



September 3, 2021

The Honorable Chiquita Brooks-LaSure, Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**Comment on The Centers for Medicare & Medicaid Services (CMS) Proposed Rule: CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1751-P)**

**Section 43, page 210: Comment Solicitation of Separate PFS Coding and Payment for Chronic Pain Management**

Dear Administrator Brooks-LaSure:

The U.S. Pain Foundation is pleased to provide comments on the CMS Proposed Rule: CY 2022 Payment Policies under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies (CMS-1751-P). We are commenting specifically on Section 43: Solicitation of Separate PFS Coding and Payment for Chronic Pain Management.

The U.S. Pain Foundation is the largest 501(c)(3) organization for people who live with chronic pain from a myriad of diseases, conditions, and serious injuries. Our mission is to empower, educate, connect, and advocate for those living with pain, as well as their caregivers and health care providers.

We are delighted that CMS recognizes the enormous and pervasive challenge that chronic pain poses to the health and well-being of CMS's beneficiaries. Pain is the most common reason why Americans seek medical care. The Centers for Disease Prevention and Control (CDC) has documented that 50 million, or 20.4% of adults, in the U.S. have chronic pain, and 20 million, or 7.4% of U.S. adults, have high-impact chronic pain that frequently limits their life and/or work activities.<sup>1</sup> Chronic pain is the leading cause of long-term disability in the U.S. and globally<sup>2</sup> and the reason why these individuals under age 65 are eligible for Medicare. Further, the World Health Organization has recognized chronic pain as a separate category of disease<sup>3</sup> that causes measurable changes in the brain, spinal cord, and peripheral nervous system.<sup>4</sup>

We strongly support CMS's assertion that chronic pain management is complex and there are no existing codes that account for all the tasks required to care for a patient with chronic pain. Even the Chronic Care Management Codes do not adequately cover the complexity and unique tasks that managing a patient with pain entails. The U.S. Pain Foundation hears weekly from chronic pain patients who cannot find primary care

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<sup>1</sup> <https://www.cdc.gov/nchs/data/databriefs/db390-H.pdf>

<sup>2</sup> <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5816a2.htm>

<sup>3</sup> <https://www.painresearchforum.org/news/109900-new-classification-chronic-pain-better-patient-care-and-research>

<sup>4</sup> National Academy of Medicine (formerly the Institute of Medicine) Report: *Relieving Pain in America, A Blueprint for Transforming Prevention, Care, Education and Research*. The National Academies Press, 2011. [http://books.nap.edu/openbook.php?record\\_id=13172&page=1](http://books.nap.edu/openbook.php?record_id=13172&page=1).



providers who will take them on as patients. We believe that one of the salient reasons why these patients have been dropped from care and are unable to find new providers is the fact that PCP's are not adequately compensated for the time involved in providing care to pain patients.

Therefore, we enthusiastically back CMS creating separate coding and payment for activities involved in chronic pain management. CMS has asked for feedback on whether a standalone code or add-on code to be billed with an evaluation and management (E/M) visit would best capture the activities involved in furnishing pain care. We believe a standalone code would best serve patients, physicians, and CMS. A standalone code would signal to physicians that when patients have complaints of pain that it is critical to take them seriously and conduct a thorough pain assessment. The most frequent concern of patients with disabling pain is that doctors do not take their complaints of pain seriously even when pain limits their ability to work or function daily.

Furthermore, a standalone code similar to CPT Code 99483 for Cognitive Impairment Assessment and Care Plan Services would allow CMS to begin to capture the salience and prevalence of chronic pain as a primary diagnosis, as well as to better understand the types of provider activities required to effectively manage and improve the care of these patients. We would expect that the amount of care required, and consequently the cost of this care to the Medicare system, to be increasing given the aging American population and the prevalence of age-associated chronic pain conditions like arthritis, cancer, and diabetic neuropathy. However, without a standalone code, CMS is likely not capturing these increasing costs to the U.S. economy.

We also note that many complementary and integrative pain therapies are typically not provided within the four walls of the primary care provider's office nor in conjunction with a standard office visit. For this reason, we urge CMS to allow wide discretion in terms of ensuring that appropriate settings (e.g. health care clinic, office setting, or other establishment) are allowed for the provision of pain management services.

Many non-pharmacological alternatives for pain management identified in the 2019 HHS Pain Management Best Practices Task Force report are not currently covered under traditional Medicare. Some services, such as acupuncture or chiropractic, are covered for certain health conditions. Other services, such as massage therapy, are covered under Medicare Advantage (MA) as a supplemental benefit for pain management, but not under Part B. For these reasons, we believe it is vital that CMS adopt appropriate indicators as to which type of provider is providing a specific therapeutic service for Medicare beneficiaries with chronic pain, in order to allow CMS to capture essential quality measurement indicators.

CMS has provided a list of provider activities involved in holistically caring for a chronic pain patient and asked if this list has the correct elements or if any should be changed or added. We applaud CMS's efforts to try to include all the elements of best practice pain care as articulated in the 2019 HHS Pain Management Best Practices Task Force report in order to decrease the inconsistencies and fragmentation of care that now severely hampers patient outcomes. The list CMS provided is as follows below. We agree with this list except for a few edits highlighted in yellow and explained below.

- Diagnosis;
- Assessment and monitoring;
- Administration of a validated rating scale(s);
- Development, **revision**, and maintenance of a person-centered care plan;



- Overall treatment management;
- Facilitation and coordination of any needed behavioral health treatment;
- Medication management;
- Patient education and self-management;
- Crisis care;
- Specialty **and interdisciplinary** care coordination such as **physical therapy, occupational therapy,** complementary, and integrative pain care, **and SUD** care; and
- Other aspects of pain and/or behavioral health services, including care rendered through telehealth modalities.

Pain treatment plans are highly individualized to the type of pain, comorbid conditions, lifestyle, and preferences of the patient; and therefore often require *revision* and close coordination between the patient and provider(s) to ensure quality patient health outcomes. This is particularly true in the initial phase of creating a treatment plan and should be called out in the list. To achieve a multidisciplinary, integrative treatment plan that has the best chance of succeeding for the patient requires the main care provider (in most cases the primary care physician (PCP)) to communicate with health care providers from *different disciplines* such as a psychologist, physical therapist, chiropractor, therapeutic massage therapist, acupuncturist, etc.

Finally, SUD treatment *should not* be included in this list of pain management tasks so as not to obfuscate the separate diseases of chronic pain and opioid use disorder. As stated earlier, 50 million Americans are living with chronic pain and 2 million with opioid use disorder in the U.S. The overwhelming majority of chronic pain patients do not have opioid use disorder. Media and policymakers confusion and obfuscation of these separate diseases have been stigmatizing and detrimental to the appropriate treatment of both groups.

While pain and SUD are comorbid in certain patients, *and these patients deserve quality care*, their treatment needs to be considered separately with careful attention and monitoring of risk assessment and medication-assisted treatment protocols.

We thank CMS for proposing separate coding for chronic pain care and hope you will take our views into consideration as you determine how best to improve health insurance coverage and care of the vast population of Americans with chronic pain who obtain their healthcare through CMS. If you have questions about our comments, please feel free to contact me using the information listed below.

Sincerely,

A handwritten signature in black ink that reads "Cindy Steinberg".

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