ASPN
AMERICAN SOCIETY of PAIN & NEUROSCIENCE

NEWSLETTER | JUNE 2026

WHERE INTELLIGENCE MEETS HUMAN INSIGHT

Innovation, Advocacy, and the Future of Pain Medicine Ahead of **ASPN 2026**

IN THIS ISSUE

Editor-in-Chief
Dr. Jordan Tate

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CHAIRMAN'S CORNER

What is an Expert?

As a person who has worked with consensus guidelines for many years, I am often asked "what is an expert"? What is the secret sauce we use to determine those chosen for inclusion in developing, writing, and publishing guidance that may lead to important changes in patient access. In the past my leadership on these issues has been successful, which has included work with many societies and organizations. This success does not always come with the absence of drama, or the turmoil of politics, so I thought I would take a moment to give some initial thoughts, which will be given in much greater detail by and upcoming editorial by Dr. Jason Pope, our past President and Senior advisor to the Executive board.

I thought an easy outline for this process would include grouping who is chosen based on category.

The Leaders of a Consensus: This group needs one very important characteristic. They should have extensive experience in the subject matter.For example, if the topic is Spinal Cord Stimulation, and your clinical experience is only a few implants a year, you should not, and in our system would not be chosen to be a leader. Many times, we have heard people speak with gravitas, judge others on their practice and then we discover the number of implants performed per year would certainly not give them experience to be a leader in a consensus but would barely make them competent. In the future, there should be a disclosure on the authors experience with the procedure in question. Would you want someone to organize the clinically relevant points who has less experience than those in whom the paper was intended? Of course not.

Subject Matter Expertise: This group represents those who do not lead the consensus but are critical for accuracy in the issues to consider. For example, if you were creating a consensus guideline on basivertebral nerve ablation, you need experts who understand and have published on vertebrogenic pain, discogenic pain and the options surrounding treatment for each. The subject matter experts are easier to determine, because the publication record serves as a reference point to the understanding of why they were chosen.

Specialty, Practice Setting, Location of Practice: The practice of interventional spine, the use of artificial intelligence, the management of peripheral nerve stimulation all are examples of the importance of diverse thought. For example, we may have a procedure where collaborative care is needed and, in those settings, we will chose those who represent different specialties. Other considerations may include site of service, location of practice, academics or private, and solo practice or large entity.In many papers, we will try to assure we have diversity in these processes to properly address the critical issues our members may face in daily practice to assure the new guidelines improve patient access when the data is supportive.

CHAIRMAN'S CORNER, CONT.

Career Experience: In choosing the participants of a consensus we have the experts who lead the project, we have subject matter expertise, we strive for diverse opinions, and lastly, we bring in early career physicians to do the work of literature review and early grading. These are the people who eventually lead these types of work in the future. I was the "early career "doctor in 1999 when Elliot Krames, MD, Sam Hassenbusch, MD, and Michael Cousins, MD gave me an opportunity. I felt it was my one shot or one opportunity to seize everything I ever wanted, and I did not just let it slip away.

Once we get this amazing group of people together, we develop rules and guidance for the project, including a grading system. Then we develop a conflict-of-interest policy, which it includes a transparency and recusal agreement that no one grades or opines on areas where they hold consultation. We do this in an open honest way and assure that we do not allow those who have "no conflicts", but go to Faculty dinners, have a room paid by the society and get the flight reimbursed to try to sway the process against honest and transparent physicians. There is no room for hypocrisy in our tent. Everyone else please join us, but not hypocrites who pretend to "find industry biased" but take their money via societies without disclosure.We welcome both the conflicted, who are often the most important key opinion leaders and the non-conflicted who have chosen to avoid industry work. The end product becomes the guideline that in many cases impact the access to care for those who suffer.

Transparency and recusal are the pillars of our ethos and critical to our impact.

So now you know. This is the soup and the ingredients. Look forward to many guidelines coming to publication soon under the ASPN umbrella. These guidelines will impact your practice.

Be safe out there my friends.

TIMOTHY DEER, MD

Chairman & Co-Founder

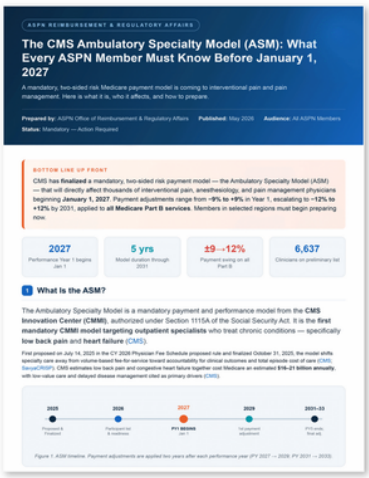
ASPN MEMBER BRIEFING

New ASPN Member Briefing: Understanding the CMS Ambulatory Specialty Model (ASM)

A significant change to Medicare reimbursement is on the horizon, and many interventional pain, anesthesiology, and PM&R physicians may be affected.

The ASPN Office of Reimbursement & Regulatory Affairs has released a new member briefing on the CMS Ambulatory Specialty Model (ASM), a mandatory payment model scheduled to begin January 1, 2027. The model introduces performance-based payment adjustments and financial risk-sharing that could have a meaningful impact on physician reimbursement.

Physicians practicing in selected geographic regions who meet CMS volume thresholds may be required to participate. Participation is mandatory for eligible providers, and there is no opt-out option.


ASPN REIMBURSEMENT & REGULATORY AFFAIRS

The CMS Ambulatory Specialty Model (ASM): What Every ASPN Member Must Know Before January 1, 2027

A mandatory, two-sided risk Medicare payment model is coming to interventional pain and pain management. Here is what it is, who it affects, and how to prepare.

Prepared by: ASPN Office of Reimbursement & Regulatory Affairs · Published: May 2026 · Audience: All ASPN Members

Status: Mandatory — Action Required

BOTTOM LINE UP FRONT

CMS has finalized a mandatory, two-sided risk payment model — the Ambulatory Specialty Model (ASM) — that will directly affect thousands of interventional pain, anesthesiology, and pain management physicians beginning January 1, 2027. Payment adjustments range from −9% to +9% in Year 1, escalating to −12% to +12% by 2031, applied to all Medicare Part B services. Members in selected regions must begin preparing now.

2027 — Performance Year 1 begins Jan 1
5 yrs — Model duration through 2031
±9 → ±12% — Payment swing on all Part B
6,637 — Clinicians on preliminary list

1 What is the ASM?

The Ambulatory Specialty Model is a mandatory payment and performance model from the CMS Innovation Center (CMMI), authorized under Section 1115A of the Social Security Act. It is the first mandatory CMMI model targeting outpatient specialists who treat chronic conditions — specifically low back pain and heart failure (CMS).

First proposed on July 14, 2025 in the CY 2026 Physician Fee Schedule proposed rule and finalized October 31, 2025, the model shifts specialty care away from volume-based fee-for-service toward accountability for clinical outcomes and total episode cost of care (CMS; SaveLCR5P). CMS estimates low back pain and congestive heart failure together cost Medicare an estimated $16–21 billion annually, with low-value care and delayed disease management cited as primary drivers (CMS).

2025 Proposed & Finalized
2026 Participant list & readiness
2027 PY1 Begins Jan 1
2029 1st payment adjustment
2031–33 PY5 ends, final adj.

Figure 1. ASM timeline. Payment adjustments are applied two years after each performance year (PY 2027 → 2029; PY 2031 → 2033).

The briefing provides an overview of:

- Who may be affected and how to verify participation status
- Key implementation dates and timelines
- Potential reimbursement impacts through 2031
- Recommended readiness and planning steps

ASPN encourages members to review the briefing and determine whether they may be impacted by the model. Early preparation will be critical as implementation approaches.

LEARN MORE

DOWNLOAD BRIEFING

HEMANT KALIA, MD

VP, Office of Reimbursement & Regulatory Affairs

FELLOW'S CORNER

As a pain medicine fellow, I am constantly reminded that the future of medicine is not just about advancing technology; it is about preserving humanity within it.

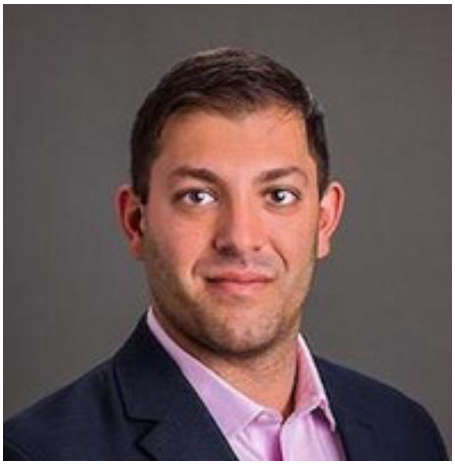
ASPN's 2026 theme, "Where Intelligence Meets Human Insight," reflects the balance our generation of physicians is learning to build every day: combining innovation, data, and emerging technologies with empathy, clinical judgment, and human connection.

We are training in a time of rapid change, where artificial intelligence, neuromodulation, and new discoveries are reshaping patient care.

Yet medicine remains deeply personal.

Technology may guide decisions, but it cannot replace listening, trust, or understanding the human experience behind pain.

For fellows and residents, ASPN offers more than education; it provides mentorship, collaboration, and the opportunity to help shape the future of patient-centered pain medicine while learning from leaders driving the field forward.



ANDREW GOLDBLUM, DO

Vice Chair, Social Media Committee

REGENERATIVE MEDICINE

The future of pain medicine is increasingly focused on restoration, not simply symptom management.

In 2024, the American Society of Pain and Neuroscience (ASPN) published comprehensive evidence-based guidelines on regenerative medicine for chronic pain, representing one of the field's most significant efforts to evaluate emerging biologic therapies through a scientific and multidisciplinary lens.

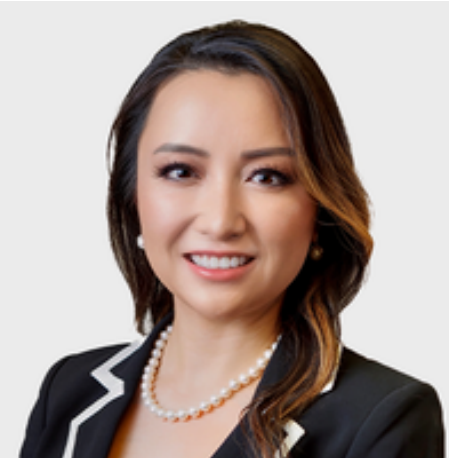
The guidelines reviewed hundreds of studies and highlighted the growing role of treatments such as platelet-rich plasma (PRP), bone marrow aspirate concentrate (BMAC), and other injectable biologics for carefully selected patients with chronic pain conditions.

Building on this momentum, ASPN is proud to launch its new Regenerative Medicine Division at the 2026 Annual Meeting in Miami Beach.

This initiative will provide a dedicated platform for advancing research, education, clinical standards, and innovation in restorative pain therapies.

The division's launch event will introduce its leadership, mission, future initiatives, and opportunities for collaboration as ASPN continues to help define the next generation of evidence-based regenerative care.

This marks an exciting new chapter in the evolution of pain and neuroscience.



MELISSA MURPHY, MD

Executive Board – Treasurer

COMMITTEES

The American Society of Pain and Neuroscience (ASPN) Advocacy and Policy Committee (ASPN-PAC) is actively tracking two major Medicare payment shifts with significant implications for pain and neuroscience physicians.

First, the CMMI WISeR model, which launched January 1, 2026, introduces prior authorization requirements for select outpatient services in Original Medicare using AI and clinical review.

Critically for ASPN members, targeted services include neuromodulation, radiofrequency neurolysis, epidural steroid injections, vertebral augmentation for compression fractures, and spinal instrumentation (e.g., cervical fusion, spinal decompression).

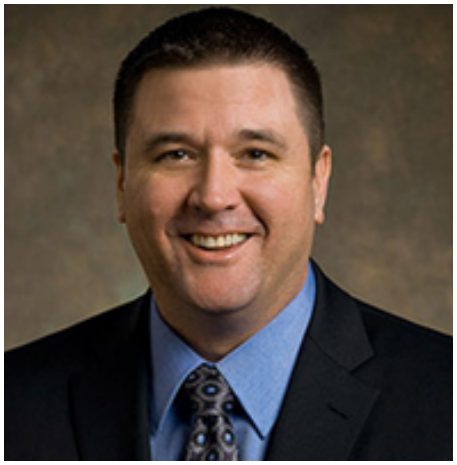
ASPN is advocating that algorithmic prior authorization tools must account for the clinical complexity unique to chronic pain patients.

Simultaneously, CMS has finalized the Ambulatory Specialty Model (ASM), a mandatory alternative payment model for physicians treating low back pain and heart failure in ambulatory settings.

The launch of the mandatory ASM marks a turning point, with payment adjustments increasingly shifting toward peer-based comparisons and two-sided financial risk arrangements.

Additionally, the new ACCESS Model introduces outcome-aligned payments specifically targeting chronic musculoskeletal pain, among other conditions.

However, ASPN-PAC is actively following these updates, and we remain actively engaged in opposition to the financial impact on physicians, and we continue to offer alternative perspectives and insights to CMS on behalf of our membership.



MARK N. MALINOWSKI, DO, DABPM, FIPP

Chair, Advocacy and Policy Committee

- *Please ensure you consider attending the ASPN Policy Forum during the 2026 Annual Meeting in Miami.*
- *To see our efforts and correspondence to CMS and other entities, please visit ASPN's Advocacy & Policy Reform resource page.*

Contact the ASPN Policy and Advocacy Committee through the member portal to get involved.

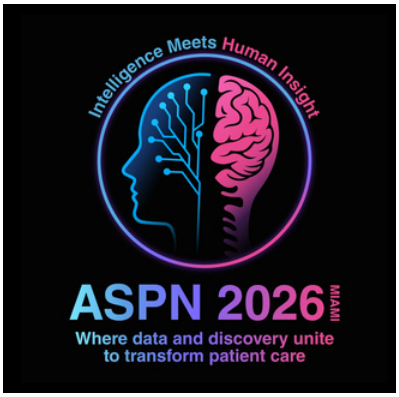
SOCIAL MEDIA COMMITTEE CHAIR

This year's theme couldn't be more timely. AI is everywhere in medicine right now. Some of it is genuinely impressive. Some of it is noise. And the conversation we need to have, the one about where the algorithm ends and clinical judgment begins, that's exactly what we're doing in Miami this July.

As your Social Media Committee Chair, I've watched this community grow into one of the most intellectually honest spaces in interventional pain and neuroscience. The people in this society don't just follow the standard of care. They question it. They build it. They redefine it.

"Intelligence Meets Human Insight" isn't just a conference theme. It's the tension we navigate every single day in practice. I'm very excited about what this year's program is going to look like.

Join us July 16-19 at Fontainebleau Miami Beach.



NIKHIL VERMA, MD

Chair, Social Media Committee

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Please tag us so we can share your posts!

A TRIBUTE TO DR. MICHAEL A. FISHMAN

A Life of Compassion, Brilliance, and Relentless Dedication to Advancing Pain Medicine

DR. MICHAEL A. FISHMAN

The sudden passing of Dr. Michael A. Fishman on May 13th has left a profound and irreplaceable void in the field of pain medicine. His loss reverberates across the neuromodulation community, among colleagues and trainees, and most deeply within the family he cherished above all else.

To know Michael was to witness a rare combination of intellectual brilliance, energy, and a deeply human commitment to easing suffering. His life's work—and the way he lived it—stands as a testament to what one person can accomplish when driven by purpose, compassion, and love.

Michael's academic path was marked by distinction at every step. From Franklin & Marshall College, where his curiosity and discipline first took root, to Thomas Jefferson Medical School, where he refined his clinical instincts, he demonstrated a rare blend of analytic and emotional intelligence. His anesthesia residency at Yale further sharpened his clinical acumen, and his fellowship at Stanford placed him at the forefront of innovation in pain medicine.

Michael's work ethic was unsurpassed. Even after the longest days in clinic or the most demanding procedural schedules, he would carve out time—often late into the night—to write, analyze data, or refine research ideas. I know this because this is the only time we could collaborate after he spent time with his family and the kids went to bed.

I had the privilege of knowing Michael for more than six years. He was the only medical resident who applied to join our practice a full year before completing his fellowship—a testament to his clarity of purpose and his eagerness to contribute. From the beginning, it was clear he wanted something exceptional.

We collaborated on numerous research projects, articles, and book chapters. I often said he was the better writer—and it wasn't false modesty. He had a gift for distilling complex ideas into elegant, compelling concepts. His academic voice was confident, precise, and always anchored in patient-centered thinking.

A TRIBUTE TO DR. MICHAEL A. FISHMAN

Within the neuromodulation community, Michael's reputation grew rapidly. He was precocious, innovative, and forward-thinking. He asked the questions others overlooked. He challenged assumptions. He pushed the field toward better science, better technology, and better outcomes.

He became a trusted voice in spinal cord stimulation, dorsal root ganglion therapy, and emerging neuromodulation technologies. His lectures were clear, engaging, and grounded in both evidence and empathy. He had the rare ability to bridge the gap between rigorous science and real-world clinical practice.

To colleagues, Michael was a source of energy and inspiration. He was generous with his time, thoughtful in his feedback, and always willing to help others refine their ideas. He mentored trainees with patience and enthusiasm, guiding them not only in technique but in the values that define great physicians.

For all his professional accomplishments, Michael's greatest pride was his family. He spoke of his wife, Megan, and their children with a warmth that softened even his most analytical moments. He loved sharing videos of his kids—drumming at age two, outshooting classmates on the basketball court, doing the kinds of precocious things that made him beam with joy. This is what I remember the most in sharing these videos and being filled with pride and joy.

At his funeral, the overflowing room—so full that a second room was needed—was a testament to the breadth of his impact. Colleagues, friends, patients, and family gathered not just to mourn, but to honor a man who lived fully, gave generously, and inspired deeply.

Dr. Michael A. Fishman leaves behind more than a body of work. He leaves a standard for clinical excellence, intellectual curiosity, mentorship, and humanity, and, above all, a family man with a loving wife and kids.

Tribute by Dr. Philip S. Kim

SHARE YOUR CONTENT & IDEAS:

Do you have videos, photos, ideas, etc. that you want to share with the ASPN community? Visit the link below to submit content to the team.

TINYURL.COM/ASPNPOSTIDEAS

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