ASPN
AMERICAN SOCIETY of PAIN & NEUROSCIENCE

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THE EVOLUTION OF PAIN MEDICINE

Growth, Innovation & What Comes Next

IN THIS ISSUE

Editor-in-Chief
Dr. Jordan Tate

Contributing Editor
Dr. Nikhil Verma

CHAIRMAN'S CORNER

Exploring Restraint of Trade

Recently, there has been discussion amongst those in some areas of medicine to try and restrict the practice of other physicians. In this setting, a limited number of physicians who have traditionally done larger, open more invasive surgeries are trying to restrict the practice of specialties outside of their scope or area of board certification. This has come under the cover of "joint society recommendations" and similar poorly veiled statements and positions.

This relates to physicians in which those trying to restrain practice were not involved in their training or credentialing. This effort, while being attempted in the past, tries to set standards of practice for those in another specialty even though they have limited knowledge of past training, protocols, or mentoring.

Trying to set rules for new, innovative, and evolving specialties by those who previously had been dominant in an area of medicine, but that has been restricted in improving outcomes, cost containment, and public acceptance, is not new. While this may be turf and financially driven, we should look at the implications of this type of misguided behavior.

In terms of old network television, we would say this is a "rerun," a term for a show that plays over and over again. In that context, interventional spine and nerve practice is more of a streaming service, delivering tailored programming, new ideas, and in many ways, getting more viewers or subscribers.

The fact is that most patients are choosing less invasive, new methods of treatment that are dependent on innovation and new paradigms of training and certification. This is the new world order, and we are just in the beginning.

Having said that, we understand the essential need for bigger, more involved surgical treatment, and we in no way would ever attempt to limit that practice or be involved in the treatment decision-making of the need for more invasive methods. The treatment decision-making for many conditions will change, and it will be essential that those in each step and each specialty determine proper patient selection, physician credentialing, and proper continued competence training.

Notably, this restraint of practice was attempted by Neurosurgery in Neurovascular Medicine. The desire of the Neurosurgeons to restrain the practice of interventional neuro-radiologists (IR) to perform neurovascular medicine was organized and aggressive.

Despite this effort of restriction, including the argument that they could not treat their own complications and did not have the structural understanding required for the techniques, the Interventional neuroradiology specialty was successful in continuing to widen the scope of practice.

CHAIRMAN'S CORNER, CONT.

The arguments centered around the inability of the IR doctors to “treat” their own complications, the lack of more extensive “surgical training,” the fact that the years of neurosurgery training made them unique in understanding and doing the methods, and finally, they were the “wrong” specialty.

Over time, it became apparent that the type of specialty was not the important part; rather, it was the training and innovation for new, less invasive methods. Interventional Radiology became a very important part of this treatment area, and the attempt to restrain this practice failed.

Now both specialties offer this therapy, and patients benefit for the less invasive methods that have evolved. Progressive surgeons now offer the newer methods, and IR has been committed to continuing to evolve the methods. In fact, they have built a collaborative field that could be a model for others.

Going back to historical parallels: Perhaps, most notable, was the battle of Cardiovascular Surgeons to limit the practice of Interventional Cardiology. This battle, which many younger physicians and APPs do not remember, was an epic case of trying to restrain the practice of Board-Certified Cardiologists in practicing stenting, angioplasty, and other advanced procedures both in the heart and in the peripheral vascular arena.

The argument used by the Cardiovascular societies was that the cardiologist “couldn’t treat their own complications,” were not appropriately trained, and would have bad outcomes. The big arguments were around Cardiologists performing angioplasty and stents, rather than open bypass surgery.

Meanwhile, the Cardiologists, avoiding the misinformation and attempted restraint of practice, continued with innovation, training, mentoring, certification, and local institutions continued with credentialing. This led to the ability to continue to build evidence, from feasibility, to prospective data, to randomized controlled trials, to big data sets.

Initially the complaint was the lack of evidence, but a few epic level-one studies led to the widespread adoption of Cardiology-based methods and the reduction but not elimination of open, larger bypass surgeries.

CHAIRMAN'S CORNER, CONT.

As the drumbeats for the impending battle are heard in the distance (the war is over; minimally invasive methods have won), we are seeing unnecessary and unforced errors by many misguided souls.

Recently, we saw evidence of this in two places. On LinkedIn, where a well-known Neurosurgeon, who should be using energy to collaborate and make productive recommendations, found the time to post inflammatory “surveys” in interventional pain. The inability to find reasonable evidence to debate is somewhat pathetic, but in the end, it seemed to be a grab to protect turf and was somewhat anemic in any well-thought argument.

The war is over, although scattered battles will continue. This is even more fascinating when you consider the history of Spinal Fusion.

When I first entered practice, I once asked the head of Neurosurgery why he always had an Ortho Spine surgeon join him in the operating room when he did Pedicle screw fusions. He told me that the Ortho Spine community nationally had blocked Neurosurgery from placing Pedicle screws since it involved bone. I am sure the politics and drama surrounding the resolution of that quagmire would be fascinating.

Eventually, as we all know, Neurosurgeons were allowed to practice this procedure independently. This resolution did not occur because Ortho spine gave in to the Neurosurgeons. It resolved because of multiple class action lawsuits against pedicle screws resulted in a need to come together to fight the litigation. Due to these legal actions, the two main societies for each field dropped the turf war and patients benefited.

Furthermore, considering the “treating your own complications” argument for any restraint of practice discussion, we must remember the number of patients undergoing spinal surgery who have infections, nerve injury, perioperative heart or pulmonary issues, blood clots, and other issues.

In addition, the presence of pain after spine surgery is a very well-known and established risk of the procedure. We know some wonderful spine surgeons, but they certainly need the help of infectious disease, pulmonary, cardiology, intensivist, and yes … Interventional pain to manage these surgically related complications.

We live in a world where collaboration is needed, expected, and most importantly the right thing to do in practice.

CHAIRMAN'S CORNER, CONT.

So as my young and energetic colleague asked me recently, “Are the actions by a group of physicians to limit the practice of others considered RESTRAINT OF TRADE?”

Not being a lawyer, but having two children that are (proud dad), I looked at the issue in an objective light:

1. Is there an agreement between parties (societies) to set unfair limits on competition and restrict the others from operating normally? (Yes)

2. Would this set an artificial limitation on freedom to do business? This would be considering that a group would be trying to set limits outside of their specialty in an area that has real or perceived financial impact on the party setting limits. (Yes)

3. Are there unfair competition limits that would interfere with the pain community’s ability to practice freely? (Yes)

4. Would there be an attempt to create a monopolistic behavior or conspiracies that manipulate market conditions, thus keeping the prices and reimbursement higher for complex large surgeries? (Yes)

5. While one could argue restraints would protect legitimate spine interests, it is a more convincing argument that innovation will change the treatment decision of the current attempts to control the actions of the other specialties

Would the actions of a group of societies to limit the actions, practice, credentialing, and training of those in other specialties violate the Sherman Act?

Go read that law and judge for yourself, but perhaps some anxiety is warranted for those engaging in those behaviors.

TIMOTHY DEER, MD

Chairman & Co-Founder

NATIONAL MEETING OVERVIEW

ASPN 2026: A Record-Setting Meeting and a Growing Community

Over eight years ago, ASPN began with a simple idea and a text message between me and Tim Deer. We both believed the field of pain and neuroscience needed something different. In July, ASPN returned to the Fontainebleau in Miami Beach, where that early vision first began taking shape: to welcome a full house for its largest Annual Meeting to date.

More than 3,000 attendees joined us for ASPN PAIN 2026, marking a new high for the society and reflecting the continued growth of our multidisciplinary community.

The theme of this year's meeting, **"Intelligence Meets Human Insight,"** reflected ASPN's broader mission: bringing together clinical expertise, emerging technology, scientific evidence, education, and innovation aiming to advance patient care.

The scale and breadth of this year's program reflected that evolution.

The meeting included **263 faculty members**, approximately 60+ more than the prior year, along with **85 industry sponsors**. More than **350 scientific abstracts** were submitted, with 27 selected for podium presentation.

Hands-on education continued to be a defining component of the ASPN experience. **Every preconference laboratory sold out**, including the inaugural Regenerative Medicine Lab, Ultrasound Course, and Hands-On Fluoroscopy Lab.

Several new programs also took place in 2026, including the second year of **Neurotech Horizons** and the inaugural **Pain and Policy Innovation Forum**, complementing an expanded APP Course and the broader scientific program. Just a few years ago, Thursday was a small day for us; this year, the rooms were all packed—a great signal that our members desire a more robust conference schedule.

Another important milestone was the celebration of the **first graduates of the ASPN MISN-C certification program**, marking an important step forward in ASPN's commitment to structured education, competency, and quality in minimally invasive spine care.

Scientific accomplishment and service to the field were recognized with **13 ASPN Awards and three Scientific Merit Awards**, while the annual ASPN race brought together **120 participants and the courts where full for the ASPN first annual Pickleball Tournament.**

NATIONAL MEETING OVERVIEW, CONT.

Just as encouraging was what happened outside the formal program. ASPN committees held more onsite working meetings than ever before, bringing members together throughout the week to advance Society initiatives. It was another indication that ASPN has grown beyond a once-a-year conference into an increasingly active year-round professional community. The lobby "Bleu Bar" was shoulder-to-shoulder most of the week; it was great to see everyone re-connecting and hanging out during off-session time.

From its beginnings in 2018 to a full house in Miami eight years later, the trajectory of ASPN has been remarkable. But growth itself is not the objective. The goal remains the same: to bring together clinicians, scientists, educators, innovators, and industry who can responsibly advance the field and improve the care we provide to patients.

We thank our members, faculty, attendees, sponsors, volunteers, and staff for making ASPN PAIN 2026 our most successful meeting yet.

ASPN PAIN 2026 — By the Numbers

- **3,000+** attendees
- **263** faculty
- **85** industry sponsors
- **350+** scientific abstracts submitted
- **27** podium abstract presentations
- **All preconference labs sold out**
- **120** race participants

Save the Dates

- **2027**: July 15–18
- **2028**: July 13–16
- **2029**: July 12–15
- **2030**: July 11–14

Reach out to me and ASPN leadership with great ideas to continue to innovate the "IT" event in our space. As I've said to hundreds of colleagues over the past years, you really need to come in person and feel the energy at ASPN to understand why this meeting has grown like no other meeting in our field.

See you in Miami next year, my friends.

DAWOOD SAYED, MD

Vice Chairman and Co-Founder

ASPN TOP ABSTRACT: PROACTIVE INTELLIGENCE

At the 2026 American Society of Pain and Neuroscience (ASPN) Annual Meeting, our study, "A Real-World Pilot Integration of Human-In-Loop Artificial Intelligence in Proactive Patient Care," was selected as an ASPN Top Abstract and presented during the meeting's featured abstract session.[1] The work evaluated Proactive Intelligence, a human-in-the-loop artificial intelligence workflow designed to identify spinal cord stimulation (SCS) patients who may benefit from proactive support using passively collected device-interaction and therapy-use data.

In this prospective, real-world pilot, a hybrid neural network-based machine learning model analyzed longitudinal behavioral patterns and generated a prioritized daily review list for the Biotronik Embrace One (Remote) Care Team, rather than making autonomous clinical decisions. Across 91 operational days, 188 cases involving 175 unique patients were reviewed. Targeted outreach achieved an 80.9% responder rate, 66% of all reviewed cases were adjudicated as therapy-related, and among reachable patients, 81.6% had therapy-related needs. Actions addressing therapy occurred in 67.8% of cases and included reprogramming, therapy adjustment, or discussion. Among patients with available follow-up pain scores, therapy-relevant cases demonstrated significant reductions in pain following outreach.[2]

The findings support a shift in SCS follow-up from a predominantly reactive model toward proactive, data-informed longitudinal care while preserving human clinical oversight. The approach also demonstrates how passive remote-monitoring data may identify meaningful changes without increasing patient reporting burden. Shortly after ASPN, the accompanying peer-reviewed manuscript was published in Frontiers in Digital Health, expanding the methodology, implementation framework, and potential implications for scalable digital, remote-care supported neuromodulation care. The prompt publication underscores the clinical relevance and provides an in-depth look at the technologic approach and study design.[2]

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1. Dickerson D, et al. "A real-world pilot integration of human-in-loop artificial intelligence in proactive patient care." ASPN Top Abstract. Oral presentation at: American Society of Pain and Neuroscience Annual Meeting; July 16-19, 2026; Miami Beach, FL.
2. Dickerson D, Lim K, Tourjé C, Naidu R, Cianni L, Kibler AB. "From behavioral signals to therapy management: a real-world pilot implementation of human-in-the-loop AI workflow in proactive patient care." *Frontiers in Digital Health.* 2026;8:1887889. doi:10.3389/fdgth.2026.1887889.

DAVID M. DICKERSON, MD

Chair, ASPN Minimally Invasive Spine and Neuromodulation Certification Program

ANNUAL MEETING TOP RESEARCH ABSTRACT

Proactive Remote Monitoring Supports Long-Term Optimization of Spinal Cord Stimulation: 24-Month Real-World Results in an Expanded Cohort

Patients receiving spinal cord stimulation (SCS) often require ongoing support and programming adjustments after implantation, underscoring the importance of longitudinal therapy management. SCS follow-up has traditionally relied on in-person care and patient-initiated communication once an issue is perceived, potentially delaying resolution of therapy-related needs.[1] Daily, automatic remote monitoring and remote programming provide an opportunity to identify and address these needs in real-time, between clinic visits.[1] This highlighted abstract evaluated how these capabilities supported SCS management through 24 months following implantation.[2]

Among 672 patients with at least 24 months of implant duration, 98.4% had at least one proactive care case flagging a need for patient support based on daily remote monitoring. The need for support varied considerably: the median was 17.5 cases per patient overall, whereas the top 25% averaged 60.7 proactive care cases over two years. These cases were addressed rapidly, with a mean resolution time of 7.4 hours and 91.2% resolved within 24 hours. Remote programming was used with 69.2% of patients.[2]

Complementary real-world data presented at ASPN from another study of patients implanted with the same SCS system showed that 89.7% were actively using therapy at a median implant duration of approximately 27 months.[3] In the same cohort, 21-month Kaplan-Meier explant rates were 8.4% for all-cause explant and 3.1% for diminished pain relief,[3] compared with historical benchmarks of approximately 14.8% and 8.0%, respectively.[4]

Together, these findings demonstrate how remote management can provide longitudinal visibility into SCS therapy needs and support a proactive, individualized approach to long-term care.

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1. Staats P, Deer TR, Hunter C, et al. "Remote Management of Spinal Cord Stimulation Devices for Chronic Pain: Expert Recommendations on Best Practices for Proper Utilization and Future Considerations." *Neuromodulation*. 2023;26(7):1295-1308. doi:10.1016/j.neurom.2023.07.003.
2. Pope JE, Levy RM, Gilligan C, et al. "Proactive Remote Monitoring Supports Long-Term Optimization of Spinal Cord Stimulation: 24-Month Real-World Results in an Expanded Cohort." Presented at the 8th Annual Meeting of the American Society of Pain and Neuroscience; July 16-19, 2026; Miami Beach, FL.
3. Pope JE, et al. "Real-World SCS Utilization and Explant Patterns in 1,000 Patients From a Multicenter Consecutive Case Series." Presented at the 8th Annual Meeting of the American Society of Pain and Neuroscience; July 16-19, 2026; Miami Beach, FL.
4. Van Buyten JP, Wille F, Smet I, et al. "Therapy-Related Explants After Spinal Cord Stimulation: Results of an International Retrospective Chart Review Study." *Neuromodulation*. 2017;20(7):642-649. doi:10.1111/ner.12642.

JASON POPE, MD

Senior Executive Advisor to the Board

ISPN MEETING UPDATE

The 3rd Annual ISPN meeting in Amsterdam will be the best one yet and offers a comprehensive, forward-looking program focused on advancing pain medicine through innovation, education, and hands-on clinical training.

The meeting begins Thursday with pre-conference opportunities, including a **Young Innovator Breakout Course** focused on building a high-impact career in pain medicine and translating innovative ideas into clinical reality. Attendees can also participate in a **full-day Ultrasound and Regenerative Medicine Course**, providing practical education in these rapidly evolving areas.

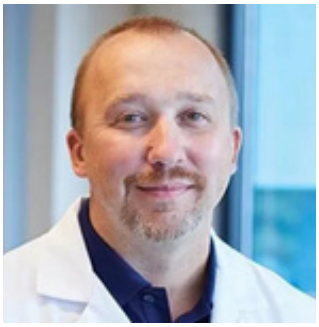
Friday features a full day of plenary programming covering the most pressing topics in interventional pain, including **Regenerative and Restorative Medicine, Intrathecal Therapies, Ablative Therapies, Artificial Intelligence, Pharmacologics**, and presentations of the **Top Abstracts**, along with the highly anticipated **Science Hour**!

Saturday continues with diverse educational sessions, including ISPN's **first Advanced Practice Nursing Breakout Session**. Additional clinical topics to shape your practice include **Expanding Indications in Neuromodulation, Spinal Cord Stimulation, Peripheral Nerve Stimulation, Advancements in Spinal Decompression, Minimally Invasive Techniques for Stabilization, Best Practices and Guidelines**, and more presentations of top research abstracts.

The meeting concludes Sunday with an **offsite hands-on laboratory**, designed to maximize practical learning through extended rotations and smaller groups, giving participants increased hands-on time and individualized instruction. This will include both didactic and cadaver training with direct access to faculty.

With a strong combination of cutting-edge science, clinical innovation, practical training, and multidisciplinary education, the ISPN meeting provides an opportunity for pain professionals at every stage of their careers to expand their knowledge, develop new skills, and help shape the future of pain medicine.

The conference is CME eligible.



STEVEN FALOWSKI, MD, FAANS
President Elect

JASON POPE, MD
Senior Executive Advisor to the Board

A WEBSITE FOR WHAT ASPN HAS BECOME

Consider what ASPN now puts into the world: conferences, webinars and videos, position papers and guidelines, training programs, advocacy, leadership, and educational resources. This is what a thriving society looks like. Together, that body of work had outgrown the way ASPN's previous website organized and presented it.

The challenge was to give it all a home where people could see the full picture and find each part more easily. Members need clear paths to resources and opportunities. Someone encountering ASPN for the first time should quickly understand what attendees feel at an ASPN meeting: This is a society with real depth and many ways to take part.

The new site brings it all together around the ways people use it. The improved jobs board and physician finder help people connect with opportunities and colleagues. The interactive agenda makes the meeting program easier to navigate, and dedicated bio pages make ASPN's leadership more visible. Important links and published material were carried forward, while the new structure leaves room for whatever ASPN creates next.

The goal was not simply to make ASPN look newer. It was to make the society's depth and energy easier to see and use.

I am grateful to ASPN's leadership and team for trusting us to build a website that reflects what the society has become and supports its continued growth.

Nick Ryan, MPhil, led the design and development of ASPN's new website through MORUSMED.

NICK RYAN, MPHIL
MORUSMED

REGENERATIVE MEDICINE

We created the Regenerative Medicine Division at ASPN for the sole purpose of educating our members on the advances and regulatory changes in regenerative and peptide medicine. Navigating the constantly changing regulatory environment and the know-how on when to and not to use is key for the growth of the field and understanding and acceptance by the greater field of medicine.

Forbes estimates the total regenerative and longevity market to be nearly ~$600 billion in 2026 with the market expected to expand by roughly 17% for the next several years. Though this field is now one of the hottest fields in medicine, it requires a road map to properly utilize these advancements and where research is required to fill in the gaps where a better understanding is needed.

We have brought and built a division at ASPN that includes both world-class clinical leaders and scientists. It is not enough that we know how to use it, but we also have a duty to our patients to understand why it works and how it can be administered safely. Alone, we are individuals with a small footprint, but together, we are a national division within an internationally recognized society that will continually deliver the latest and best information out there and be a beacon of knowledge for those seeking.

If you missed our first annual regenerative medicine course, it is never too late to sign up for the ones to come. If you cannot make it, we will have world-class webinars for you, but at the minimum, we got you covered.

"Individually, we are one drop. Together, we are an ocean." —Ryunosuke Satoro

CHRISTOPHER L. ROBINSON, MD, PHD

Regenerative Medicine Division

ADVOCACY & POLICY UPDATE

ASPN Advocacy & Policy Committee continues to advocate for its members and for the subspecialty of interventional pain and neuroscience. Here are the highlights we would like to share.

1. CY 2027 Medicare Proposed Rules - PFS and OPPS/ASC:
ASPN submitted formal comment letters to CMS on both the CY 2027 Physician Fee Schedule and the OPPS/ASC proposed rule. On the PFS, our letter addresses the conversion factor and the 2.5% "efficiency adjustment" finalized in the CY 2026 rule. CMS has not indicated whether it will extend that adjustment into CY 2027; we asked for explicit clarification, since an extension would compound an already significant cut to procedural reimbursement. On the OPPS/ASC rule, we responded to CMS's solicitation on whether device portions of device-intensive procedures should be treated as scalable expenditures under the ASC weight scaler. By CMS's own estimate, that change would move the scaler from 0.809 to 0.865 while cutting device-portion payment by approximately 14%—a direct threat to ASC access for implantable therapies. We also supported reassignment of the non-invasive PNS codes consistent with the HOP Panel's recommendation.

2. Commercial payer advocacy for Peripheral Nerve Stimulation (PNS):
Sustained advocacy is producing results: In the last month alone, PNS gained coverage from Aetna, Humana Medicare Advantage, Peak Health, and several managed Medicaid plans. ASPN is preparing a society letter of support for the next round of outreach. Priority targets include the Blue Cross Blue Shield Association evidence review, expected to close in September and likely to influence coverage across individual Blues plans, along with Cigna, Kaiser, UnitedHealthcare, and more than 20 regional health plans—all of which still classify PNS as unproven or not medically necessary despite new published evidence and society guidelines.

3. Sacroiliac joint—education and appropriate use:
Following the OIG report estimating $15.2 million in improper Medicare payments for sacroiliac joint injections, our committee chose to lead with member education rather than await restrictive policy. We developed the ASPN SIJ Medicare Coding and Compliance Guide, aligned with current LCD requirements, now available on the ASPN website. In parallel, we continue to engage CMS and the MACs directly, including a reconsideration request on SI joint ablation, so that coverage policy reflects appropriate use rather than blunt restriction.

We continue to work tirelessly for our members. Please feel free to reach out if you have policy-related challenges in your region.

HEMANT KALIA, MD, MPH, FIPP
Vice President, Reimbursement & Regulatory Affairs

MARK MALINOWSKI, DO, DABA, FIPP
Chair, Advocacy & Policy Committee

TARIQ ALFARRA, DO
Vice-Chair, Advocacy & Policy Committee

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