Health Policy Review

# Ambulatory Surgery Centers and Medicare Payment Policy for Calendar Year 2027: Impact on Interventional Pain Management

Laxmaiah Manchikanti, MD[1], Mahendra R. Sanapati, MD[2], Vidyasagar Pampati, MSc[1], Ramarao Pasupuleti, MD[3], Alexander Bautista, MD[4], Amol Soin, MD[5], Annu Navani, MD[6], Alan D. Kaye, MD, PhD[7], Rajesh Naidu Janapala, MD[8], Mayank Gupta, MD[9], Alaa Abd-Elsayed, MD[10], and Joshua A. Hirsch, MD[11]

From: [1]Pain Management Centers of America, Paducah, KY; [2]Pain Management Centers of America, Evansville, IN, University of Louisville School of Medicine, Louisville, KY, and Indiana University School of Medicine, Evansville, IN; [3]Center for Pain Management, Bowling Green, KY; [4]Duke University, Durham, NC; [5]Ohio Pain Clinic and Wright State University, Dayton, OH; [6]Reve Health Institute, San Jose, CA, and Boomerang Health Care, Walnut Creek, CA; [7]Louisiana State University Health Sciences Center at Shreveport, Shreveport, LA, Tulane School of Medicine, and LSU School of Medicine, New Orleans, LA; [8]Forrest General Hospital, Hattiesburg, MS; [9]Kansas Pain Management and Neuroscience Research Center, LLC, Overland Park, KS, and Kansas City University, Kansas City, MO; [10]UW Pain Clinic and Anesthesiology and University of Wisconsin, Madison, WI; [11]Keck School of Medicine of USC, Los Angeles, CA

Address Correspondence:
Laxmaiah Manchikanti, MD
Pain Management Centers of America
67 Lakeview Drive
Paducah, Kentucky 42001
E-mail: drlm@thepainmd.com

Disclaimer: There was no external funding in the preparation of this article.

Conflict of interest: See pg. E479

Article received: 06-15-2026
Accepted for publication: 07-30-2026

Free full article: www.painphysicianjournal.com

**Background:** Ambulatory surgery centers (ASCs) have become a common site of service for interventional pain management (IPM) procedures over the past three decades, driven by lower costs, physician ownership incentives, and a permissive regulatory environment. Medicare payment policy for ASCs has evolved through repeated rulemaking cycles since the original 1982 ASC payment system, with each cycle reshaping which procedures may be performed in the ASC setting and their relative payment. On July 2, 2026, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2027 Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System proposed rule (CMS-1850-P), representing the latest development in this continuum.

**Objective:** To review the historical evolution of ASC payment policy relevant to interventional pain management and provide a detailed analysis of the CY 2027 OPPS/ASC proposed rule, its projected impact on IPM procedure reimbursement, and its implications for the survival of independent interventional pain practices.

**Methods:** A narrative policy review was conducted using the CY 2027 OPPS/ASC proposed rule (CMS-1850-P; Federal Register, July 2026), CMS fact sheets and impact tables, and prior peer-reviewed analyses of ASC payment policy published in Pain Physician.

**Results:** The 2.4% ASC payment update, reflecting a 3.2% market basket update less a 0.8-percentage-point productivity adjustment, is offset for some services by changes in relative payment weights, resulting in substantial variation in payment changes across individual procedures. CMS also proposes continuing, for an additional year, the use of the more favorable hospital market basket rather than the consumer price index as the ASC update factor. Device-intensive, neuromodulation-related codes central to interventional pain practice, including SCS generator insertion (+14.8%), peripheral nerve stimulator electrode implantation (+9.8%), and sacral neuromodulation (+8.0%), receive substantial proposed increases; however, these increases are muted by unfavorable changes incorporating multiple procedure discounts, ultimately resulting in payment reductions when multiple procedures are performed. Minimally invasive sacroiliac joint fusion (+7.1%) and basivertebral nerve ablation (+6.5%) also receive substantial proposed increases.
In contrast, core injection-based procedures, including interlaminar and transforaminal epidural steroid injections, facet joint injections, and facet joint radiofrequency ablation, are proposed to decrease by 3.8% to 4.3%.
Prior authorization requirements continue to apply to selected procedures in hospital outpatient departments but not in ASCs, and CMS proposes expanding prior authorization requirements for HOPDs to additional botulinum toxin codes, effective July 2027.

**Limitations:** This analysis is based on a proposed rule; CMS may materially alter payment rates, covered-procedure additions, and policy provisions in the CY 2027 OPPS/ASC final rule, expected in approximately November 2026. Code-specific rates cited here are derived from CMS impact tables and specialty-society analyses of the proposed rule, rather than from the final Addenda AA/B.

**Conclusion:** The CY 2027 proposed rule continues a payment trajectory that is relatively favorable to device-based, procedural IPM performed in ASCs compared with hospital outpatient departments, while core injection-based services continue to experience slow, compounding erosion in relative payment. However, proposed multiple-procedure discounting may substantially offset increases in neuromodulation and other device-intensive procedures when multiple procedures are performed during the same session. Practices should evaluate service-line composition, maintain compliance with the ASC Quality Reporting (ASCQR) Program, prepare for the scheduled 2028 non-opioid payment cliff, and submit comments during the rulemaking period.

**Key words:** Ambulatory surgery center, Centers for Medicare and Medicaid Services, Hospital Outpatient Prospective Payment System, ASC Payment System, interventional pain management, Medicare, physician reimbursement, proposed rule, site of service

**Pain Physician 2026: 29:E469-E480**

Ambulatory surgery centers (ASCs) occupy a central and increasingly important position in the delivery of interventional pain management (IPM) in the United States (1-16). Since the Health Care Financing Administration (HCFA) (now CMS) first established a prospective payment system for ASCs in 1982, Medicare payment policy for the ASC setting has undergone a continuous series of rulemaking cycles. Each cycle has redefined the boundaries between procedures performed in the hospital inpatient or hospital outpatient department (HOPD) setting and those permitted and separately reimbursed in the ASC setting (9). For interventional pain physicians and IPM centers, whose practices depend substantially on access to facilities where procedures can be performed reliably and conveniently, as well as on ASC-generated revenue, each annual rulemaking cycle has direct and potentially significant consequences for practice viability.

Current data from MedPAC and other sources indicate that 36% (2,349) of facilities offer pain management services. Among 5,436 Medicare-certified facilities, ownership models across the ASC landscape vary widely. Physicians represent a substantial proportion of ASC ownership, with 22% operating as solo-physician ownership, 29% as physician-hospital joint ventures, 13% as physician-corporate partnerships, and 3% as physician-hospital-corporate combinations. Corporations alone, hospitals alone, and alternative ownership arrangements account for approximately 10%. Further, 13%, or 410 Medicare-certified ASCs, are dedicated exclusively to pain management, with approximately 800 ASCs operating as single-specialty IPM centers. Beyond centers solely focused on pain management, IPM is one of the most widely represented specialties across the country. An additional 262 multispecialty centers are dedicated specifically to a dual focus on pain management and orthopedics, while hundreds of other multispecialty centers provide IPM alongside podiatry and spine services.

Figures 1 and 2 describe the ownership structure and growth of the ambulatory surgical center (ASC) sector. Nearly 90% of U.S. ASCs have some degree of physician ownership: 52% are physician-only, 22% are hospital–physician joint ventures, 13% are corporate–physician partnerships, and 3% combine all three, while only 5% are owned solely by a corporation or a hospital (Fig. 1). That ownership base is gradually eroding, as independent facilities declined from 70% of the market in 2022 to 68% in 2023, 48% of hospital systems now own at least one ASC (up from 41% in 2019), and the five largest chains hold 21.5% of facilities. The sector itself continues to expand: Medicare-certified ASCs grew from 5,760 in 2019 to 6,566 in 2025, a net gain of 806 centers, or approximately 2.2% annually, with 248 openings against 108 closures in 2024 (Fig. 2).

The total volume of interventional pain procedures has been estimated at more than 4.2 million across all outpatient facilities in the United States. Of these, ASCs account for approximately 1.1 million interventional procedures annually, representing approximately 25.6% of the nationwide outpatient pain volume. The remaining volume is distributed between HOPD and physician clinics (2). Consequently, IPM is the third-largest specialty across the entire ASC industry in terms of facility footprint. In addition to common spine procedures, ASCs also perform high-intensity procedures, including spinal cord stimulators (SCS), intrathecal implantables, and percutaneous fusions of the sacroiliac joints and lumbar spine. Available data indicate that ASCs perform approximately 38% of permanent implants. However, ASCs perform an even higher proportion of temporary pre-implant trials, accounting for more than 50% of trial placements.

Figure 3 and Table 1 compares each specialty's share of Medicare ambulatory surgical center (ASC) volume with its share of estimated revenue, using MedPAC's 20 most common ASC procedures for 2024 (68% of fee-for-service volume) priced at CY 2026 final ASC national

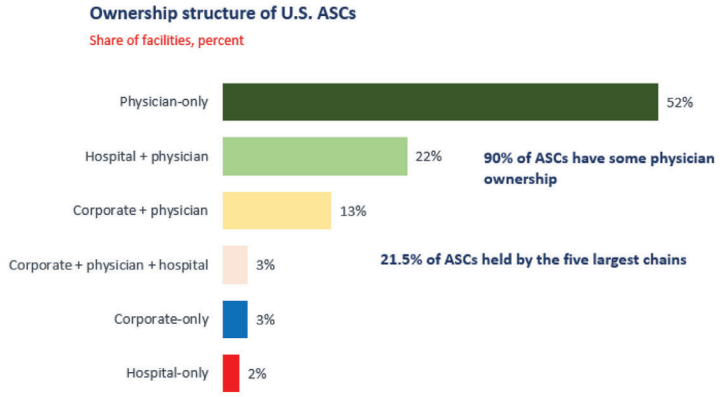



Fig 1. *Physician ownership of ambulatory surgical centers. Trend: independent ASCs slipped from 70% of the market in 2022 to 68% in 2023, while 48% of hospital systems now own at least one ASC — up from 41% in 2019.*
Sources: ASC Data, Q4 2025 (Medicare-certified facility count); MedPAC, Report to the Congress, March 2026, ch. 11 (2024 facility count, for-profit share, chain concentration); ASCA 2023 Salary & Benefits Survey via ASC Data (ownership mix; components may not sum to 100%); VMG Health and Avanza Healthcare Strategies (independent share, hospital-system ownership).

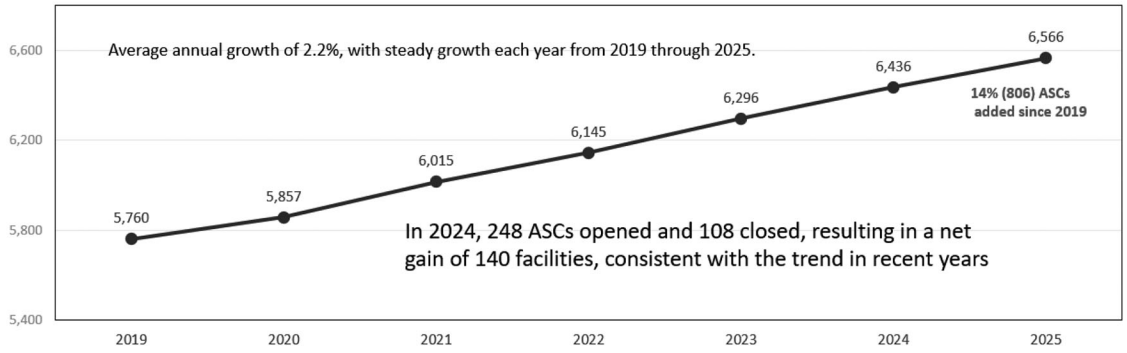



Fig 2. *Growth of Medicare-certified ASCs, 2019–2025.*
Sources: MedPAC, Report to the Congress, March 2026, ch. 11, Table 11-1 (2019–2024 counts, openings and closures); ASC Data, Q4 2025 (2025 count). Counts are Medicare-certified facilities only; total U.S. ASCs including non-certified centers are substantially higher.

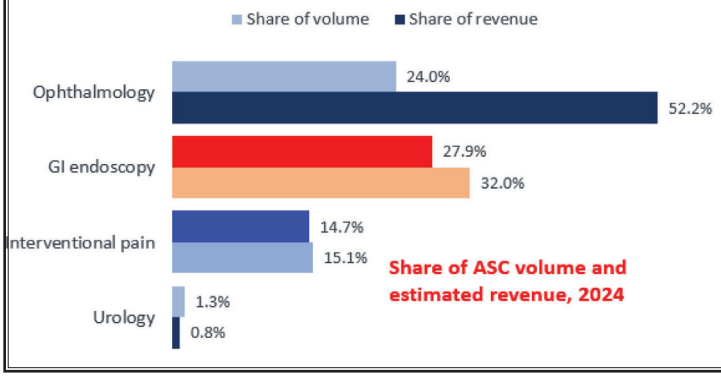



Fig 3. *ASC utilization by specialty 2024: volume vs. revenue.*

rates. Ophthalmology accounted for 24.0% of volume but 52.2% of estimated revenue, reflecting the high payment for cataract extraction ($1,255.73 per case), while gastrointestinal endoscopy represented 27.9% of volume and 32.0% of revenue. Interventional pain procedures accounted for 14.7% of volume and 15.1% of revenue, roughly $490 million annually, led by transforaminal epidural injection (64483), facet joint denervation (64635), and facet joint injection (64493). Rates proposed for CY 2027 reduce payment for these seven procedures by 3.8% to 4.3%, an estimated $19 million annually; comparable reductions apply across other

Table 1. *Interventional pain procedures: rates and estimated revenue.*

| Procedure | CPT | CY 2026 | CY 2027 | Change | Est. rev. |
|---|---|---|---|---|---|
| Transforaminal epidural, L/S | 64483 | $485.51 | $466.96 | −3.8% | $131M |
| Facet injection, L/S | 64493 | $485.51 | $466.96 | −3.8% | $99M |
| Facet denervation, L/S | 64635 | $948.66 | $908.27 | −4.3% | $121M |
| Interlaminar epidural, L/S | 62323 | $387.46 | $372.75 | −3.8% | $47M |
| Sacroiliac joint injection | G0260 | $387.46 | $372.75 | −3.8% | $37M |
| Facet injection, C/T | 64490 | $485.51 | $466.96 | −3.8% | $34M |
| Interlaminar epidural, C/T | 62321 | $387.46 | $372.75 | −3.8% | $20M |
| Combined | | | | | $490M |

high-volume ASC services, as a 2.6% conversion factor increase is offset by lower relative weights, which fall most steeply for the pain procedures (6.2% to 6.7%). Estimates are unadjusted for geographic wage index.

An early analysis described the 2007 revision of the ASC payment system and its transition to an outpatient-prospective-payment-system-based relative weight methodology, noting the rapid growth in ASC-based procedure volume and total ASC payments, which increased from approximately $1 billion in 1996 to $2.9 billion in 2006 (10). A subsequent 2010 review and a companion 2011 analysis of ASC ownership models examined how physician-ownership structures, federal fraud-and-abuse laws, and payment incentives were collectively reshaping the site-of-service landscape, characterizing the shift toward ambulatory and office-based care as a broader "managed care shift" in American health care delivery (11,12). A 2012 update, "Saga of Payment Systems of ASCs for Interventional Techniques," traced the cumulative effects of successive Centers for Medicare and Medicaid Services (CMS) rules on interventional technique reimbursement and cautioned that value-based reimbursement initiatives and continued cost-shifting were narrowing the economic margins that had originally made ASC-based practice viable (13). By 2016, in "Facility Payments for IPM Procedures: Impact of Proposed Rules," the authors evaluated the calendar year (CY) 2017 hospital Outpatient Prospective Payment System (OPPS)/ASC proposed rule against the backdrop of Affordable Care Act implementation and the newly enacted Merit-Based Incentive Payment System (MIPS), observing that facility payment policy had become inseparable from the broader trajectory of physician payment reform (14).

The consistent theme across this body of work is clear: Medicare ASC payment policy has repeatedly favored device-intensive, technically complex procedures over core injection-based interventional techniques, even as overall system-wide updates have nominally kept pace with or modestly exceeded inflation. A decade later, this pattern continues in the CY 2027 proposed rule, now unfolding within a materially more adverse physician fee schedule (PFS) environment, with a nearly one-third cumulative decline in inflation-adjusted physician reimbursement since 2001 and mounting operational burdens, prior authorization requirements, audit risks, and documentation demands that were either absent or far less developed at the time of the authors' earlier analyses (15,16).

This article reviews the CY 2027 OPPS/ASC proposed rule (CMS-1850-P), released by CMS on July 2, 2026, with particular attention to its implications for ASCs performing IPM procedures. It places the rule within the broader payment reform context described in the analysis of physician payment reform in IPM (15,16).

## Historical Evolution of ASC Payment Policy: A 25-year Perspective

### The Foundational Payment System and Early Interventional Technique Restrictions

The modern ASC payment system traces to a 1982 HCFA rule establishing prospective, procedure-group-based payment for facility services furnished in freestanding surgery centers (10). Interventional pain procedures were treated inconsistently within this framework from the outset. As documented previously, a 1998 HCFA proposal would have eliminated approximately 60% of interventional procedures from ASC coverage entirely and subjected the remaining 40% to substantial payment reductions. The proposal was substantially narrowed only after public comment and congressional intervention (10). In addition, low payments for HOPD threatened the closure of many hospital-based programs. This episode established a durable pattern: interventional pain procedures, lacking the

political and clinical constituency of higher-profile surgical specialties, have repeatedly been among the first targets when CMS has sought to narrow ASC-CPLs or recalibrate relative payment weights. Manchikanti and Boswell (10) described this emerging pattern in 2007.

### Transition to the OPPS-Based Relative Weight System (2007–2008)

CMS's 2007–2008 overhaul aligned ASC relative payment weights with the hospital OPPS ambulatory payment classification (APC) system, replacing the prior nine-group ASC-specific classification. As described in the 2007 review, this transition materially expanded the list of procedures eligible for ASC payment while tying ASC rates to a fixed proportion of the corresponding OPPS rate. This linkage persists through periodic revisions to the current CY 2027 proposed rule (10). The present classification of interventional techniques originated during the 2000 APC Panel meeting. The American Society of Interventional Pain Physicians (ASIPP) proposed a reclassification of interventional procedures, resulting in increased payments over subsequent years, as detailed in the article (10).

### Managed Care, and the 2010–2012 Period

The 2010 and 2011 analyses examined the federal regulatory framework governing physician ownership of ASCs, principally the Stark Law and Anti-Kickback Statute safe harbors, and argued that physician-owned, procedurally focused ASCs often represented a structurally lower-cost alternative to hospital-based care for Medicare and for beneficiary cost-sharing (11,12). The 2012 update quantified the cumulative effect of intervening CMS rules specifically on interventional technique payments, identifying a pattern of year-over-year compression in relative payment for epidural and facet joint procedures despite generally positive system-wide updates. This divergence between device/procedure-based and injection-based reimbursement trajectories recurs in the CY 2027 rule discussed below (13).

### The Affordable Care Act, MIPS, and the 2016 Analysis

The 2016 review of the CY 2017 OPPS/ASC proposed rule was published amid the initial implementation of Medicare Access and CHIP Reauthorization Acts (MACRA's), MIPs and continuing ACA-driven delivery-system reform (17,18). That analysis emphasized the growing integration of facility payment policy with quality-reporting programs, foreshadowing the ASC Quality Reporting (ASCQR) Program penalty structure that, in the CY 2027 proposed rule, now reduces the ASC update from 2.4% to 0.4% for non-reporting facilities (14). It also raised early concerns, subsequently borne out, that solo and small independent practices would bear a disproportionate administrative and financial burden from simultaneously managing quality-reporting, MACRA, and facility payment requirements.

### 2020–2026: Site-Neutrality, the Inpatient-Only List Phase-Out, and Accelerating Physician Payment Decline

The most recent period, synthesized in the authors' 2025 Health Policy Perspective on physician payment reform, documents an acceleration of two parallel trends directly relevant to ASC-based interventional pain practice (15,16). First, CMS began a multi-year phase-out of the hospital Inpatient Only (IPO) list beginning in CY 2021, systematically reassigning procedures to outpatient APCs and, in many cases, subsequently to the ASC CPL. This process continues in the CY 2027 proposed rule with 637 additional IPO removals and 618 proposed CPL additions. Second, and in sharp contrast to the facility-side trajectory, physician professional payment under the Medicare PFS has declined by approximately 33% in inflation-adjusted terms since 2001, with an estimated 41% decline specific to interventional pain management, compounded by annual 2% sequestration and the prospect of further PAYGO-driven cuts (15,16). The consequence, developed further below, is a widening divergence between facility-side payment policy, which continues to expand ASC opportunities and, for device-based procedures, payments, and professional-side payment policy, which continues to compress physician reimbursement for the same underlying procedures.

## The CY 2027 OPPS/ASC Proposed Rule (CMS-1850-P)

### Overview and Timeline

CMS released the CY 2027 Hospital OPPS and ASC Payment System proposed rule (CMS-1850-P) on July 2, 2026, with publication in the Federal Register on July 7, 2026 (19,20). The rule proposes payment policies affecting approximately 3,500 hospitals and 6,400 ASCs, with estimated total CY 2027 payments of $110.9 billion under OPPS and $9.9 billion under the ASC Payment System, representing increases of approximately $9.5 billion and $520 million, respectively, over CY 2026

(21). Public comments were due approximately 60 days following publication, with the final rule anticipated in November 2026.

### Payment Update and Conversion Factor

CMS proposes a 2.4% payment update for ASCs meeting ASCQR Program requirements, reflecting a projected 3.2% hospital market basket increase reduced by a 0.8-percentage-point productivity adjustment (20,21). This increases the ASC conversion factor from $56.322 to $57.766. ASCs that fail to meet ASCQR reporting requirements receive a 2.0-percentage-point reduction, resulting in a conversion factor of only $56.638 and an update of 0.4% rather than 2.4%. This represents approximately a 2% difference in total Medicare facility revenue attributable to a single compliance variable (22,23). Notably, CMS proposes to continue using the hospital market basket, rather than the consumer price index for all urban consumers (CPI-U), as the ASC update factor for one additional year, extending a policy the ASC industry has sought to preserve since it was initially adopted on a temporary basis (21,22).

ASC payment rates remain scaled to OPPS relative weights using a proposed weight scalar of 0.809, meaning that ASC facility payment for a given procedure remains, on average, approximately 81% of the corresponding OPPS payment before accounting for differences in the conversion factors between the two systems (22). Because the proposed OPPS conversion factor increases more substantially, to $102.004, driven largely by an 8.44% increase applied to non-drug OPPS services to offset a proposed reduction in 340B drug payment, the absolute facility-fee gap between HOPDs and ASCs widens under the CY 2027 proposed rule, even as ASC payments increase in nominal terms (22).

### Continued Phase-Out of the Inpatient Only List and Expansion of the ASC Covered Procedures List

Consistent with the multi-year transition begun in CY 2021, CMS proposes removing 637 additional procedures from the IPO list for CY 2027 and assigning them to clinical APCs, while 801 more clinically complex procedures remain on the list for the current cycle (21). In parallel, CMS proposes adding 618 procedures to the ASC CPL (20,22). CMS frames this continued expansion in terms of increasing patient choice and reducing beneficiary cost-sharing, noting that ASC beneficiary coinsurance, calculated as a flat 20% of the lower ASC payment rate, is consistently lower in absolute dollar terms than coinsurance for the same procedure performed in an HOPD (22). Removal from the IPO list does not automatically establish that a procedure is appropriate for every patient or every ASC. Clinical selection, facility capability, anesthesia resources, postoperative monitoring requirements, and patient comorbidity remain relevant determinants of site-of-service appropriateness.)

### Site-Neutral Payment Expansion

CMS proposes to extend its existing site-neutral payment methodology for excepted off-campus provider-based departments, first adopted for clinic visit services in the CY 2019 final rule and expanded to drug administration services in CY 2026, to include non-contrast imaging services for CY 2027, using CMS's authority under section 1833(t)(2)(F) of the Social Security Act (20). While this provision principally affects hospital-owned off-campus departments rather than ASCs directly, it illustrates CMS's continuing programmatic direction toward site-neutral payment and lower-cost settings. Over the preceding decade, this policy direction has generally favored ASC-based care relative to HOPD-based care for comparable procedures. Continued expansion of site-neutral policies could alter the relative financial attractiveness of HOPD versus ASC care and may influence hospital acquisition strategies, physician alignment models, and procedural migration between sites of service.

### Software as a Medical Service and Device Pass-Through

As an initial step toward developing a comprehensive payment methodology for software-as-a-medical-service (SaMS) technologies, CMS proposes assigning qualifying SaMS technologies to new-technology APCs (23). Separately, the rule proposes a new device pass-through payment status for seven devices and eliminates the alternative pathway for future device pass-through applications. Pass-through status is proposed to expire for 49 existing drugs, biologicals, and radiopharmaceuticals while continuing for 45 others (23). Among pain-relevant technologies, CMS is separately reviewing device pass-through status for at least one high-frequency nerve block system intended for chronic post-amputation pain.

### Quality Reporting Program Updates

CMS proposes modest changes to the ASCQR Pro-

gram, including the removal of the colonoscopy follow-up interval measure and a request for information on the stratification of the transfer/admission outcome measure (22). The rule separately proposes revising the methodology for the Overall Hospital Quality Star Rating to place greater emphasis on the Safety of Care domain (20). While this change is not directly applicable to freestanding ASCs, it may influence referral patterns and quality considerations for hospital-affiliated ASC programs.

## Impact On Interventional Pain Management: The Widening Split Between Device-based and Injection-Based Procedures

The clearest signal for IPM in the CY 2027 proposed rule is the widening divergence between device-based neuromodulation procedures, which appear to receive substantial proposed payment increases but may realize smaller net gains as discussed below, and core injection-based procedures, which continue to experience modest but compounding payment reductions despite the positive 2.4% system-wide update. Table 2 summarizes the proposed CY 2027 payment changes for interventional pain procedures with the largest projected changes, based on CMS impact estimates for high-spend ASC procedures.

At the specialty-group level, CMS projects CY 2027 ASC payment increases of approximately 6% for the musculoskeletal specialty group, representing an estimated $2.0 billion in aggregate payments, and 6% for the nervous system specialty group, representing an estimated $1.6 billion in aggregate payments. These two groups together comprise nearly all IPM procedures. In comparison, CMS projects increase of approximately 5% for cardiovascular and 1% for genitourinary procedures, while eye and gastrointestinal procedures are projected to decrease by 1% and 2%, respectively, against a system-wide average increase of 2% (24). CMS attributes these comparatively larger increases to updated device-cost data underlying the relative weights for device-intensive procedures, including spinal cord stimulators, peripheral nerve stimulators, and sacroiliac joint fusion hardware.

This divergence is not new; rather, the CY 2027 cycle reproduces the same pattern identified by the authors in the 2012 review of successive ASC rules affecting interventional techniques (13). What has changed is the increasing structural reliance of ASC-based IPM revenue on the device-intensive procedure mix and the corresponding financial exposure of practices whose procedural volume remains concentrated in epidural, facet, and radiofrequency ablation services. These procedures continue to be constrained by the office-based payment cap, under which such codes are paid at the lesser of the ASC rate or the PFS non-facility practice-expense amount. This represents a longstanding structural limitation on ASC facility payments for these codes that has persisted across every rulemaking cycle reviewed in this and the authors' prior publications (24,25).

### ASC Code-Level Reality: A Divided Picture

As shown in Table 2, the proposed fee schedule provides significant increases for several implantable procedures; however, the apparent increases for neuro-

Table 2. *Proposed payment changes for implant.*

| CPT/HCPCS Code | Procedure | Proposed Change vs. CY 2026 to CY 2027 |
|---|---|---|
| 63685 | Spinal cord stimulator generator insertion/replacement | +14.8% |
| 0627T | Percutaneous intradiscal allograft injection | +9% |
| 64555 | Peripheral nerve stimulator electrode implantation | +9.8% |
| 64561 / 64590 | Sacral neuromodulation electrode / pulse generator | +8.0% |
| 27279 | Minimally invasive sacroiliac joint fusion | +7.1% |
| 64628 | Basivertebral nerve ablation | +6.5% |
| 63650 | Percutaneous spinal cord stimulator lead implantation | +6.2% |
| 62323 | Interlaminar epidural steroid injection, lumbar/sacral | −3.8% |
| 64483 | Transforaminal epidural steroid injection, lumbar/sacral, first level | −3.8% |
| 64493 | Lumbar/sacral facet joint injection, first level | −3.8% |
| 64635 | Lumbar facet joint radiofrequency ablation, single joint | −4.3% |

Source: CMS CY 2027 OPPS/ASC proposed rule impact tables (Table 90) and specialty-society analysis of the proposed rule (24,25). Final figures are published separately in Addenda AA and BB and may differ from the proposed values shown here.

stimulator implants are substantially offset by payment reductions at various levels. CMS has changed the multiple procedure discounting status for 13 codes, as shown in Table 3. These include implantable procedures that were not subject to multiple-procedure discounting in 2026 but would be subject to it in 2027 unless this policy is modified in the final rule. Table 4 demonstrates the effect of multiple-procedure discounting for the implantation of 2 leads and a pulse generator. Despite the proposed increases in individual procedure rates,

Table 3. *Procedures newly subject to multiple-procedure discounting under the CY 2027 proposed rule.*

| CPT | Description | Subject to Multiple Procedure Discounting | |
|---|---|---|---|
| | | 2026 | 2027 Proposed |
| 61885 | Insertion or replacement of cranial neurostimulator | NO | YES |
| 63650 | Implantation of Neurostimulator – Percutaneous | NO | YES |
| 63655 | Implantation of Neurostimulator – Laminectomy | NO | YES |
| 63663 | Revision of Spinal Neurostimulator Electrode - Percutaneous | NO | YES |
| 63664 | Revision of Spinal Neurostimulator Electrode – Laminectomy | NO | YES |
| 63685 | Insertion or Replacement of Spinal Neurostimulator Pulse Generator or Receiver | NO | YES |
| 64553 | Percutaneous implantation of Neurostimulator electrode array; Cranial nerve | NO | YES |
| 64555 | Percutaneous implantation of Neurostimulator electrode array; Peripheral nerve | NO | YES |
| 64561 | Percutaneous implantation of Neurostimulator electrode array; Sacral nerve | NO | YES |
| 64569 | Revision or replacement of cranial nerve (e.g. vagus nerve) neurostimulator electrode array | NO | YES |
| 64575 | Incision for implantation of Neurostimulator electrode array; Peripheral nerve (excludes sacral nerve) | NO | YES |
| 64581 | Incision for implantation of Neurostimulator electrode array; Sacral nerve | NO | YES |
| 64590 | Insertion or Replacement of Peripheral Neurostimulator Pulse Generator or Receiver | NO | YES |

Table 4. *Multiple-procedure discounting affects ASC payment, with a cut rather than an increase for spinal cord stimulator implant.*

A. *Spinal cord stimulator trial lead placement.*

| Multiple-Procedure Discounting<br>1. *Rank by allowable* (All procedures in the session are ordered by ASC payment amount, highest first.)<br>2. *Top procedure pays full* (The highest-valued procedure is reimbursed at 100% of its ASC allowable.)<br>3. *Others cut to 50%* (Each additional procedure's facility payment is reduced by 50%.) | | | 2026 Rate | % | Paid | 2027 Rate (P) | % | Paid |
|---|---|---|---|---|---|---|---|---|
| | 63650 | First Lead | 5,030.95 | 100% | $5,030.95 | $5,342.44 | 100% | $5,342.44 |
| | 63650 | Second Lead | 5,030.95 | 100% | $5,030.95 | $5,342.44 | 50% | $2,671.22 |
| | | Total | | | $10,061.90 | | | $8,013.66 |
| | Net Reduction in 2027 Compared to 2026, Including Multiple-procedure Discounting | | | | ↓ 2,048.24(−20.3%) | | | |

B. *Generator (63685) + percutaneous lead (63650), two leads.*

| | | 2026 Rate | % | Paid | 2027 Rate (P) | % | Paid |
|---|---|---|---|---|---|---|---|
| 63685 | Pulse Generator | 27,485.81 | 100% | $27,485.81 | $31,549.35 | 100% | $31,549.35 |
| 63650 | First Lead | 5,030.95 | 100% | $5,030.95 | $5,342.44 | 50% | $2,671.22 |
| 63650 | Second Lead | 5,030.95 | 100% | $5,030.95 | $5,342.44 | 50% | $2,671.22 |
| | Total | | | $37,547.71 | | | $36,891.79 |
| Net Reduction in 2027 Compared to 2026, Including Multiple-procedure Discounting | | | | | ↓ $655.92 (−1.7%) | | |

the combined procedure results in a $655.92 payment reduction, representing a 1.7% decrease in reimbursement rather than an increase. Table 5A shows PNS pulse generator implantation with 2 percutaneous leads, resulting in a $3,815.54 reimbursement reduction, representing a substantial 14% decrease. However, Table 5B shows implantation of a pulse generator with only one electrode array, resulting in a smaller reduction of 6% rather than 14%. In contrast, as shown in Table 6, pump implantation is not subject to multiple procedure discounting and results in a net reimbursement increase of $1,407.10, or 6%. Thus, the code-level reality presents a divided picture, with payment reductions occurring across multiple procedures despite increases in the conversion factor and apparent increases in individual procedure payment rates. These findings demonstrate why interpreting percentage changes in individual CPT payment rates alone may overstate the financial benefit of the CY 2027 proposed rule. For procedures commonly performed using multiple reimbursable components, session-level reimbursement provides a more clinically and economically meaningful measure.

## Prior Authorization Asymmetry Between Hospital Outpatient and ASC Settings

CMS proposes expanding the existing HOPD prior authorization program, effective July 1, 2027, to include eight additional botulinum toxin injection procedures commonly used in pain and spasticity management (CPT 64611, 64616, 64617, 64642–64647; HCPCS J0589) (20,25). This expansion adds to the existing HOPD prior authorization requirements, which already include facet joint injections and facet joint radiofrequency ablation (CPT 64490–64494, 64633–64636), percutaneous spinal cord stimulator (SCS) lead implantation (CPT 63650), and cervical fusion procedures. Critically, these nationwide HOPD prior authorization requirements generally do not apply to the same procedures when performed in the ASC setting; however, CMS is separately conducting a five-year prior authorization demonstration for selected ASC services in 10 states. This asymmetry, which has developed incrementally over several rulemaking cycles, now provides a meaningful administrative and scheduling advantage for ASC-based interventional pain practice compared with HOPD-based practice. Consequently, for many Medicare-covered interventional pain procedures, the ASC may provide a more efficient site of service with fewer prior authorization barriers and, as demonstrated by the payment analysis above, favorable reimbursement for selected procedures.

Table 5. *Multiple-procedure discounting affects ASC payment of peripheral nerve stimulator implants.*

A. *PNS generator (64590) + percutaneous lead (64555), two electrode arrays.*

| | | 2026 Rate | % | Paid | 2027 Rate (P) | % | Paid |
|---|---|---|---|---|---|---|---|
| 64590 | PNS Pulse Generator | $16,224.24 | 100% | $16,224.24 | $17,619.62 | 100% | $17,619.62 |
| 64555 | First electrode array | $5,774.91 | 100% | $5,774.91 | $6,338.90 | 50% | $3,169.45 |
| 64555 | Second electrode array | $5,774.91 | 100% | $5,774.91 | $6,338.90 | 50% | $3,169.45 |
| | | | | $27,774.06 | | | $23,958.52 |
| Net Reduction in 2027 Compared to 2026, Including Multiple-procedure Discounting | | | | | ↓ $3,815.54 (−13.7%) | | |

B. *PNS generator (64590) + percutaneous lead (64555), one electrode array.*

| CPT | Procedure | 2026 Rate | % | Paid | 2027 Rate (P) | % | Paid |
|---|---|---|---|---|---|---|---|
| 64590 | PNS Pulse Generator | $16,224.24 | 100% | $16,224.24 | $17,619.62 | 100% | $17,619.62 |
| 64555 | First electrode array | $5,774.91 | 100% | $5,774.91 | $6,338.90 | 50% | $3,169.45 |
| | | | | $21,999.15 | | | $20,789.07 |
| Net reduction in 2027 Compared with 2026, Including Multiple-procedure Discounting | | | | | ↓ $1,210.08 (-6%) | | |

Table 6. *Pump implantation.*

| CPT | Procedure | 2026 Rate | % | Paid | 2027 Rate (P) | % | Paid |
|---|---|---|---|---|---|---|---|
| 62360 | Pump Implantation | $15,522.45 | 100% | $16,224.24 | $17,619.62 | 100% | $17,619.62 |
| 62350 | Catheter | $5,690.58 | 100% | $5,774.91 | $5,786.63 | 100% | %5,786.63 |
| | | | | $21,999.15 | | | $23,406.25 |

### The Scheduled Expiration of Separate Non-Opioid Payment

Section 4135 of the Consolidated Appropriations Act, 2023, established a temporary separate payment for qualifying non-opioid pain treatments furnished in the HOPD and ASC settings, including certain long-acting local anesthetics and qualifying non-opioid analgesic devices, with payment capped at 18% of the associated procedure payment. The CY 2027 proposed rule confirms that this separate payment provision will continue through December 31, 2027, its final statutory year absent congressional action (25). Practices with procedural volume dependent on qualifying non-opioid products should anticipate the potential loss of this separate payment beginning in CY 2028 and plan accordingly, including monitoring legislative efforts to extend the provision.

## Discussion: Implications for Independent Interventional Pain Practice

The CY 2027 OPPS/ASC proposed rule is comparatively favorable to IPM as a specialty in terms of facility payment, even as it continues to disadvantage specific procedures, including epidural and facet joint injections and facet radiofrequency ablation, which constitute the largest share of procedural volume for most community-based interventional pain practices. This bifurcation carries several important practical implications.

First, practice-level financial exposure to the CY 2027 rule depends heavily on procedural case mix. A practice with a substantial and growing neuromodulation and device-based program, including spinal cord stimulation and peripheral nerve stimulation, will experience some payment reductions. However, sacroiliac joint fusion, intrathecal implantable system implants, and basivertebral nerve ablation are positioned to experience meaningful growth in facility revenue under the proposed rule. A practice whose ASC volume remains concentrated in spinal cord and peripheral nerve stimulators, epidural steroid injections, and facet joint procedures should expect essentially flat to modestly declining real facility revenue, notwithstanding the positive 2.4% system-wide update. This is because the relative-weight recalibration underlying these specific codes remains below the system average, as it has in each rulemaking cycle since at least the analysis published in 2012 (13).

Second, continuation of the Medicare sequestration cut, which applies to Medicare and Medicare Advantage payments, will remain in effect until 2031, resulting in an additional 2% reduction in revenue (15,16).

Third, the facility-payment picture described here must be considered together with, rather than in isolation from, the professional-payment environment described in the authors' companion 2025 analysis of physician payment reform (15). The CY 2027 Medicare PFS proposed rule, released separately from the OPPS/ASC rule, proposes a combined approximately 2% negative impact on IPM professional payment, including reductions of 3% to 5% for many of the same epidural, transforaminal, and facet joint codes discussed above, along with a proposed restructuring of modifier -25 billing for same-day evaluation-and-management services furnished with procedural care. A practice's total Medicare revenue for a given procedure is therefore a composite of a facility-side trajectory that, for injection-based codes, is flat to modestly negative, and a professional-side trajectory that is substantially more negative. This combination intensifies, rather than offsets, the financial pressure on independent, injection-focused practices identified in the authors' prior work.

Fourth, the ASCQR compliance penalty embedded in the CY 2027 rule, reducing the update from 2.4% to 0.4% and representing approximately 2 percentage points of total Medicare ASC revenue, is one of the largest controllable payment variables available to practice administrators. It merits the same emphasis given to quality-reporting compliance in the authors' 2016 review of the MIPS implementation period (14). Given the magnitude of the penalty relative to the administrative burden of ASCQR reporting, maintaining reporting compliance should be treated as a first-order operational priority rather than a peripheral compliance matter.

Fifth, one of the most important issues affecting low back pain management by interventional pain physicians is the mandatory Ambulatory Specialty Model (ASM) for low back pain (26-30). Site-of-service, including office, ASC, and HOPD settings, can be a major driver of episode costs based on where procedures are performed. As previously described, costs for interventional techniques performed in ASC and HOPD settings are higher than those performed in office settings (26). This has direct consequences for ASM because total episode cost may be substantially influenced by the site of service, creating a potential confounding factor in cost comparisons. Thus, a practice with similar clinical decision-making but a higher proportion of ASC/HOPD-based interventional

procedures, including implant procedures, compared with a practice performing lower-intensity injections primarily in the office setting, may demonstrate a structurally higher average episode cost, independent of any difference in the appropriateness or quality of care. Because IPM procedures are typically benchmarked against peers in the same specialty, differences in site-of-service mix among pain physicians become particularly important. Consequently, two IPM practices with similar patient populations may have substantially different episode costs based on where, rather than simply how much, care is delivered (26).

Finally, commercial payer contracting is directly affected by these Medicare policy changes because ASC facility-fee schedules in commercial contracts are commonly benchmarked to a percentage of the current Medicare ASC rate. Under such benchmarking arrangements, the injection-code reductions proposed for CY 2027 may automatically flow into commercial reimbursement unless the contract language specifies otherwise. Practices renegotiating commercial ASC agreements during this period may consider fixed-year Medicare rate references rather than floating current-year benchmarks, separate case-rate or carve-out provisions for high-cost implantable devices, explicit provisions addressing non-opioid product payment in anticipation of the 2028 Medicare payment cliff, and contract language exempting ASC claims from payer prior-authorization policies that mirror the Medicare HOPD/ASC asymmetry described above.

## Conclusion

The CY 2027 OPPS/ASC proposed rule presents a mixed payment environment for interventional pain management. The 2.4% system-wide ASC update, continued use of the hospital market basket, and expansion of the ASC Covered Procedures List generally support continued migration of appropriate procedures to the ambulatory setting. However, procedure-level effects are highly heterogeneous. Core epidural, facet, and radiofrequency procedures continue to experience relative payment erosion, while apparent increases for several neuromodulation procedures may be substantially reduced when proposed multiple-procedure discounting is applied. Consequently, the economic effect of the rule cannot be assessed from individual CPT payment changes alone but must be evaluated at the procedural-session and practice-case-mix levels. The final CY 2027 rule will determine whether these proposed policies ultimately improve or further constrain the financial sustainability of ASC-based interventional pain care.

## Author Contributions, Disclosures, and Acknowledgments

All authors contributed to the conception of the summary, the extraction and verification of the recommendations and supporting evidence, drafting and critical revision of the article, and approval of the final version.

The authors wish to thank Melinda "Mindy" D. Adams, transcriptionist, for her assistance in the preparation of this article. We also thank the editorial board of Pain Physician for their review and criticism, which helped improve the article.

This article was prepared with the assistance of Claude, an AI assistant developed by Anthropic. The authors have verified all materials, figures, and tables generated by Claude.

## ORCID IDS

Laxmaiah Manchikanti, MD
0000-0002-4201-9063

## Conflicts of Interest

Dr. Soin has several patents in non-opioid pain pharmaceuticals and neuromodulation (SCS and PNS) and artificial intelligence, has leadership roles: OHSIPP-CEO and ASIPP- Director, has stock options with Neuros Medical, has received equipment, materials, drugs, medical writing, gifts or other services from Avanos for research, and has other financial or nonfinancial interests with Alyea Therapeutics, Neuros Medical, Neuronoff, BioTronik Neuro, and Avanos.

Dr. Gupta receives payment or honoraria from Vertex Pharmaceuticals, Advis for Semnur Pharmaceuticals Scientific Advisory Board- non fiduciary – payment to intuition and KSIPP President, Board of Directors – non-fiduciary – volunteer; Leadership or fiduciary role in society, committee or advocacy group or unpaid, ASIPP Director-at-Large Board of Directors 2025-2027 – non-fiduciary – volunteer and NANS PNS Guidelines Committee – non-fiduciary – volunteer.

Dr. Abd-Elsayed is a consultant for Medtronic, Curonix, Avanos, and Averitas.

Dr. Hirsch receives grants or contracts from the Neiman Health Policy Institute, participates in data and safety monitoring board (DSMB) work for Regeltech, Arsenal, Rapid Medical, and volunteers as an ASIPP Board Member, JNIS Deputy Editor, and SNIS Chair of the health policy committee

## References


1. MedPAC. July 2026 Data Book Section 7: Ambulatory care. 2026. Accessed 8/20/2026. www.medpac.gov/document/july-2026-data-book-section-7-ambulatory-care/
2. Manchikanti L, Pampati V, Sanapati M, et al. Updated analysis of decline of 16.8% in utilization of interventional pain management techniques among traditional (Fee-for-Service) Medicare beneficiaries from 2019 to 2024. *Pain Physician* 2025; 28:S121-S136.
3. Manchikanti L, Sanapati M, Pampati V, et al. Updated analysis of declining utilization rate of 13% epidural procedures for chronic spinal pain management in the traditional Medicare population from 2019 to 2024. *Pain Physician* 2026; 29:1-16.
4. Manchikanti L, Pampati V, Sanapati M, et al. Updated analysis of continued decline of utilization patterns of facet joint interventions in managing spinal pain in the traditional Medicare population: From 2000 to 2024. *Pain Physician* 2026; 29:E163-E181.
5. Manchikanti L, Pampati V, Kaye AD, et al. An updated review of utilization patterns of sacroiliac joint interventions in the Fee-for-service (ffs) Medicare population from 2000 to 2022. *Curr Pain Headache Rep* 2026; 30:34.
6. Manchikanti L, Sanapati MR, Pampati V, et al. A 24% decline in the utilization of epidural procedure visits for chronic spinal pain management in the Medicare population from 2019 to 2022: Updated analysis of the effect of multiple factors. *Pain Physician* 2024; 27:E983-E994.
7. Manchikanti L, Abd-Elsayed A, Kaye AD, et al. Escalating growth to rapid decline of utilization patterns of facet joint interventions in managing spinal pain in the Medicare population: Updated analysis of the effect of multiple factors from 2000 To 2022. *Pain Physician* 2024; 27:E979-E982.
8. Manchikanti L, Pampati V, Sanapati MR, et al. Exponential decline of 28.9% in utilization of interventional pain management techniques among Medicare beneficiaries from 2019 to 2022: Updated analysis on the ongoing effects of COVID-19, economic decline, the Affordable Care Act (ACA), and medical policies. *Pain Physician* 2024; 27:455-467.
9. Manchikanti L, McMahon EB. An overview of federal laws and regulations governing ownership in and reimbursement for ambulatory surgical centers. *Pain Physician* 2007; 10:725-741.
10. Manchikanti L. Interventional techniques in ambulatory surgical centers: A look at the new payment system. Pain Physician 2007; 10:627-650.
11. Manchikanti L, Boswell MV, Giordano J. Ambulatory surgery centers: Harbinger of managed care shift. *Pain Physician* 2010; 13:E1-E11.
12. Manchikanti L, Parr AT, Singh V, Fellows B. Ambulatory surgery centers and interventional techniques: A look at long-term survival. *Pain Physician* 2011; 14:E177-E215.
13. Manchikanti L, Singh V, Hirsch JA. Saga of payment systems of ambulatory surgery centers for interventional techniques: An update. *Pain Physician* 2012; 15:109-130.
14. Manchikanti L, Singh V, Hirsch JA. Facility payments for interventional pain management procedures: Impact of proposed rules. *Pain Physician* 2016; 19:E957-E984.
15. Manchikanti L, Sanapati M, Pampati V et al. Physician payment reform in interventional pain management: Balancing cost, quality, access, and survival of independent practices. *Pain Physician* 2025; 28:377-396.
16. Manchikanti L, Sanapati M, Pampati V, et al. The CY 2027 Medicare physician fee schedule and the continuing struggle to balance cost, quality, access, and the survival of interventional pain management. *Pain Physician* 2026; 29:411-428.
17. Manchikanti L, Helm S 2nd, Benyamin RM, Hirsch JA. A critical analysis of Obamacare: Affordable care or insurance for many and coverage for few? *Pain Physician* 2017; 20:111-138.
18. Centers for Medicare & Medicaid Services. CMS finalizes hospital outpatient prospective payment changes for 2017. 2016. Accessed 8/20/2026. www.cms.gov/newsroom/fact-sheets/cms-finalizes-hospital-outpatient-prospective-payment-changes-2017
19. Centers for Medicare & Medicaid Services. Calendar Year 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Proposed Rule (CMS-1850-P). CMS Newsroom Fact Sheet. Released July 2, 2026.
20. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs for CY 2027, 91 Fed. Reg. (proposed July 7, 2026) (to be codified at 42 C.F.R. pts. 410, 416, 419).
21. McDermott+ Consulting. CMS releases CY 2027 Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System proposed rule. July 2026.
22. Ropes & Gray LLP. CMS issues proposed calendar year 2027 payment rules: Outpatient Prospective Payment System/Ambulatory Surgical Center and Physician Fee Schedule. Ropes & Gray Insights, July 2026.
23. Holland & Knight LLP. CMS issues sweeping CY 2027 hospital OPPS/Ambulatory Surgical Center proposed rule. Holland & Knight Insights, July 2026.
24. American Society of Interventional Pain Physicians. CY 2027 Medicare OPPS/ASC proposed rule — interventional pain and ASC analysis. ASIPP, July 2026.
25. American Society of Interventional Pain Physicians. CY 2027 Medicare ASC proposed rule: The good, the bad, and the ugly for pain practices. ASIPP News, July 7, 2026.
26. Manchikanti L, Sanapati M, Soin A, et al. Implications of the CMS Ambulatory Specialty Model for low back pain for interventional pain management: The good, the bad, and the ugly. *Pain Physician* 2026; 29:445-468.
27. McDermott+. The Ambulatory Specialty Model: Officially Coming Your Way in 2027. Accessed 8/19/2026. https://mcdermottplus.com/blog/regs-eggs
28. Centers for Medicare & Medicaid Services. Ambulatory Specialty Model (ASM) Fact Sheet. Accessed 8/19/2026. https://cms.gov/priorities/innovation/innovation-models/asm
29. Epstein Becker Green. CMS Proposes Mandatory Ambulatory Specialty Model to Advance Value-Based Care for Chronic Conditions. Accessed 8/19/2026. www.ebglaw.com/health-law-advisor/?keyword=CMS+Proposes+Mandatory+Ambulatory+Specialty+Model+to+Advance+Value-Based+Care+for+Chronic+Conditions.+&do_item_search=1
30. American Society of Anesthesiologists, Center for Anesthesia and Perioperative Economics. Assessing CMS' Ambulatory Specialty Model: Policy Recommendations to Reduce Administrative Burden for Anesthesiologists and Pain Medicine Physicians. Accessed 8/19/2026. www.asahq.org/advocating-for-you/center-for-anesthesia-and-perioperative-economics/ambulatory-specialists-model