have shown that many of these models have not improved care or quality or generated meaningful savings (2,3). Some have argued that inadequate engagement of specialists, who frequently manage the highest cost patients and account for the majority of healthcare spending, has been a shortcoming of value-based models (2). In their continuing zeal for such models, CMS recently announced the Ambulatory Specialty Model (ASM), a new value-based model that directly engages specialists in the ambulatory care setting (4).

Importantly, the ASM reportedly attempts to address several structural shortcomings that plagued previous value-based models. One major advantage of a mandatory program, as described by CMS, is that voluntary pilot programs are prone to selection bias and may not be broadly generalizable, making them difficult to definitively evaluate (5). Further, prior outpatient value-based payment models allowed clinicians to select which quality measures to report, making it challenging to compare performance across physicians reporting different measures. This ASM will require physicians to report on a common set of measures relevant to their specialty and will assess performance only against physicians treating the same condition, with the intent of ensuring fair and consistent comparisons. Even though it appears promising, ASM still relies on the same framework and many of the flawed underlying assumptions that limited the impact of its value-based payment predecessors, and several issues may ultimately undermine its success.

A major issue related to IPM is that ASM comes at a time when independent practices are already struggling to survive, with continued payment cuts resulting in reductions of 33% for all physicians and 41% for interventional pain physicians from 2001 to 2026. These continued reductions have created substantial turbulence and uncertainty regarding the survival of independent practices, with additional cuts forecasted across different settings. ASM adds another layer to these continuing challenges. The expiration of the temporary 2.5% statutory increase, the efficiency adjustment, and the practice expense redesign finalized for calendar year (CY) 2026 continue to compound financial pressures. The 2% fed-

eral sequestration cut adds yet another burden, while ASM holds IPM physicians financially accountable for the longitudinal management of low back pain, a condition whose overall utilization these physicians do not control (6-8). Further, IPM technique utilization has decreased substantially over the years, particularly following the COVID-19 pandemic, due to a multitude of factors, including restrictive local coverage determinations (LCDs), medical policies, audit fears, and other issues (9-14). Ironically, under ASM, all revenues are not distributed, as CMS retains 15% of the higher amount. However, this approach may be unrealistic in the majority of IPM settings because many patients undergoing interventional techniques are considered high-risk and have multiple medical problems, including hypertension, diabetes, obesity, other comorbidities, and psychological conditions. On the other hand, some patients undergoing implantable therapies for diabetic peripheral neuropathy or similar conditions may be considerably healthier and have few or no significant comorbidities.

In this review, in addition to assessing various aspects of ASM and its impact on interventional pain physicians, we will examine the good, the bad, and the ugly aspects of the model. We also discuss whether this policy represents a carrot-and-stick approach or an aversive policy. It is also important to recognize that ASM is promoted as an innovation, while physicians may view it as an additional limitation.

AMBULATORY SPECIALTY MODEL

ASM is a 5-year, mandatory Center for Medicare and Medicaid Innovation (CMMI) model finalized alongside the CY2026 Medicare Physician Fee Schedule (PFS) (15-17). It builds on the existing Merit-based Incentive Payment System (MIPS) Value Pathways (MVP) framework rather than replacing it, applying modified quality, cost, improvement-activity, and Promoting Interoperability scoring rules to 2 clinical cohorts: heart failure (cardiology) and low back pain (anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation) (16).

Unlike MIPS, participation is not voluntary. Clinicians are pulled into ASM automatically if they (a) practice in one of approximately one-quarter of core-based statistical areas (CBSAs) or metropolitan divisions selected by CMS, and (b) have historically been attributed at least 20 low back pain episodes annually under CMS's episode-based cost measure methodology (17). Performance is assessed at the individual clinician

(TIN/NPI) level for quality and cost, a departure from MIPS, which permits group- or Advanced Alternative Payment Model (APM)-entity-level reporting, while improvement activities and interoperability are assessed at the group level (18).

The model runs for 5 performance years (2027–2031) with payment years lagging 2 years behind (2029–2033). Maximum payment adjustments begin at $\pm 9\%$ in the first payment year and rise to $\pm 12\%$ by the model's final year, applied on top of standard PFS payments as shown in Table 1 (19–24).

SELECTION OF PARTICIPATING PHYSICIANS

ASM selection operates on 2 independent axes, geography and individual clinician eligibility, both applied using retrospective claims data rather than prospective attestation or opt-in enrollment as shown in Table 2 (24).

CMS used stratified random sampling, rather than selecting only the highest-spending or highest-volume areas, specifically to build a study design capable of comparing ASM regions against non-ASM regions over time (24). CMS released a preliminary participant list in February 2026 (approximately 6,637 clinicians nationally across both cohorts) with a final list expected in summer 2026 ahead of the January 1, 2027 start (25).

A practical consequence of individual (TIN/NPI)-level selection is that 2 physicians in the same group practice, same building, and same specialty can have different ASM status in a given year, one may clear the

20-episode/30%-attribution threshold while a partner who shares more of the LBP workload with physical therapy or a mid-level provider does not (26).

CALCULATION OF ASM PAYMENTS

Funding the Incentive Pool

ASM is budget-neutral by design. CMS forms a separate incentive pool for each cohort (heart failure; low back pain) using the formula: Incentive Pool = (Total Medicare Part B payments to ASM participants during the performance year) $\times$ (ASM risk level) $\times$ (redistribution percentage) (27).

The redistribution percentage is set at 85% for the 2027 performance year, meaning 15% of the total dollars placed at risk flows to the Medicare Trust Fund rather than back to participants, regardless of aggregate performance (27). The risk level is the percentage tied to that performance year on the glidepath shown in Table 1 (9% in year 1, rising to 12% by year 5).

Table 1. *Illustration of application of ASM.*

Performance Year	Calendar Year	Payment Year	Max Adjustment ($\pm$)
1	2027	2029	9%
2	2028	2030	9%
3	2029	2031	$\sim 10\text{--}11\%^*$
4	2030	2032	$\sim 11\%^*$
5	2031	2033	12%

Table 2. *Selection of participating physicians*

Selection Factor	How It Works
Specialty designation	Determined by the specialty code appearing on the plurality (largest share) of the clinician's Medicare Part B claims, using claims data from the calendar year 2 years prior to the performance year.
Episode volume threshold	Clinician must be attributed at least 20 low back pain episodes annually under the MIPS episode-based cost measure (EBCM) methodology.
Attribution rule	An episode only counts toward a clinician's volume if that clinician billed at least 30% of the Part B services within the episode, incidental or one-off encounters do not count.
Geographic selection	Roughly one-quarter of core-based statistical areas (CBSAs) and metropolitan divisions are selected via stratified random sampling, designed to vary by per-beneficiary Medicare spending (high/low), episode volume (low/high/very high), and metropolitan division status.
Level of participation	Individual clinician (TIN/NPI) level, not practice-group or ACO level, CMS explicitly rejected group-level attribution to prevent large systems from diluting individual outlier performance.
Multiple practice locations	Clinicians practicing across more than one CBSA/metropolitan division are assigned to whichever area accounted for the majority of their episodes.
Duration of selection	Once selected, a clinician remains an ASM participant for the full model duration (through 2031), even in years they later fall below the 20-episode threshold, though payment adjustments only apply in years the threshold is met; below-threshold years default back to standard MIPS reporting.
Exemption from MIPS	Clinicians selected into ASM are exempt from separate MIPS reporting and MIPS payment adjustments for any year in which they are an active ASM participant.

Composite Scoring

Each participant earns a composite performance score built from 2 categories that, unlike MIPS, do essentially all of the weighting:

- **Quality** — 50% of the composite score. Clinicians are scored against a small set of condition-specific clinical measures (e.g., functional status improvement for LBP) and assigned achievement points based on which decile their result falls into relative to their peer benchmark.
- **Cost** — 50% of the composite score, using the MIPS episode-based cost measure (EBCM) methodology already used elsewhere in MIPS. CMS calculates a standardized ratio of each clinician's observed episode costs to their risk-adjusted expected episode costs, multiplies that ratio by the benchmark average episode cost, and assigns decile-based achievement points the same way.
- **Improvement Activities (IA)** and assessed at the group level and function only as penalties (score reductions) if minimum requirements are not met; they do not add bonus points the way they can under standard MIPS.

Quality performance is scored "in equal deciles among peers," and cost performance uses an "around-the-median" distribution with ranges based on standard deviations from a cohort-specific median, both are relative, curve-based comparisons rather than fixed national thresholds (42).

From Composite Score to Payment Adjustment

A clinician's share of the incentive pool, and therefore their payment adjustment, from the current maximum of $\pm 9\%$ up to $\pm 12\%$ in later years, is a function of where their composite score falls relative to the distribution of scores among all eligible clinicians. Clinicians in top-performing deciles draw a positive adjustment

funded by the pool; clinicians in bottom-performing deciles absorb a negative adjustment that helps fund it. Because the model is required to net to budget neutrality (after CMS retains its 15%), an individual physician's actual adjustment is inherently relative to how peers performed that year, not fixed to an absolute quality or cost target set in advance (27,42).

Importantly, the American College of Surgeons (ACS) has flagged that payment adjustments apply against all Medicare Part B payments the clinician receives, not only payments tied to LBP episodes, meaning a negative adjustment earned through LBP cost/quality performance reduces revenue across a physician's entire Part B Medicare book of business, including unrelated procedures (29).

Cost Performance Based on Procedure Mix

A common question for procedurally intensive IPM practices: if a physician performs a higher share of well-reimbursed implantable procedures (e.g., spinal cord stimulators (SCSs)) and a lower share of lower-cost injections relative to peers, how does that affect ASM cost scoring? The EBCM methodology is risk-adjusted and specialty-adjusted, it is meant to compare a clinician's observed episode spending to an expected cost benchmark built from patients with similar diagnoses, comorbidities, and episode characteristics, not simply to penalize higher absolute spending outright (30). In practice, this creates an important distinction as shown in Table 3:

- If a practice's higher implant rate reflects appropriately selected, higher-acuity patients (e.g., documented failure of conservative care and lower-cost interventional options, consistent with SCS coverage criteria), and if that acuity is reflected in the diagnosis and severity codes driving the risk-adjustment model, the expected-cost benchmark for that practice's patient mix should be adjusted upward accordingly, limiting the cost-decile penalty.

Table 3. Cost performance based on case mix

Scenario	LBP Episodes / Year	Procedure Mix	Approx. Avg. Episode Cost*	Effect Under EBCM Scoring
Physician A (implant-heavy)	40	12 SCS implants, 20 ESIs, 8 facet/RFA	Higher than cohort median	Observed cost likely exceeds risk-adjusted expected cost for the episode mix → pushed toward a lower cost decile unless diagnosis/acuity coding supports the higher expected-cost tier
Physician B (injection-heavy, low implant volume)	40	0 SCS implants, 30 ESIs/facet injections, 10 RFA	Lower than cohort median	Observed cost more likely to sit at or below risk-adjusted expected cost → tends toward a higher cost decile, all else equal

- If the higher implant rate is not fully explained by the risk-adjustment variables the EBCM model uses, the observed-to-expected ratio will exceed 1.0, which lowers cost-category achievement points even if outcomes are excellent, a criticism the ACS has raised directly, describing the underlying Acumen cost-measure methodology as “very narrowly defined” and not well suited to capturing surgeon- or proceduralist-level quality context behind higher-cost care.
- Because cost is 50% of the composite score and quality is the other 50%, an implant-heavy practice with strong, well-documented functional outcomes can still offset cost-decile pressure through quality-decile performance, but this depends on how well the practice’s quality measures and documentation capture that outcome benefit.

Practical implication for interventional pain management (IPM) groups: documentation that clearly links implant decisions to failed conservative and lower-intensity interventional steps (with dates, prior current procedural terminology (CPT) codes, and outcome measures) is not just clinically appropriate, it is the mechanism by which the risk-adjustment model can recognize a higher-acuity, higher-cost patient rather than scoring the episode as simple cost overuse.

Multiple Region Involvement and Impact

Particularly important for IPM is that many of the patients present with involvement of multiple

regions. Consequently, they receive different modalities of treatments. Based on the present information. It appears that they may not be able to separate the treatment encounters and the costs related to low back from neck pain or thoracic pain.

Site-of-Service: Office vs. ASC vs. Hospital Outpatient

A second, often larger driver of episode cost is not which procedures are performed but where they are performed. The physician fee schedule pays a lower professional-fee amount for the same CPT code when it is performed in a facility (an ambulatory surgery center (ASC) or hospital outpatient department (HOPD)) than in an office, because the facility, not the physician’s practice, absorbs equipment, staff, and overhead costs. But that lower professional fee is only part of the picture: Medicare pays the facility a separate payment on top of the physician’s fee, an ASC payment or a Hospital Outpatient Prospective Payment Systems (OPPS) Ambulatory Payment Classification (APC) payment, and for device-intensive procedures as shown in Table 4 (30-42).

Two consequences follow directly for ASM:

- Total episode cost, not physician revenue, is what the EBCM measures. Because the low back pain EBCM captures total Medicare Part A and B spending associated with the episode, an SCS trial and implant performed in an ASC or HOPD adds tens of thousands of dollars in facility payments to that episode’s total cost, spending the treating physician does not receive, but for which the physician’s

Table 4. Cost calculations for various settings for interventional techniques.

CPT Code	Procedure	Physician Fee — Office (Non-Facility)	Physician Fee — Facility (ASC/HOPD)	Separate ASC/HOPD Facility Payment*	Approx. Total Episode Cost (Facility Setting)
64493	Lumbar facet joint injection, single level	~\$190	~\$82	ASC: several hundred dollars (procedure-specific APC/ASC group)	~\$400–\$600
64635	Lumbar radiofrequency ablation, first level	~\$465	~\$173	ASC: several hundred dollars (procedure-specific APC/ASC group)	~\$600–\$900
63650	SCS trial lead placement (percutaneous)	Rarely performed in-office	Physician professional fee only, typically a few hundred dollars	OPPS/ASC national average ≈ \$5,031 (device-intensive C-APC)	≈ \$5,300–\$5,600
63685	SCS permanent pulse generator implant	Not performed in-office	Physician professional fee only, typically a few hundred dollars	OPPS national average ≈ \$27,500–\$30,000 (device cost included in C-APC)	≈ \$28,000–\$30,500

*ASC and OPPS/HOPD facility payments are separate line items paid to the facility, not the physician, and are not reflected in the physician fee schedule amounts shown earlier in this article. SCS facility figures reflect device-intensive Comprehensive APC (C-APC) status, which bundles the implant hardware cost into the facility payment. Figures are national averages before geographic wage adjustment; actual amounts vary by locality and are updated quarterly. Verify current rates via the CMS ASC Payment Rates Addenda and OPPS Addendum B.

episode is still held accountable under the cost performance category.

- Site-of-service is itself a lever, and a confound. A practice with identical clinical decision-making but a higher share of ASC/HOPD level-based interventional techniques including implant procedures (versus a practice that performs comparably indicated but lower-intensity injections primarily in-office) will show a structurally higher average episode cost, independent of any difference in appropriateness or quality of care. Because IPM procedures are typically benchmarked against same-specialty peers (Section 4), this mainly matters relative to other pain physicians' site-of-service mix, but it still means 2 IPM practices with similar patient panels can land in very different cost deciles based on where not just how much care is delivered.

This reinforces the same documentation principle raised in Section 3.4: when a facility-based, device-intensive procedure is clinically necessary, the medical necessity and site-of-service justification (e.g., inability to safely perform the procedure in-office, anesthesia requirements, device programming needs) should be clearly documented, since this is what allows the risk-adjustment methodology to the extent it accounts for site-of-service mix to distinguish appropriate facility-based care from a discretionary shift in venue.

COMPARISON OF PHYSICIANS ACROSS SPECIALTIES

Multiple independent analyses of the final rule indicate that both quality and cost performance are benchmarked against specialty-specific peer groups within the LBP cohort, not against the pooled average of all 6 eligible specialties (31). This mirrors how EBCMs already function elsewhere in MIPS, for example, the existing prostate cancer episode-based cost measure is described by CMS documentation as both risk-adjusted and specialty-adjusted, precisely so that a urologist is not benchmarked against a radiation oncologist's cost profile for a comparable episode (32).

Applied to the LBP cohort, this means a neurosurgeon's episode costs and quality scores should be benchmarked primarily against other neurosurgeons (or a closely related peer construct), and an interventional pain physician against other IPM physicians, not against each other directly. This design choice addresses an obvious fairness problem: neurosurgery and

orthopedic spine surgery episodes are structurally more expensive (surgical facility fees, implants, longer post-acute recovery) than a typical IPM interventional-based episodes, and a single blended benchmark across all 6 specialties would systematically disadvantage the more surgical specialties regardless of care quality.

The specialty-specific peer-grouping detail comes primarily from health-policy consultancy and specialty-society interpretation of the final rule rather than from a single, fully explicit CMS peer-grouping specification document available at the time of writing. Practices should confirm the precise peer-comparison construct and whether it is defined at the specialty-code level, the EBCM sub-cohort level, or some hybrid against CMS's final ASM scoring methodology documentation as it is published, since this mechanic materially affects how implant-heavy or surgical practices should interpret their own cost-decile results (31,42).

REQUIRED QUALITY MEASURES AND PATIENT-REPORTED OUTCOME MEASURES (PROMS)

ASM quality performance is scored across 3 domains, excess utilization, evidence-based care and outcomes, and patient-reported outcomes and experience combining claims-based measures with self-reported and survey-based measures rather than allowing clinicians to select from a broad menu as under standard MIPS as shown in Table 5 (17).

The inclusion of MIPS Quality ID #220 as a required patient-reported outcome measure (PROM) is notable because of its documented reporting history: according to specialty-society analysis, no pain medicine physician nationally reported this measure in 2023, the most recent year with available data, meaning ASM will require many IPM and pain medicine practices to stand up a functional-status data-collection workflow essentially from scratch rather than building on existing reporting infrastructure (33).

COLLABORATIVE CARE ARRANGEMENTS — WHAT THE MODEL GUIDELINES REQUIRE

Beyond quality and cost, ASM's Improvement Activities category requires each participant to maintain at least one practice-level Collaborative Care Arrangement (CCA) with a primary care practice that shares ASM beneficiaries, a formal requirement codified in the model's implementing regulation (36). This is a materially different bar than the informal referral relationships most specialty practices maintain today, and CMS has been explicit that such arrangements are not

required today under existing Medicare Shared Savings Program (MSSP) ACOs, making this one of the more operationally novel requirements in the model (38).

A qualifying CCA must include at least 3 of the following 5 elements as shown in Table 6.

IA and PI function only as penalties under ASM, they can subtract points (up to a reported combined 20-point penalty for non-compliance across both categories) but cannot add bonus points the way select Improvement Activities can under standard MIPS (38). CMS partially offsets this burden: participants treating patients with higher medical or social complexity, and small practices with 15 or fewer clinicians, receive a score boost of up to 10% (39). Because ASM performance for payment year 2029 is based on 2027 data collected from calendar year 2025 forward in the underlying eligibility determination, and CCAs must reasonably be operating during the performance year itself, practices without existing structured PCP relationships have a narrow runway to build this infrastructure before it affects their score (26).

ASM IN CONTEXT: COMPARING MEDICARE PHYSICIAN PAYMENT MODELS

IPM practices increasingly operate under more than one Medicare payment framework simultaneously, traditional MIPS, ASM (for those selected), and, in some cases, an Advanced APM relationship through a 2-sided-risk Accountable Care Organization (ACO). These models differ substantially in how participation is triggered, how performance is benchmarked, and how much revenue is genuinely at stake (Table 7).

The practical distinction that matters most for IPM practices: MIPS has historically behaved like a modest, largely voluntary carrot-and-stick program clinicians can shape through measure selection; Advanced APM participation is a voluntary, contractual decision to trade more risk for more potential upside (a bonus plus shared savings); ASM is neither voluntary nor shaped by clinician choice, it is a mandatory, fixed-measure, 2-sided-risk model applied at the individual level with consequences that reach a clinician's entire Medicare Part B revenue, not just the revenue tied to the targeted condition (30,48).

Table 5. *Performance measures across 3 domains.*

Domain	Measure	Type	Notable Issue
Patient-Reported Outcomes	Functional Status Change for Patients with Low Back Impairments (MIPS Quality ID #220)	PROM — functional status/disability change score	Reporting is historically very low, pain medicine clinician nationally reported this measure in 2023, the last year of available data
Evidence-Based Care / Overuse	Use of High-Risk Medication in Persons with Low Back Pain	Claims-based utilization measure (opioid/high-risk medication exposure)	Captured via claims, not self-reported, reducing reporting burden but limiting clinical nuance exposing to higher risk of prescriptions from other providers
Excess Utilization	Episode-based cost measure overuse signals (e.g., low-value imaging, repeat procedures)	Claims-based cost/utilization measure	Tied directly to the EBCM cost category rather than scored as a separate quality measure
Patient Experience	Patient-reported outcomes and experience domain (CAHPS-aligned or MVP-specific survey element)	Patient-reported experience measure	Adds a data-collection workflow (surveys) many procedural practices do not currently run

Table 6. *Components of collaborative care, arrangements, comparison of various Medicare physician payment models including MIPS, ASM, and Advanced APM*

#	Element	Description
1	Bi-directional data sharing	Structured, 2-way clinical data exchange between the specialist and the primary care practice (e.g., via HIE, TEFCA-enabled exchange, or electronic referral loops).
2	Co-management of care	Defined, shared processes for jointly managing the patient's condition rather than a one-way referral relationship.
3	Transitions-of-care planning	Documented protocols for handoffs as a patient moves between the specialist and primary care (e.g., post-procedure, post-escalation).
4	Closed-loop referrals	Referral communication that confirms receipt and outcome, rather than a one-way send with no confirmation loop.
5	Integrated care coordination workflow	Structured processes that embed care-coordination steps directly into the practice's day-to-day workflow, not an ad hoc or occasional activity.

Table 7. Comparison of Medicare physician payment models

Dimension	Traditional MIPS	ASM	Advanced APM (e.g., 2-sided MSSP ACO)
Participation	Voluntary reporting; small/exempt practices can opt out	Mandatory for eligible clinicians in selected regions; no opt-out	Voluntary practice/organization decision to join and sign a risk-bearing contract
Level of accountability	Individual clinician or group, clinician's choice	Individual clinician (TIN/NPI)	APM Entity / ACO level, with clinician-level QP determination
Measure selection	Clinician chooses from a broad menu of measures (or an MVP)	Fixed, condition-specific MVP-based measure set, no clinician choice	Reports via APM Performance Pathway (APP); fixed quality set (e.g., 50% weight on quality for MSSP ACOs)
Peer comparison basis	Benchmarked against all MIPS-reporting clinicians nationally	Benchmarked against specialty-specific peers within the same condition cohort	ACO benchmarked against its own historical spending blended with regional trend, not against peer clinicians directly
Risk type	One-sided in effect for many (adjustments funded by a shared national pool; large practices can absorb variance)	Explicit 2-sided risk from day one, symmetric upside/downside	Two-sided risk only in "Advanced" tracks; lower-risk MSSP tracks are one-sided and are not Advanced APMs
Maximum adjustment	Historically up to $\pm 9\%$ depending on performance-year rules; recent years have shown much smaller realized swings	$\pm 9\%$ in 2027, scaling to $\pm 12\%$ by 2031, applied against ALL Part B payments, not just condition-related ones	5% (now 3.5%, phasing to a 0.75% PFS conversion factor bump from 2026) lump-sum bonus for Qualifying Participants; separate ACO shared savings/losses on top
Care coordination requirement	Encouraged via Improvement Activities category (clinician's choice of activities)	Mandatory Collaborative Care Arrangement with a PCP, defined elements required, new requirement not present in MIPS	Care coordination is inherent to the ACO structure but no equivalent codified "CCA with defined elements" requirement exists today
MIPS exemption	N/A. This is MIPS	ASM participants are exempt from separate MIPS reporting/adjustments in years they participate in ASM	Qualifying Participants (QPs) in Advanced APMs are exempt from MIPS; Partial QPs may elect into MIPS
Budget neutrality	Yes. CMS pool funded by negative adjustments largely funds positive adjustments	Yes. Incentive pool built from 85% of Part B payments at risk; CMS retains the other 15%	Not strictly budget neutral in the same sense — shared savings/losses are calculated against each ACO's own benchmark

The practical value and documented disadvantages of MIPS for low back pain are highly polarized. Peer-reviewed literature and health policy analyses present 2 distinctly contrasting narratives: one highlighting its potential effectiveness in promoting cost-saving conservative care, and the other identifying structural failures that may penalize physicians treating vulnerable and medically complex populations. Substantial financial savings associated with conservative management were reported in a major study published in *The American Journal of Managed Care*, highlighting why MIPS cost metrics may be considered important. The study showed that patients receiving early, non-indicated MRIs accrued approximately \$2,500 more in Medicare expenditures during the first year than conservatively managed patients, while those receiving CT scans accrued approximately \$19,900 more. The researchers estimated that Medicare could save \$360 million annually if all clinicians adhered to conservative guidelines, the type of behavior MIPS measures are intended to penalize or reward (43). However, the methodology utilized

and the projected savings are highly questionable. In another study evaluating the cost-effectiveness of guideline-endorsed treatments for low back pain (44), the findings indicated that MIPS-supported pathways, such as physical therapy, interdisciplinary rehabilitation, acupuncture, and spinal manipulation, may be cost-effective for subacute and chronic low back pain, thereby encouraging multidisciplinary interventions. Yet another study demonstrated potential mitigation of risks associated with escalated care (45). According to data compiled by the American Chiropractic Association regarding Medicare savings associated with chiropractic services, introducing early conservative care may substantially reduce downstream spinal surgeries and dependence on primary care services, potentially mitigating the high-resource events tracked by the MIPS low back pain episode-based cost measure. However, these studies have questionable methodologies, evaluations, and outcome reporting.

Conversely, systematic evaluations of MIPS reveal significant operational flaws, suggesting that the

program often functions as an administrative requirement rather than as a meaningful driver of patient improvement. In fact, an article published in JAMA examining the association between individual physician MIPS scores and clinical outcomes (46) found that MIPS scores were inconsistently associated with actual patient process and outcome measures. The program frequently failed to accurately capture the true quality of care provided. In addition, the same JAMA study noted that physicians caring for more medically complex and socially vulnerable patients were significantly more likely to receive low MIPS scores, even when providing high-quality care. Thus, in low back pain management, where socioeconomic variables may substantially influence functional recovery, clinicians may be unfairly penalized for poor outcomes driven by systemic social determinants of health rather than deficiencies in clinical care. Further, the American Medical Association (AMA) issued a strong critique explaining why it is time to revamp Medicare's broken MIPS program (47). The AMA, along with multiple other societies, argued that the reporting requirements are burdensome and expensive and forced clinicians to focus on compliance and documentation rather than engaging in meaningful face-to-face care with patients suffering from low back pain. In summary, the potential practical value of MIPS is that it may discourage unnecessary early MRIs, provide mathematical adjustments to account for basic specialty differences, and incentivize long-term functional outcome tracking through metrics such as the Oswestry Disability Index (ODI). However, ODI has not been routinely utilized by pain physicians. Conversely, key disadvantages supporting arguments against MIPS include the potential for delays in necessary imaging because of provider concerns regarding cost penalties, systematic disadvantages for physicians treating poor, rural, or highly complex low back pain populations, and an administrative burden that may exceed 200 hours of compliance-related "box checking" for a practice. These administrative costs are never recovered.

The above stated concerns further support ASIPPs opinions and opposition to ASM, which is considerably more complicated and punitive than MIPS and has the potential to substantially damage independent practices.

POLICY DESIGN: CARROT-AND-STICK, OR AN AVERSION POLICY?

Whether ASM functions primarily as a carrot-and-stick incentive system or as what behavioral-economics

literature calls an aversion or loss-avoidance policy depends on which design feature is emphasized.

- **Case for carrot-and-stick:** The model does pay genuine upside. Clinicians in top-performing deciles draw positive adjustments funded by the incentive pool, and the pool mechanics mean strong performers are rewarded, not merely spared. In this framing, ASM is a more forceful, mandatory version of MIPS's existing budget-neutral, relative-performance design.
- **Case for an aversion policy:** Several structural choices push toward avoidance rather than reward. Improvement Activities and Promoting Interoperability can only be penalized, never rewarded, under ASM. A pure downside design in those 2 categories. Participation is mandatory with no opt-out, unlike MIPS (where small or exempt practices can avoid the program entirely) and unlike Advanced APMs (which clinicians voluntarily choose for their upside potential). And because payment adjustments apply to a clinician's entire Part B revenue rather than only condition-specific revenue, the credible threat of a broad revenue cut functions as a strong deterrent against low-value care, independent of whether any given clinician actually earns a positive adjustment.

Read together, ASM is probably best described as a hybrid: it retains a genuine upside (carrot) financed through the same budget-neutral pool that MIPS uses, but layers a materially larger and more encompassing downside (stick) on top mandatory enrollment, penalty-only IA/PI scoring, and Part-B-wide exposure, that together push the model's behavioral logic closer to loss-aversion than a typical voluntary bonus program (6-8,38).

INNOVATION OR LIMITATION?

Reasonable observers differ on whether ASM represents meaningful innovation in Medicare specialty-care payment or a premature, overly rigid constraint on it. Both cases have support in the published record (2).

The Case for Innovation

- ASM is CMS's first mandatory ambulatory specialty-level risk model, a structural expansion beyond the hospital- and primary-care-centered value-based models (bundled payments, ACOs) that have dominated the last decade, directly targeting 2 conditions responsible for roughly 6% of total traditional Medicare spending.

- The episode-cost methodology is risk- and specialty-adjusted rather than a blunt spending comparison, building on EBCM infrastructure already validated elsewhere in MIPS (e.g., the Prostate Cancer and cataract surgery episode measures).
- Mandating structured primary-care coordination directly addresses a documented gap, fragmented, poorly coordinated specialist-PCP communication that voluntary models have struggled to move the needle on.

The Case for Limitation

- CMS is mandating a fixed measure set built on the MVP framework before that framework has substantial voluntary participation data to validate it, a concern multiple commenters raised during the rulemaking process, which CMS acknowledged but proceeded past. (2,6-8,35)
- Requiring specific PROMs with near-zero historical reporting compliance (e.g., MIPS #220) risks penalizing practices for infrastructure gaps rather than for care quality, at least in the model's early years.
- The narrow, procedure-focused scope of the underlying Acumen cost methodology has drawn direct criticism from surgical and procedural specialty

societies as insufficiently able to capture legitimate quality-driven cost variation.

Whether ASM is ultimately judged an innovation or a limitation may depend less on its design intent, which draws on reasonably well-established EBCM and MVP infrastructure and more on execution details that are still emerging: how leniently CMS treats early-year reporting gaps, how transparently peer-comparison groups are defined, and whether the model's 5-year track record shows the cost and quality improvements CMS is targeting.

THE GOOD, THE BAD, AND THE UGLY

For all types of regulations, there are the good, the bad, and the ugly. These aspects have been described for the ACA, MIPS, Advanced APMs, and multiple other regulatory and payment systems, particularly the physician payment system, which increasingly appears to vary predominantly between the bad and the ugly. Similarly, ASM appears to encompass substantially more of the bad and the ugly than the good. However, applying fair and objective principles, we describe the good, the bad, and the ugly aspects of ASM, as summarized in Table 8.

Table 8. Illustration of various aspects of ASM showing the good, the bad, and the ugly aspects.

Good	Bad	Ugly
Targets 2 genuinely high-spend, high-variation chronic conditions where better upstream management can plausibly reduce avoidable hospitalizations and surgeries.	Required measure set is rigid and specialty-specific with no clinician choice, unlike MIPS's flexible menu, a real departure from how procedural specialists have reported quality for years.	One of the mandatory measures (Functional Status Change for LBP, MIPS #220) had essentially zero reporting history among anesthesiology/pain medicine clinicians as of the last available data, practices are being held accountable on a measure the specialty has not operationally built workflows around.
Cost methodology is risk- and specialty-adjusted (comparing observed to expected cost for similar patients within the same specialty), rather than a blunt, unadjusted spending comparison.	Payment adjustments apply against a clinician's entire Medicare Part B revenue, not only revenue tied to LBP or heart failure episodes, a poor cost-quality year on a small slice of practice can move the whole practice's Medicare payment.	Participation is fully mandatory with no opt-out once selected, and clinicians remain locked into the model for its full multi-year duration even if their practice profile changes, a level of forced participation that exceeds prior MIPS/APM designs.
Small practices (≤ 15 clinicians) and those treating higher medical/social complexity patients receive a scoring boost of up to 10%, partially offsetting resource disparities.	New infrastructure is required — a formal Collaborative Care Arrangement with defined elements, CEHRT reporting, and (for many procedural practices) a first-time patient experience survey workflow — on a relatively short runway before the 2027 start.	Because Improvement Activities and Promoting Interoperability function only as penalties (not bonus opportunities) under ASM, the model is structurally weighted toward loss-avoidance rather than reward — practices can only lose points in these categories, never gain them.
Exemption from parallel MIPS reporting reduces duplicate reporting burden for clinicians who are also ASM participants.	The underlying Acumen episode-cost methodology has been criticized by specialty societies (e.g., ACS) as "narrowly defined" and not well suited to capturing quality context behind higher-cost, higher-acuity care.	CMS has described ASM as a proof-of-concept for extending this mandatory, no-opt-out design to other specialty areas in the future — meaning the LBP and heart failure cohorts are effectively piloting a model with live patient care and real financial stakes.

IMPACT ON INTERVENTIONAL PAIN MANAGEMENT

Direct Inclusion in the Mandatory Cohort

IPM is explicitly named as one of 6 specialty types in the LBP cohort, alongside anesthesiology, pain management, neurosurgery, orthopedic surgery, and Physical Medicine and Rehabilitation (PM&R) (2). Because IPM practices frequently exceed the 20-episode annual threshold and commonly practice in metropolitan CBSAs, a large share of interventional pain physicians are expected to be swept into mandatory participation rather than opting in.

Financial Exposure

The American Society of Anesthesiologists' (ASA) Center for Anesthesia and Perioperative Economics (CAPE) has raised specific concerns about ASM's treatment of pain medicine participants. Its analysis found that over two-thirds of anesthesiology and interventional pain participants and over half of pain management participants would qualify for at least one MIPS special-status exemption (e.g., small practice, non-patient-facing, rural) that ASM does not honor (19). This means IPM practices that would otherwise be shielded from certain reporting burdens under MIPS lose that protection under ASM, increasing both administrative burden and downside risk exposure.

Collaborative Care Requirements

ASM requires each participating specialist to main-

tain at least one CCA with a primary care provider, incorporating at least 3 of 5 elements: bidirectional data sharing, co-management, transition planning, closed-loop referrals, and integrated care coordination (17). For IPM practices that have historically operated as procedural referral destinations with limited longitudinal primary-care integration, this represents a substantive workflow change requiring new EHR interoperability capabilities and formal referral agreements.

COMPARATIVE ANALYSIS: LOW BACK PAIN MANAGEMENT ACROSS SPECIALTIES

Low back pain is managed across a wide spectrum of specialties and practitioner types, only some of which fall within ASM's mandatory cohort. CMS explicitly declined requests from commenters to include physical therapists, chiropractors, and non-physician practitioners, citing limitations in Medicare specialty coding and concerns about outcome comparability across provider types as shown in Table 9 (16).

Evidence on Comparative Effectiveness

The North American Spine Society's (NASS) multidisciplinary low back pain guideline effort drawing on physical therapy, chiropractic, orthopedic surgery, neurosurgery, anesthesiology, pain medicine, and physiatry stakeholders organizes LBP evidence into diagnosis, medical/psychological treatment, rehabilitation and exercise, interventional treatment, surgical treatment, and cost-effectiveness domains, reflecting

Table 9. Comparative analysis of low back pain management across specialties.

Specialty	Primary Role in LBP Care	Typical Modalities	Included in ASM LBP Cohort?
Interventional Pain Management (IPM)	Diagnostic and therapeutic image-guided procedures for axial and radicular pain	Epidural injections, facet blocks, RFA, neuromodulation	Yes
Anesthesiology / Pain Medicine	Overlaps substantially with IPM; often the parent specialty for fellowship-trained pain physicians	Same procedural spectrum as IPM plus pharmacologic management	Yes
Physical Medicine & Rehabilitation (PM&R)	Functional restoration, non-surgical musculoskeletal management, EMG diagnostics	Therapeutic exercise prescription, bracing, selected injections	Yes
Orthopedic Spine Surgery	Surgical management of structural pathology (stenosis, instability, deformity)	Decompression, fusion, disc replacement	Yes
Neurosurgery (Spine)	Surgical management, often for more complex or neurologically involved cases	Decompression, fusion, tumor/deformity correction	Yes
Physical Therapy	First-line conservative, non-procedural rehabilitation	Manual therapy, exercise, education	No (excluded from mandatory cohort)
Chiropractic Care	Conservative spinal manipulation and manual therapy, largely first-line	Spinal manipulative therapy (SMT), mobilization	No (excluded from mandatory cohort)

the reality that no single specialty owns the LBP care pathway (22).

A systematic review of pragmatic randomized controlled trials found that chiropractic spinal manipulative therapy produced outcomes for pain and functional status that were broadly similar to exercise therapy, physical therapy, and standard medical care, with no reports of serious adverse events across the included trials (23). This is clinically relevant to IPM practices because it reinforces LBP guideline concordance around conservative, non-procedural first-line care before escalation to interventional or surgical treatment, a sequencing that also underlies Medicare coverage policy for procedures such as radiofrequency ablation (RFA) and epidural injections.

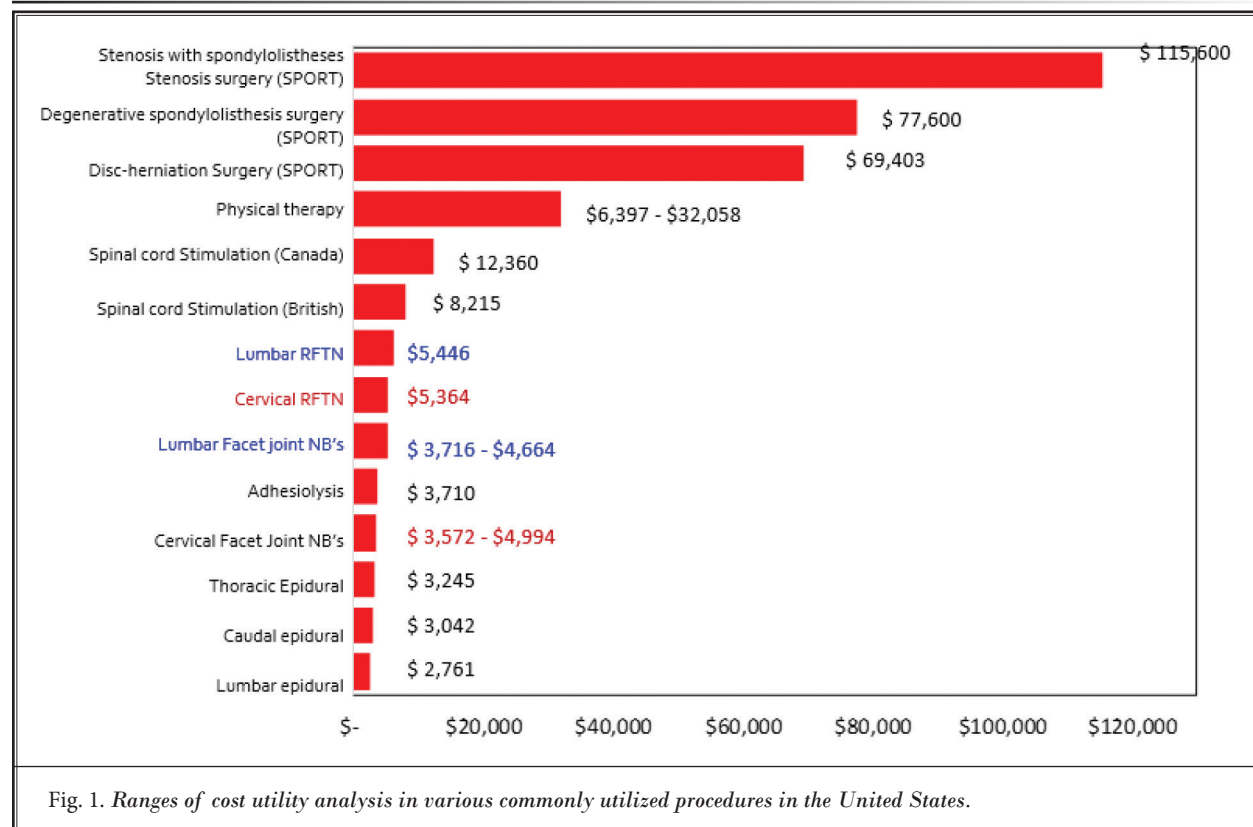
Interventional pain management has been demonstrated to be clinically effective and cost-effective based on multiple randomized controlled studies, systematic reviews, and guidelines (49-57). In fact, based on the available literature, interventional techniques have demonstrated favorable cost utility compared with surgical interventions, as well as conservative interventions such as physical therapy, as shown in Fig. 1.

Within the ASM-eligible cohort itself, the specialties differ substantially in their default treatment phi-

losophy: PM&R and IPM emphasize function-preserving, non-surgical and minimally invasive approaches, while orthopedic spine surgery and neurosurgery are positioned toward structural correction when conservative and interventional measures fail. Because ASM's episode-based cost measure attributes an entire episode's spending to whichever specialist is identified as the plurality billing provider, practices whose referral patterns lean more surgical or whose patients are referred late after failed conservative care may show higher episode costs independent of the quality of care delivered at any single step (17,18).

NEXT STEPS FOR IPM PRACTICES

- Determine exposure early: cross-reference practice location against CMS's preliminary ASM participant list (finalized list expected summer 2026) and internally audit whether the practice historically meets the 20-episode LBP threshold.
- Model financial risk: run practice-level scenarios at $\pm 9\%$ (year 1) through $\pm 12\%$ (year 5) payment adjustment against current LBP-related Medicare revenue, since ASM does not permit opt-out once a clinician is selected.



- Formalize primary care relationships now: begin establishing CCSs with referring primary care physicians (PCPs) ahead of the 2027 start, including data-sharing and closed-loop referral workflows, rather than building these under time pressure.
- Strengthen documentation of conservative-care sequencing: given that Medicare coverage and episode cost attribution both reward guideline-concordant stepped care, ensure documentation clearly reflects prior conservative treatment (physical therapy, medication trials) before interventional escalation.
- If feasible, invest in interoperable electronic health record (EHR)/certified electronic health record technology (CEHRT) capability: PI performance is scored at the group level and is a required category under ASM's MVP-based framework.

This is an extremely difficult measure to implement. Investing in interoperable EHRs can cost thousands of dollars and may be financially burdensome for smaller and independent practices. Major EHR vendors, such as EPIC, are predominantly utilized by hospitals and large health systems, where many primary care physicians practice, and may not be readily accessible or financially feasible for smaller or even group practices. Further, physicians have used multiple types of EHRs for many years based on their individual practice needs and preferences, creating significant interoperability challenges. In addition, some physicians continue to practice without EHRs, further complicating the implementation of this measure.

ACTION LIST

The following checklist consolidates the practical steps discussed throughout this article, each paired with the primary CMS or federal source to consult.

- Confirm your ASM status. Check whether you appear on CMS's preliminary or final ASM participant list for the low back pain cohort. CMS ASM Model Page: <https://cms.gov/priorities/innovation/innovation-models/asm>
- Read the official model overview. Review the CMS ASM Model Fact Sheet for the authoritative summary of goals, timelines, and performance categories. <https://cms.gov/files/document/asm-model-fact-sheet.pdf>
- Review the frequently asked questions (FAQ) for operational specifics. CMS maintains a running ASM FAQ addressing eligibility, scoring, and

MIPS-overlap questions. <https://cms.gov/priorities/innovation/asm-ambulatory-specialty-model-frequently-asked-questions>

- Check the regulatory text directly. The finalized ASM requirements are codified at 42 CFR Part 512, Subpart G, including the exact Collaborative Care Arrangement elements. <https://ecfr.gov> (Title 42, Chapter IV, Subchapter H, Part 512, Subpart G)
- Verify current procedure-level payment by locality. Use the CMS Physician Fee Schedule Look-Up Tool for office vs. facility physician payment, and the CMS ASC Payment Rates Addenda / OPPS Addendum B for facility payments, before modeling episode cost exposure. <https://cms.gov/medicare/physician-fee-schedule/search/overview> and cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda
- Review the MVP measure specifications for low back pain. Confirm the exact quality measure set (including MIPS #220 and the high-risk medication measure) via the Quality Payment Program resource library. <https://qpp.cms.gov>
- Start CCA conversations now. Identify referring PCP practices and begin structuring data-sharing and co-management workflows against the 5-element CCA standard well before the 2027 performance year.
- Model financial exposure at the TIN/NPI level, not the practice level. Because ASM scores and adjusts individual clinicians, run scenarios per physician, including the effect of site-of-service mix on episode cost per Section 3.5.
- Track specialty-society advocacy actively engaging CMS regarding potential withdrawal or modification of the model, measure burden, special-status exemptions, and cost-methodology concerns.
- Contact CMS directly with model-specific questions. — Email: AmbulatorySpecialtyModel@cms.hhs.gov

CONCLUSION

ASM represents CMS's first mandatory move to place ambulatory specialists rather than only hospitals and post-acute providers under 2-sided financial risk. For interventional pain management, inclusion in the LBP cohort means new accountability for episode-level costs that extend beyond the procedures IPM physi-

cians directly perform, combined with loss of certain MIPS special-status protections and new primary-care coordination requirements. Positioning IPM practices for 2027 will require early risk modeling, documentation discipline around conservative-care sequencing, and investment in care-coordination infrastructure well ahead of the model's mandatory start date.

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