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Results of a Delphi Panel Survey Among German Specialists in Pain Management on the Use of High-Concentration Capsaicin Patch (HCCP)

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INTRODUCTION

Peripheral neuropathic pain (PNP) is caused by lesions or disease of the peripheral somatosensory system[1] and affects approximately 7–10% of the general population.[2]

The high-concentration capsaicin patch (HCCP; 179 mg, 8% w/w) is approved for the treatment of peripheral neuropathic pain in adults and is a guideline-recommended topical second-line option.[3,4]

Unlike oral therapy, HCCP must be applied by a physician or by non-physician healthcare professionals under physician supervision, with a fixed in-office skin-contact time of 30 min (feet) or 60 min (other sites).[5]

In Germany, HCCP application is reimbursed through specialty-specific basic flat fees whose predefined calculation times may not reflect the time actually spent.[6] Robust data on the time HCCP application requires in routine outpatient practice are lacking.[7]

AIM

To quantify the time required for HCCP application in Germany and to evaluate the discrepancy between actual procedural time and reimbursed time across the three specialties that predominantly provide it.

METHODS

Design Classical three-round, anonymised online Delphi survey conducted in Germany between 2 February and 22 March 2026.

Panel 29 physicians from the three specialties that predominantly provide HCCP (neurology n=8, diabetology n=10, pain specialists n=11), with a mean of 16 years of experience in pain treatment and routine HCCP use (≥5 applications/year).

Procedure HCCP application was decomposed into 10 procedural steps based on the German Qutenza® Summary of Product Characteristics (sections 4.2 and 4.4) and validated by an independent clinical expert. Times include all staff, physician or non-physician.

Rounds Round 1: open-ended numeric time estimates per step. Rounds 2–3: anonymised feedback of the group mean and median; participants rated agreement on a 5-point Likert scale and could revise their estimate.

Consensus Defined a priori as ≥70% of the panel (≥21/29) agreeing. Steps with no consensus are reported as means from round 1/2.

Reimbursement Each specialty's EBM basic flat fee (GOP 16211 / 13341 / 30700; point value €0.1274; billable once per case) was divided by its calculation time to give a rate per minute, which was applied to the hands-on time of steps with consensus. The whole flat fee was credited to HCCP, although it also covers general pain management (e.g. diagnosis). The supplement GOP 30702 is not HCCP-specific, requires authorisation and is capped, so it is tested in the sensitivity analysis.[6]

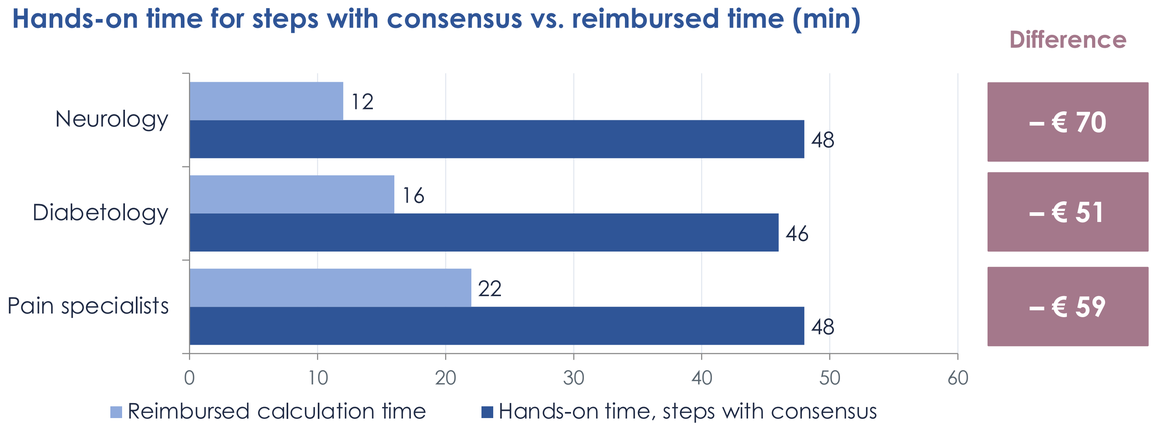
Sensitivity analyses Bootstrap 95% CIs (10,000 resamples), outlier-adjusted means, consensus thresholds 66.7–80%, and leave-one-out tests.

RESULTS

Consensus was reached on 7 of 10 procedural steps (completion rate 100%). Times: neurology / diabetology / pain specialists. Step 8 counts only active checks during skin contact (e.g. blood pressure, treatment-related discomfort).

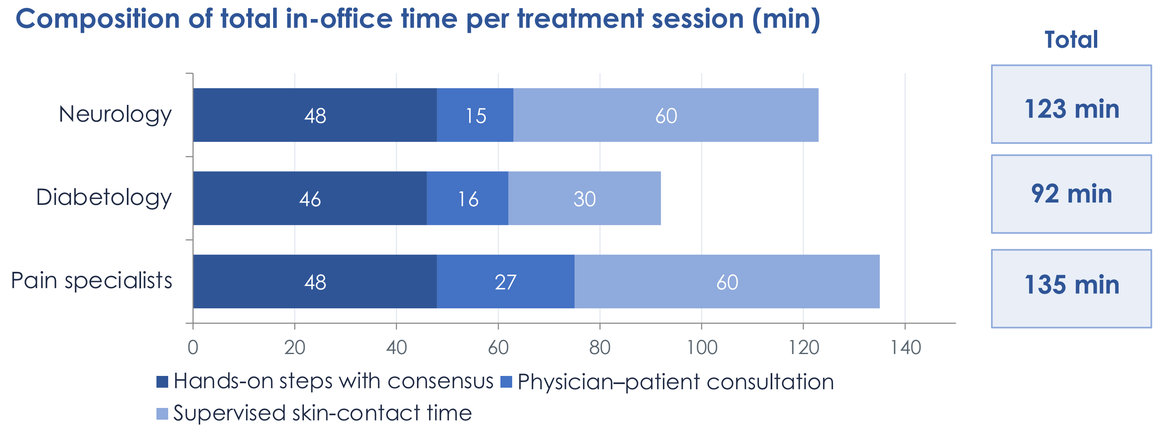
1	2	3	4	5	6	7	8	9	10
Preparation and airing of the treatment room	Physician–patient consultation	Identification and preparation of the treatment area	Administration of analgesic / anaesthetic	Implementation of protective measures	Trimming the patch	Patch application	Monitoring during the skin-contact time	Patch removal and area cleaning	Final examination
CONSENSUS mean 7 / 7 / 7 min	NO CONSENSUS mean 15 / 16 / 27 min	**CONSENSUS** mean 11 / 11 / 11 min	NO CONSENSUS mean 8 min	**CONSENSUS** mean 1 / 1 / 1 min	NO CONSENSUS mean 7 min	**CONSENSUS** mean 7 / 10 / 7 min	**CONSENSUS** mean 9 / 4 / 9 min	**CONSENSUS** mean 8 / 8 / 8 min	**CONSENSUS** mean 5 / 5 / 5 min

Hands-on time for steps with consensus vs. reimbursed time (min)



Per HCCP session, crediting the full quarterly flat fee: neurology €23.44 reimbursed vs. €93.76 of time value; diabetology €27.14 vs. €78.03; pain specialists €50.20 vs. €109.53. GOP 13341 is the endocrinology flat fee, applied to diabetology. Where a practice holds the pain-therapy authorisation, the supplement GOP 30702 (28 min, €63.45) may be billed in addition and closes the gap, see the sensitivity analysis below.

Composition of total in-office time per treatment session (min)



Bootstrap 95% CIs for total in-office time: 119 min (111–127) neurology, 96 min (84–107) diabetology, 138 min (125–151) pain specialists. The consultation is a mean estimate from a step without consensus. Skin-contact time per SmPC: 30 min in diabetology (feet), 60 min otherwise. Excludes the two steps without consensus needed only in some sessions (trimming, analgesia), which add about 7.5 min per session on average.

Sensitivity of the reimbursement gap (€ per HCCP session)

Deterministic scenario analysis on the time estimate, the procedural time definition and the reimbursement basis. Negative values denote unreimbursed time value.

Scenario	Neurology	Diabetology	Pain specialists
Base case — basic flat fee, 7 steps with consensus	**– € 70**	**– € 51**	**– € 59**
Steps without consensus added (trimming, analgesia)	– € 85	– € 63	– € 76
Outlier-adjusted time estimates (hands-on time −8%)	– € 63	– € 45	– € 51
Pain-therapy supplement GOP 30702 credited	n/a	n/a	**+ € 5**
Flat fee shared over two contacts per quarter	– € 82	– € 64	– € 52

GOP 16211 / 13341 / 30700 are general consultation fee codes and GOP 30702 a quarterly pain-therapy supplement; none is specific to HCCP. GOP 30702 is available to pain specialists only and is capped by case volume. All are billable once per treatment case, so the base case credits a full quarter's fee to one session — conservative in favour of the payer.

A team-delivered, not a physician-only procedure

The panel agreed unanimously (100%) that HCCP application can be delegated to non-physician healthcare professionals (e.g. nurses). Share of the panel stating that each hands-on step can, in principle, be delegated:



Only identification and marking of the treatment area — the diagnostic act itself — retained substantial physician involvement. In routine practice, non-physician healthcare professionals performed these steps in about 9 of 10 cases.

CONCLUSIONS

HCCP is time- and resource-intensive, but most of the work can be delegated: 92–135 minutes of in-office time per session, of which 46–48 minutes are hands-on work by non-physician healthcare professionals.

Hands-on time exceeds the calculation time underlying the EBM basic flat fee by a factor of 2.2–4.0, leaving a shortfall of €51–70 per HCCP session in every specialty surveyed.

This gap is a supply-side disincentive that may limit access to a guideline-recommended therapy, and it recurs with every repeat application.

The gap is closable within the existing framework: GOP 30702 can offset it for pain specialists, but its billability is capped and it covers a wide spectrum of therapeutic measures rather than HCCP. Since 1 June 2026 the statutory accident insurance schedule (UV-GOÄ) explicitly covers HCCP application including the supervised observation period — a principle extendable to statutory health insurance.

LIMITATIONS

Expert estimates rather than direct observation; subject to recall and self-presentation bias.

Small per-specialty panels (n=8–11); bootstrap CIs encompassed every consensus estimate.

Monetary figures are specific to the German EBM at the time of the study.

The base case credits a full quarterly flat fee to one HCCP session; further contacts enlarge it.

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