October 4, 2023

The Honorable Charles Schumer
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

Honorable Ron Wyden
Chair
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Leader Schumer, Leader McConnell, Chairman Wyden and Ranking Member Crapo:

On behalf of the undersigned 47 organizations, representing over 1.2 million physician and non-physician providers and the patients they serve, **we are writing to urge Congress to halt the implementation of Healthcare Common Procedure Coding Systems add-on code G2211**, set forth by the Centers for Medicare & Medicaid Services (CMS) in the calendar year (CY) 2024 Medicare Physician Fee Schedule (MPFS) proposed rule. Absent congressional intervention, this code and the resulting Medicare payment cuts will negatively impact many medical practices and threaten patients' timely access to care.

Background

In the CY 2021 MPFS final rule, CMS finalized the implementation of two policies that *substantially increased* payments to primary care and other specialties that frequently bill office-based evaluation and management (E/M) codes. The first was a major overhaul of all outpatient/office E/M codes, which reduced documentation burdens and increased the values to account for the continuous patient care and complexity associated with these visits. The second was the introduction of the G2211 add-on code, an unnecessary, duplicative CMS-generated code also intended to capture the perceived additional complexity associated with primary care services. The G2211 add-on code was finalized despite major objections from the clinician community, the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), and the Medicare Payment Advisory Commission (MedPAC).[1]

[1] In its comment letter on the CY 2020 MPFS proposed rule, MedPAC noted that it did "not support the creation of a new add-on code" because the code was no longer necessary since the agency decided to maintain Level 2-5 E/M codes. MedPAC stated in the letter that because clinicians can use different levels of E/M codes to indicate whether an office/outpatient visit took more time or required more complex medical decision making, "there no longer needs to be an add-on code to account for the additional resources required for more complex visits." Similarly, the RUC — representing all clinical specialties, including primary care, surgeons and other specialists — echoed the MedPAC concerns.

As a result of these code changes, MPFS expenditures were estimated to increase by over $11 billion,[2] requiring CMS to reduce the CY 2021 conversion factor (CF) to comply with Medicare's budget neutrality requirements. While primary care and other office-based specialties were slated to realize significant payment increases resulting from these code changes (irrespective of the reductions to the CF), many specialties — including those physician and non-physician clinicians who rarely, if ever, bill E/M — were slated for steep payment cuts if the G2211 code was implemented. Furthermore, even without the G2211 code, primary care and office-based specialties received payment increases related to concurrent changes in CPT coding rules, while the others continued to face cuts.[3]

Recognizing that cuts of this magnitude were unsustainable and could jeopardize patient access to care, in the *Consolidated Appropriations Act, 2021 (CAA)*, Congress provided funds to mitigate these cuts, increasing the 2021 MPFS CF by 3.75%. Congress also postponed the implementation of G2211 until at least 2024.[4]

Current Status

The three-year Congressional moratorium on G2211 expires at the end of this year, and CMS is again proposing to move forward with its implementation. In the CY 2024 MPFS proposed rule, CMS estimates that G2211 is responsible for roughly 90% of the proposed budget neutrality reduction to the CF for 2024. Similar to the actions taken in the CAA, Congress can prevent CMS from implementing G2211, thereby mitigating 2% of the proposed cut to the 2024 CF **at no cost to the Federal government,** which would benefit all clinicians, including primary care and other office-based clinicians.

[2] See CY 2021 PFS Final Rule Utilization Estimates for EM Add-on Code available at https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f.

[3] The following chart is based on an analysis conducted by Health Policy Alternatives in 2020 when CMS first proposed implementing this add-on code.

Specialties w/Highest Payment Increases			Specialties w/Highest Payment Decreases		
Specialty	**2021 E/M policies & proposals**	**2021 E/M policies w/out add-on code**	**Specialty**	**2021 E/M policies & proposals**	**2021 E/M policies w/out add-on code**
Endocrinology	17.6%	9.3%	Ophthalmology	-6.0%	-2.1%
Rheumatology	16.6%	6.7%	Neurosurgery	-6.5%	-2.4%
Medical oncology	15.7%	6.1%	General surgery	-6.2%	-2.7%
Family practice	14.4%	7.8%	Occupational therapist	-9.2%	-4.2%
General practice	9.7%	4.9%	Vascular surgery	-6.5%	-5.7%
Allergy/immunology	9.4%	2.0%	Thoracic surgery	-7.7%	-4.3%
Psychiatry	8.2%	4.8%	Physical therapist	-9.1%	-4.4%
Neurology	6.4%	3.3%	Cardiac surgery	-8.1%	-4.9%
Internal medicine	6.4%	3.3%	Pathology	-9.1%	-4.9%
Nephrology	5.9%	7.2%	Speech language pathology	-9.0%	-2.9%
Geriatric medicine	4.0%	2.2%	Diagnostic radiology	-10.3%	-6.9%

[4] It should be noted that delaying the G2211 code did not cost Congress any additional funds. Similarly, if the G2211 code is halted again, Congress will not need to allocate any funds to accomplish this change.

We believe G2211 remains duplicative of work already accounted for by existing codes, which have been updated and, if implemented, will inappropriately result in overpayments to those using it. The code is poorly defined, lacks detail regarding appropriate use, and is not resource-based. Furthermore, additional code sets, such as the chronic care management codes, have been implemented and provide payment for primary care work that was previously unrecognized.[5] At the same time, implementing G2211 will penalize clinicians who cannot, or do not, use it with yet another budget-neutrality-related reduction to the CF.

These year-over-year reductions to the CF caused by the application of budget neutrality continues to demonstrate that the Medicare physician payment system is broken. We reiterate our commitment to work with you on permanent reform, including modifications to Medicare's budget neutrality policy, the addition of an inflationary update to the MPFS and improvements in the Quality Payment Program.

However, in the short term, **we ask that you permanently halt the implementation of G2211** because it is significantly flawed and would give our clinicians the fiscal stability needed to ensure Medicare beneficiaries have access to a broad continuum of care in their communities.

Thank you for considering our views and request.

Sincerely,

Academy of Nutrition and Dietetics
Academy of Orthopaedic Physical Therapy
Alliance for Physical Therapy Quality and Innovation
Ambulatory Surgery Center Association
American Academy of Dermatology Association
American Academy of Ophthalmology
American Association of Hip & Knee Surgeons
American Association of Neurological Surgeons
American Association of Nurse Anesthesiology
American Association of Oral and Maxillofacial Surgeons
American Association of Orthopaedic Surgeons
American Chiropractic Association
American College of Emergency Physicians
American College of Mohs Surgery
American College of Obstetricians and Gynecologists
American College of Radiation Oncology
American College of Radiology
American College of Surgeons
American Health Care Association
American Occupational Therapy Association
American Optometric Association
American Physical Therapy Association

[5] The AMA RUC and MedPAC reiterated their opposition to G2211 in their CY 2024 MPFS Proposed Rule comment letters.

American Podiatric Medical Association
American Society for Dermatologic Surgery Association
American Society for Radiation Oncology
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Hand Therapists
American Society of Neuroradiology
American Society of Plastic Surgeons
American Speech-Language-Hearing Association
American Urogynecologic Society
American Vein & Lymphatic Society
APTA Private Practice, a section of the American Physical Therapy Association
CardioVascular Coalition
College of American Pathologists
Congress of Neurological Surgeons
Dialysis Vascular Access Coalition
Emergency Department Practice Management Association
National Association of Rehabilitation Providers and Agencies
Outpatient Endovascular and Interventional Society
Society for Vascular Surgery
Society of Interventional Radiology
Society of NeuroInterventional Surgery
The Society for Cardiovascular Angiography and Interventions
The Society of Thoracic Surgeons
United Specialists for Patient Access