PAYMENT

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Reimbursement Tips:

FQHC Requirements for Medicare Chronic Pain Management and Treatment Services (CPM)

Chronic Pain Management and Treatment Services (CPM) is a new Medicare benefit designed to support the complex needs of beneficiaries with chronic pain.

Program Requirements

CMS began, on January 1, 2023, to reimburse health centers separately from the Prospective Payment System (PPS) visit rate for Chronic Pain Management and Treatment Services (CPM). These services integrate multiple methods of pain care as part of a comprehensive, patient-centered care plan. Care coordination and medication management are recognizable elements of pain care that are incorporated into this plan.

Patient Eligibility & Consent

Medicare beneficiaries with persistent or recurrent pain that lasts longer than 3 months are eligible for CPM. The patient does not have to have a chronic pain history, diagnosis of chronic pain, or a condition that causes or involves chronic pain. CMS leaves it up to the clinician "to establish, confirm, or reject a chronic pain and/or pain-related diagnosis when the patient first presents for care." Examples of chronic pain diagnosis that would qualify include osteoarthritis, cancer, and other conditions that cause pain over extended periods of time. Consent for services must be obtained before the practitioner bills for them.

Timeframe & Services

CMS requires that certain elements be included in the provision of chronic pain management and treatment services. However, CMS acknowledges that not all the elements in the bundle of CPM services apply to every patient and the ones that do would be specific to the patient's needs. For example, not every patient requires medication for their pain.

The following elements are those included in the list of required CPM services:

- Diagnosis of persistent or chronic pain management lasting longer than 3 months
- Administration of a validated pain rating scale or tool
- Patient-centered care plan

- Patient assessment and monitoring of their diagnosis and treatment
- Medication management
- Overall treatment management
- Pain and health literacy counseling
- Facilitation, coordination, and on-going communication with other necessary providers (e.g., behavioral health, physical and/or occupational therapy, home care)
- Facilitation for crisis care for chronic pain

The role of the provider is to develop, implement, revise, and/or maintain the patient-centered care plan. The care plan must include patient goals, clinical needs, strengths, and desired treatment outcomes.

Standardized Pain Assessment Tools	Opioid Risk Tool
Clinical assessment of pain using the below tools may include elements of location, intensity, description, and onset/duration of chronic pain.	Assessment for risk of future opioid use disorder is to be conducted prior to beginning or continuing opioid therapy for pain management.
Brief Pain Inventory (BPI) Faces Pain Scale (FPS) McGill Pain Questionnaire (MPQ) Multidimensional Pain Inventory (MPI) Neuropathic Pain Scale (NPS) Numerical Rating Scale (NRS) Oswestry Disability Index (ODI) Rolan Morris Disability Questionnaire (RMDQ) Non-Verbal Pain Scale (NVPS) Verbal Descriptor Scale (VDS) Verbal Numeric Rating Scale (VRNS) Visual Analog Scale (VAS) Patient-Reported Outcomes Measurement Information System (PROMIS)	Opioid Risk Tool (ORT)

👤➕ Initiating Visit

An initiating visit is not required for CPM; however, an initial, in-person visit is required at the start of services. This means that unlike the requirements for chronic care management services, which require an initiating visit within 12 months prior to the start of such services and where discussion about those services must first occur, CPM may be initiated at the same time a diagnosis of chronic pain is made.

Authorized Provider/Staff

CPM services include both in-person and non-face-to-face services. The initial face-to-face visit addressing the CPM elements must be at least 30 minutes and is provided by a physician or qualified health care professional (QHP). CMS cites the complexity of the initial assessment as the rationale for the requirement that it be face-to-face and of at least 30 minutes in length (CY 2023 Proposed MPS, Section 45935). Any subsequent chronic pain management and ongoing treatment, also to be furnished by a physician or QHP, could be delivered non-face-to-face. The physician or QHP and the patient would determine whether and when subsequent services may occur in-person.

There is no provision within the Calendar Year 2023 Medicare Physician Fee Schedule Final Rule ("Final Rule") or service code descriptions that allow for the face-to-face components of CPM to be furnished by clinical or auxiliary staff incident to (i.e., under direct supervision) a physician or QHP (CY2023 Final Rule, Section 69538). CMS commented that they may consider further development of the elements of the management and treatment services which, in the future, could possibly be furnished by clinical and auxiliary personnel incident to a physician or QHP.

CMS acknowledges that certain components (i.e., care planning and care coordination) of CPM are typically non-face-to-face services. In other Medicare chronic care management programs (i.e., Chronic Care Management, Principal Care Management, Complex Chronic Care Management), CMS explicitly provides that clinical staff and/or auxiliary staff may furnish certain non-face-to-face services under the general or direct supervision of the treating physician or QHP. However, CMS does not issue explicit guidance about the role of clinical staff and/or auxiliary staff in the provision of non-face-to-face CPM services. The only allowed treating and billing providers defined in the service codes are physicians or QHPs.

TREATING (BILLING) PRACTITIONERS

Physicians (MD or DO)	Non-Physician Practitioners		
	NP	PA	CNM
X	X	X	X

- *Physicians: Medical Doctor (MD) or Doctor of Osteopathy (DO)*
- *Non-Physician Practitioners: Nurse Practitioners (NP), Physician Assistants (PA), and Certified Nurse Midwives (CNM) as per training and State licensure and scope of practice parameters.*

➕ Coding & Billing

CMS created two new HCPCS codes which must be submitted when the requirements to bill for CPM have been met. CPM services are to be billed by FQHCs along with HCPCS G0511, which is the code billed by FQHCs for general care management services (Chronic Care Management, Primary Care Management, Complex Chronic Care Management, and BHI). The payment rate for G0511 is the average of the national non-facility Physician Fee Schedule payment for FQHC care management and general behavioral health codes (CPT codes 99424, 99425, 99848, 99487, 99490, 99491). CMS has valued CPM services using a crosswalk to the Primary Care Management (PCM) CPT code 99424. As a result, there is no change to the average used to calculate G0511 payment.

WHAT PROVIDER CODES	*Services+*	*What FQHC bills to CMS*	*CMS/ Medicare 2023 Fees*
HCPCS G3002	Initial face-to-face CPM visit by a physician or QHP; first 30 minutes; per calendar month	G0511	$77.94
HCPCS G3003	Each add'l 15 minutes of CPM by a physician or QHP, per calendar month		
	The extension of the COVID-19 PHE flexibility allows FQHCs to furnish CPM services, through December 31, 2024, using audio and visual telehealth telecommunications technology.	G2025	$98.27

+ Services for each service code are those CPM elements listed in Time Frame & Services section of this document.

G3002 has a minimum service time of 30 minutes per calendar month and that threshold must be met to bill the for CPM.

Note: Rates here are based on the 2023 Medicare Physician Fee Schedule; no Geographical Adjustment Factor (GAF) of Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.

HCPCS G3002 may be furnished monthly and, other than this initial assessment, may be furnished with telehealth as an appropriate substitute for the in-person visit. The physician or QHP and patient would together determine whether a subsequent CPM service should be in-person.

HCPCS G3003 captures the additional CPM time furnished by a physician or QHP in a calendar month. G3003 captures each additional 15 minutes of medically necessary CPM, for an unlimited number of times in a calendar month, after G3002 services are provided and billed. However, as is the case for all add-on services, CMS will not reimburse FQHCs an additional payment amount for the additional CPM service time. CMS views the higher FQHC reimbursement associated with the encounter rate as adequate compensation for the service time spent with the patient. However, it is important for FQHCs to capture the add-on codes in order to accurately capture the cost of providing these services.

⚠️ **PHE Exception.** *During the COVID-19 PHE, Medicare will reimburse CPM furnished via telehealth (audio and visual) at the G2025 telehealth rate of $98.27. The PHE telehealth flexibilities will continue through December 31, 2024.*

CMS included G3002 and G3003 on the permanent list of Medicare Approved Telehealth Services. CMS has determined that any of the CPM in-person components included in HCPCS G3002 and G3003 may be furnished via telehealth, as clinically appropriate, in order to increase access to care (CY2023 MPS Final Rule, Section 69459-69460). CPM services may not be rendered using audio-only technology. At the time of this writing, CMS has not provided any clarifying guidance on the use of telehealth once the PHE flexibility expires or how to then manage care to FQHC patients who had been receiving CPM via telehealth technology.

CMS explains that the in-person components of G3002 and G3003 may be furnished using telehealth but stresses that the first time G3002 is billed, the patient must be seen in-person without the use of telecommunications technology (CY2023 MPS Final Rule, Section 69545). CMS views the in-person visit at the onset of services as being helpful to foster the relationship between the clinician and patient and improves the clinician's accuracy in administering the G3002 service elements. (CY2023 MPS Final Rule, Section 69533)

Telehealth services are defined at the Federal level as the use of two-way, real-time, interactive, audio, and visual telecommunications technology permitting communications between a qualified FQHC practitioner and their patient. Telehealth visits are a substitute for an in-person visit. The definition of telehealth often differs for each state.

New in 2023, CMS is allowing FQHCs to bill G0511 more than one time per calendar month for multiple, distinct care management services furnished for the same beneficiary during the same period. This includes CPM along with other care management services as long as the requirements for billing each service are met.

An FQHC may submit a Medicare claim for a billable CMS PPS "G" code visit and a care management service on a single claim. If billing for CPM and a CMS PPS "G" code on the same claim, payment for the PPS "G" code will be the lesser of its charges or the fully adjusted PPS rate for the billable visit plus 80% of the charges for CPM. The date of service (DOS) used on the claim may be the date when the requirements to bill for the service have been met for that month or any date before the last day of the month.

📁 Documentation

Physicians and QHPs will need to be sure they include documentation pertaining to the required CPM services elements. The provider must note when an element (i.e., medication management) is not deemed to be a needed part of the treatment plan.

- Diagnosis of persistent or chronic pain management lasting longer than 3 months
- Administration and results of a validated pain rating scale or tool
- Patient-centered care plan with updates
- Patient assessment and monitoring of their diagnosis and treatment
- Medication management plan and monitoring
- Overall treatment management
- Pain and health literacy counseling that is provided
- Facilitation, coordination, and on-going communication with other necessary providers (e.g., neurologist, behavioral health, physical and/or occupational therapy, home care)
- Facilitation for crisis care for chronic pain that has or is occurring

The date of the initial and subsequent visits, referrals made to other providers, availability of community resources, and labs and/or diagnostic test results should also be documented. Any changes to the plan of care or treatment would be updated and noted in the medical record. Basic documentation guidelines associated with establishing medical necessity, including the documentation of a comprehensive history and physical examination, should also be followed.

References

- CMS CY 2023 Physician Fee Schedule Medicare Final Rule. Accessed at https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other

- CMS CY 2023 Proposed Physician Fee Schedule Medicare Final Rule. Accessed at https://www.govinfo.gov/content/pkg/FR-2022-07-29/pdf/2022-14562.pdf

- CMS MIPS Pain Assessment and Follow-up. Accessed at https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2019_Measure_131_MIPSCQM.pdf

- Medicare Benefit Policy Manual FQHC Services. Chapter 13. Accessed at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf

- Medicare Approved Telehealth Services List. Access at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

- National Institute on Drug Abuse. Opioid Risk Tool. Accessed at https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/opioid-risk-tool-oud-ort-oud#:~:text=This%20tool%20should%20be%20administered,risk%20for%20opioid%20use%20disorder