

July 26, 2023

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1784-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure:

On behalf of the undersigned 19 surgical organizations, we write to strongly oppose the implementation of Healthcare Common Procedure Coding Systems (HCPCS) add-on code G2211 as set forth in the Centers for Medicare & Medicaid Services' (CMS or the Agency) calendar year (CY) 2024 Medicare Physician Fee Schedule (PFS) proposed rule. Our groups have expressed our opposition for years because this code will harm surgeons and, in turn, surgical patients. A summary of our views is as follows:

- There is no longer a valid justification for G2211 because under the new office or outpatient evaluation and management (E/M) coding structure, physicians and qualified healthcare professionals (QHPs) have the flexibility to bill a higher-level E/M code to account for increased medical decision-making *or* total time of the encounter.
- Numerous reportable and resource-based validated codes are available for documenting work and time across various complexity levels and continuing care, making G2211 duplicative of work already represented by existing codes.
- If implemented, this code will inappropriately result in overpayments to those using it while at the same time penalizing all physicians due to a reduction in the Medicare conversion factor that will be required to maintain budget neutrality under the PFS.
- Implementing G2211 is expected to introduce disruptions to the resource-based relative value units (RVUs) of E/M services under the PFS.

RULEMAKING AND PUBLIC LAW HISTORY OF G2211

CY 2019 Medicare PFS Proposed Rule

In 2018, CMS proposed to change the documentation requirements for office/outpatient E/M codes such that practitioners would have the choice to use either the 1995 E/M documentation

guidelines, the 1997 E/M documentation guidelines, time, or medical decision making (MDM) as described by the 2019 Current Procedural Terminology (CPT®) code set to determine the E/M code level to report. In addition, providers would only need to meet documentation requirements associated with a level 2 visit for history, exam, and/or MDM (except when using time to document the service).

CMS Proposes a Single Payment for Office Visits

In alignment with these proposed documentation changes, CMS also proposed to develop a single payment rate for office/outpatient E/M visit levels 2 through 5 for new patients (CPT codes 99202-99205) and a single payment rate for office/outpatient E/M visit levels 2 through 5 for established patients (CPT codes 99212-99215). Instead of creating a new HCPCS G-code related to the two new single payments, CMS proposed to maintain the 2019 CPT office/outpatient E/M code set and assign the same payment rate for each of the codes that were being collapsed into a single payment—specifically, a single payment for all codes 99202-99205 and a single payment for all codes 99212-99215, no matter what code was reported or how the code was documented. CMS stated that these single payment rates would eliminate the increasingly outdated distinction between the kinds of visits reflected in the 2019 CPT E/M code levels in both the coding and the associated documentation rules.

To set the single payment for each family of office/outpatient E/M codes, CMS used a weighted Medicare frequency calculation for both RVUs and time. This resulted in work RVUs that were slightly higher than the CY 2019 level 3 office/outpatient E/M visit for each family of codes, as shown in the tables below.

Preliminary Comparison of Work RVUs for Office Visits: New Patients		
CPT Code	CY 2019 Non-Facility Work RVUs	CY 2021 Proposed Non-Facility Work RVUs
99201	0.48	0.48
99202	0.93	1.90
99203	1.43	
99204	2.43	
99205	3.17	

Preliminary Comparison of Work RVUs for Office Visits: Established Patients		
CPT Code	CY 2019 Non-Facility Work RVUs	CY 2021 Proposed Non-Facility Work RVUs
99211	0.18	0.18
99212	0.48	1.22
99213	0.97	
99214	1.50	
99215	2.11	

In addition to these proposals, CMS stated that the typical office/outpatient E/M visits, as described in the 2019 CPT code set, did not appropriately reflect different resource costs associated with primary care E/M visits for continuous patient care, nor did they reflect the resource costs associated with certain types of specialist E/M visits, including those with inherent visit complexity. CMS indicated that rather than maintaining distinctions in services and payments based on the 2019 E/M visit code descriptors, the Agency could better capture differential resource costs and minimize reporting and documentation burden with single payment rates and several corollary payment policies and rate-setting adjustments.

Two Add-on Codes Proposed to Ensure All Specialties Held Harmless from Cuts

In proposing a single payment rate for all levels 2 through 5 of office/outpatient E/M codes, CMS noted that the distribution of reported levels was not uniform across all providers and would result in payment cuts to a subset of providers—an unintended consequence of this proposal. To remedy this payment differential, CMS proposed two HCPCS add-on codes for certain providers in order to recognize the additional relative resources and inherent visit complexity typical of higher-level visits. These visits require additional work beyond that which is accounted for in the proposed single payment rates, which were only slightly greater than a level 3 visit. Most importantly, CMS stated that it believed that primary care and some specialist services frequently involve substantial non-face-to-face work. The Agency also believed no codes were available in the 2019 CPT E/M code set or the single payment rate to account for the extra non-face-to-face time.

CMS proposed HCPCS code GPC1X¹ to be billed with the office/outpatient E/M codes for the purposes of adjusting payment to account for additional costs incurred in the provision of E/M services beyond the typical resources involved, including non-face-to-face work and to account for additional resource costs above the proposed single payment rate for the levels 2 through 5 visits. In tandem with establishing GPC1X, CMS also proposed HCPCS code GCG0X² to be reported by specialty providers for whom E/M visit codes make up a large percentage of their overall allowed charges and whose treatment approaches CMS believed were generally reported using the level 4 and level 5 E/M visit codes rather than procedural coding. CMS thought these two proposed add-on codes would help mitigate potential payment instability resulting from a single payment rate for office/outpatient E/M code levels 2 through 5 for providers who typically report level 4 and 5 E/M visit codes based on Medicare billing patterns. As shown below, the

¹ **GPC1X** *Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an evaluation and management visit)*

² **GCG0X** *Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit)*

proposed work RVUs for each new code were based on budget neutrality considerations in concert with the single payment rate for levels 2 through 5 office/outpatient E/M codes.

Preliminary Comparison of Work RVUs for Office Visit Add-On Codes		
CPT Code	CY 2019 Non-Facility Work RVUs	CY 2021 Non-Facility Work RVUs
GPC1X	0.00	0.07
GCG0X	0.00	0.25

CY 2019 Medicare PFS Final Rule

After consideration of the comments received on the proposed payment changes, CMS finalized for CY 2021 a revised single payment rate for office/outpatient E/M visits from one payment for levels 2 through 5 to one payment for levels 2 through 4. CMS also finalized for CY 2021 the two slightly revised add-on HCPCS codes GPC1X³ and GCG0X,⁴ along with a revised policy that these add-on codes may only be reported with levels 2 through 4 office/outpatient E/M visit codes. CMS repeated statements that the 2019 office/outpatient E/M codes did not allow for the additional resource complexities for providers who would typically report higher level codes and that the add-on codes would mitigate the consequences of a single payment rate. A comparison of the 2019 work RVUs and the finalized 2021 work RVUs is shown below.

Comparison of 2019 and 2021 Work RVUs for Office Visits: New Patients		
CPT Code	CY 2019 Non-Facility Work RVUs	CY 2021 Non-Facility Work RVUs
99201	0.48	0.48
99202	0.93	1.76
99203	1.42	
99204	2.43	
99205	3.17	3.17
GPC1X	0.00	0.25
GCG0X	0.00	0.25

³ **GPC1X** Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)

⁴ **GCG0X** Visit complexity inherent to evaluation and management associated with nonprocedural specialty care including endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonology. (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)

Comparison of 2019 and 2021 Work RVUs for Office Visits: Established Patients		
CPT Code	CY 2019 Non-Facility Work RVUs	CY 2021 Non-Facility Work RVUs
99211	0.18	0.18
99212	0.48	1.18
99213	0.97	
99214	1.50	
99215	2.11	
GPC1X	0.00	0.25
GCG0X	0.00	0.25

CY 2020 Medicare PFS Final Rule

In response to extensive changes to the office/outpatient E/M CPT code descriptors and reporting guidelines, CMS rescinded its policy to establish a single blended payment rate for levels 2 through 4 office/outpatient E/M visits in CY 2021 and instead retained the 5 levels of office/outpatient E/M codes (albeit 4 levels for new patients). CMS also finalized a new coding structure that: (1) requires a physical exam and history only when medically necessary and (2) allows code level selection using either MDM or total face-to-face and non-face-to-face time of both the physician and/or other QHP on the day of the encounter. In addition, the value of the revised CPT codes would include work performed three days prior to and seven days after the date of the encounter to allow for different practice patterns related to non-face-to-face work.

CMS Doubles Down on Unnecessary Add-on Codes

Although the revised office/outpatient E/M codes retained multiple code levels (with separate values) and could be reported using MDM that reflected different levels of patient complexity or total face-to-face and non-face-to-face time by both physicians and QHPs, CMS still asserted that the code set did not appropriately reflect differences in resource costs between certain types of office visits and therefore maintained that an add-on code was needed to describe work associated with visits that are part of ongoing comprehensive primary care and/or visits that are part of ongoing care related to a patient’s single serious or complex chronic condition. CMS finalized for CY 2021 deletion of code GCG0X and a revised code descriptor for code GPC1X.⁵ While the revised descriptor removed references to specialty type that had existed in the previous iterations of the code, as part of the CY 2020 Medicare PFS final rule’s regulatory impact discussion, CMS communicated that it continued to base utilization assumptions on the

⁵ **GPC1X** *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/ outpatient evaluation and management visit, new or established)*

specialties that it had previously listed as part of the code descriptor when the code was designed to address the payment cuts that would have resulted from collapsing the code levels. CMS stated:

[W]e assumed that the following specialties would bill HCPCS code GPC1X with 100 percent of their office/outpatient E/M visit codes: family practice, general practice, internal medicine, pediatrics, geriatrics, nurse practitioner, physician assistant, endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonary disease. We want to underscore that this was an assumption regarding which specialties are likely to furnish the types of medical care services that serve as the continuing focal point for all needed health care services or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition and is not meant to be prescriptive as to which specialties may bill for this service. As stated earlier, there are no specialty restrictions for billing HCPCS code GPC1X.⁶

Overview of Policies Finalized in CY 2020 for CY 2021 for Office/Outpatient Visits

CMS finalized the new office/outpatient E/M codes 99202-99215 and American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC)-recommended work RVUs, along with adopting (generally) the new CPT prefatory language and interpretive guidance framework.

CMS disagreed with the new add-on CPT code 99417⁷ for prolonged office/outpatient visits and instead finalized HCPCS add-on code G2212⁸ which varied from 99417 in defining the *minimal* time that must be met before reporting additional time for a prolonged visit rather than the *maximum* time. HCPCS add-on code G2212 allows reporting additional time only above the highest level office/outpatient E/M codes (when code selection is based on time instead of MDM).

⁶ 84 Fed. Reg. 63157 (November 15, 2019).

⁷ **99417** Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)

⁸ **G2212** Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)

CMS finalized separate payment for HCPCS add-on code G2211 (previously referred to as GPC1X) for additional payment for visit complexity inherent to an office/outpatient E/M associated with care management services that serve as the continuing focal point for all needed services and/or with services that are part of ongoing care related to a patient's single, serious condition, or a complex condition.

Medical Groups Oppose Add-on Code as Unnecessary

Despite much opposition to G2211 by multiple specialty societies and the AMA, CMS continued to assert that G2211 was needed because the typical office/outpatient visit described by (1) the revised and revalued office/outpatient E/M code set, (2) the new prolonged services add-on code G2212, and (3) the family of principle care/chronic care/complex care management services still did not adequately describe or reflect the resources associated with primary care and certain types of other specialty visits. At this point, in the regulatory text included in the *Federal Register*, CMS removed references to the specialties that had been listed in previous iterations of the add-on code. However, CMS provided a Public Use File with its utilization assumptions for G2211, listing the specialties that were impacted due to the *original* code level collapse proposal, which continued to serve as the basis of CMS' utilization assumptions.⁹

Public Law Moratorium on Payment of G2211

Following the publication of the CY 2020 Medicare PFS final rule, Congress took note of the significant payment cuts resulting from this new coding scheme for many medical specialties. For surgical specialties, this cut was approximately 3 percent. Concerned about the problematic impact of this policy, Congress included the following language in Section 113 of the *Consolidated Appropriations Act, 2021*:

The Secretary of Health and Human Services may not, prior to January 1, 2024, make payment under the fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) for services described by Healthcare Common Procedure Coding System (HCPCS) code G2211 (or any successor or substantially similar code), as described in section II.F. of the final rule filed by the Secretary with the Office of the Federal Register for public inspection on December 2, 2020...¹⁰

CY 2023 Medicare PFS Final Rule

CMS noted that HCPCS add-on code G2211 was finalized for CY 2021 Medicare PFS as a corollary to payment for the revised office/outpatient E/M code set. However, Section 113 of the

⁹ Centers for Medicare & Medicaid Services. CY 2020 PFS Final Rule Utilization Estimates for EM Add-on Code. 2020. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2020-PFS-FR-EM-Add-on-Code.zip>.

¹⁰ Consolidated Appropriations Act, 1 U.S.C. § 113 (2021).

Consolidated Appropriations Act, 2021 delayed Medicare payment for G2211 until “at least” January 1, 2024. CMS adopted the RUC-recommended values for other non-office/outpatient E/M visits beginning in CY 2023. However, the Agency still does not believe that the current visit payment structure among and between care settings fully accounts for the complexity of certain kinds of visits, especially for those in the office setting, nor do they fully reflect appropriate relative values since separate payment is not yet made for G2211. No other references to G2211 were made in this final rule.

CY 2024 Medicare PFS Proposed Rule

CMS proposes implementing HCPCS add-on code G2211 for separate payment for office/outpatient E/M visits starting January 1, 2024. CMS reiterated that, to the extent that the Agency adopted the RUC-recommended values for E/M visits beginning in CY 2023, CMS does not believe that the RUC-recommended relative values for E/M visits fully reflected appropriate relative values given that separate payment was not yet made for G2211. CMS refined the G2211 policy in two ways: (1) CMS proposes that G2211 will not be payable when the office/outpatient E/M visit is reported with payment modifier-25; and (2) CMS revised its utilization assumption of G2211 to be billed with 38 percent of all office/outpatient E/M visits initially, and billed with 54 percent of all office/outpatient E/M visits when fully adopted after several years. CMS states that approximately 90 percent of the budget neutrality adjustment in the CY 2024 Medicare PFS proposed rule is attributable to the implementation of G2211, with all other proposed valuation changes making up the other 10 percent.

CMS SHOULD NOT IMPLEMENT G2211 BECAUSE IT IS UNJUSTIFIED, DUPLICATIVE, AND NOT RESOURCE-BASED

G2211 is No Longer Justified

We maintain our opposition to the implementation of G2211 and emphasize that there is no longer a valid justification for its existence. The original rationale for the add-on code was based on CMS’ policy for a single payment rate for office/outpatient E/M visit levels 2 through 5, which has since been rescinded. CMS argued that primary care and certain specialty services often involve significant non-face-to-face work, and there were no coding options in the 2019 CPT E/M code set or the single payment rate to account for this additional non-face-to-face time and work—this is no longer true. Additionally, CMS believed that the proposed G2211 add-on code would address potential payment instability resulting from the adoption of a single payment rate for office/outpatient E/M code levels 2 through 5 — particularly for providers who typically billed level 4 or level 5 E/M visit codes based on Medicare billing patterns. This is also no longer true because there is no payment instability with the new E/M visit code set.

The current code set no longer supports the justification for G2211, as CMS has retained the various office/outpatient E/M levels and accepted the revised coding structure that incorporates both face-to-face and non-face-to-face work and time of physicians and/or QHPs. This revised

structure now includes work and time for three days prior to and seven days after the encounter date. **Consequently, payment for HCPCS code G2211 is not justified because under the new coding structure, physicians and QHPs have the flexibility to bill a higher-level E/M code to account for increased patient complexity or a higher-level code based on total time, which includes non-face-to-face time, even if the encounter itself was not complex.**

G2211 is Duplicative of Separately Reportable Work and Results in “Double-Dipping”

CMS maintains that the payment for add-on code G2211 is necessary because the Agency believes the revised office/outpatient E/M visit code set fails to adequately describe or encompass the resources involved in primary care and certain specialty visits for ongoing care management of patients with chronic conditions. However, CMS has not provided details regarding the specific resources required. For instance, it remains unclear what additional resources beyond the already accounted 10 days of time and work are typically involved and not covered by the revised office/outpatient E/M codes, other non-face-to-face care management codes, and/or other new digital medicine codes. **Any additional resources, if required, are already reportable using other newly developed codes for ongoing care as an added payment to a single office visit, making payment for G2211 duplicative.** Examples of some of these codes are described below.

- ***Principal Care Management (PCM)***. In the CY 2022 Medicare PFS, CMS accepted new CPT codes for PCM services, which describe ongoing care management services for one single chronic condition. CMS stated that — especially for specialties that use office/outpatient E/Ms to report most of their services — there could be significant resources involved in ongoing care management for a single high-risk disease or complex condition that is not well accounted for in existing coding.
- ***Chronic Care Management (CCM)***. In the CY 2022 Medicare PFS, CMS also accepted new CPT codes for CCM, which describe ongoing care management services for two or more chronic conditions. CMS stated that physicians and nonphysician practitioners who furnish ongoing care to patients with multiple chronic conditions require greater resources than those needed to support patient care in a typical E/M service.
- ***Complex Care Management (Complex CCM)***. These codes were added in the CY 2017 Medicare PFS and are similar to the CCM codes but are also separately reportable for ongoing non-face-to-face patient care.
- ***Transitional Care Management (TCM)***. The TCM codes were added in the CY 2012 Medicare PFS and provide additional reimbursement for care management and care coordination services beginning when a physician discharges a Medicare patient from an inpatient stay and continuing for the next 29 days.

- ***Prolonged Services Code.*** In the CY 2020 Medicare PFS, CMS added a new HCPCS add-on code for 15 minutes of prolonged office/outpatient E/M services that require additional time beyond the maximum time for the highest-level codes. The AMA's CPT/RUC Workgroup on E/M specifically included this add-on code to account for more time and resources in response to the earlier CMS proposals.
- ***Remote Physiologic Monitoring.*** CMS accepted new CPT codes in CYs 2019 and 2020 to account and pay for additional provider non-face-to-face time and practice expense resources related to ongoing patient care management of a chronic condition.
- ***Remote Therapeutic Monitoring (RTM).*** In the CY 2022 Medicare PFS, CMS finalized the RTM codes for managing patients who use medical devices to collect non-physiological data such as medication adherence, medication response, and pain levels.

It is important to reemphasize that numerous reportable and resource-based validated codes are available for documenting work and time across various complexity levels and continuing care, making the arbitrary, poorly-defined add-on code G2211 duplicative of work already represented by existing codes. If implemented, this code will inappropriately result in overpayments to those using it while at the same time penalizing all physicians with the reduced conversion factor required to maintain budget neutrality.

G2211 is Not Resource-Based

CMS has faced challenges in providing a clear and validated description of the additional resources associated with G2211. The assignment of work RVUs and time to the code was confusing and primarily driven by considerations of budget neutrality and the mitigation of potential payment instability for particular physicians resulting from adopting a single payment rate for office/outpatient E/M visit levels 2 through 5. In other words, the resources allocated to G2211 were primarily based on redistributing available work RVUs due to changes in documentation and payment policies rather than being firmly grounded in resource-based criteria. **Given that the proposal to collapse E/M visit levels 2 through 5 into a single payment was rescinded and the new office/outpatient E/M structure based on MDM (complexity) or time was accepted, it can no longer be asserted that code G2211 describes any additional and unaccounted for resources.**

That said, if the resources that CMS may be contemplating were for extraordinary circumstances, the chronic/complex care management codes for longitudinal patient-centered care would be appropriate instead of G2211. At the other extreme, it is difficult to justify adding G2211 to a level 2 E/M visit involving a patient with a self-limited or minor problem, minimal or no need for data to be reviewed, and/or minimal risk of morbidity because this visit would not require additional resources to integrate the treatment/management of the illness or injury or to

coordinate specialty care in a longitudinal care model. The other visits in between the complex and minor cases would be covered by the current office/outpatient E/M coding structure or other newly available codes and not require add-on code G2211. This argument is even more compelling when code level selection is based on time because if additional time is needed, a higher-level code could be reported even if the visit was not complex. Furthermore, there is no limit when reporting using time because the prolonged services add-on code G2212 (or CPT code 99417) may be billed for each additional 15 minutes required. **Therefore, time can never be considered a resource cost for G2211.**

CONSEQUENCES OF IMPLEMENTING G2211

There are significant consequences for physician practices if G2211 is implemented. For example:

- **Implementing G2211 is expected to result in payment reductions for many physicians due to its expected impact on the Medicare conversion factor.** In the CY 2024 Medicare PFS proposed rule, CMS somewhat mitigated the cut's impact on the conversion factor by estimating lower utilization assumptions for implementing G2211. However, CMS also states in the rule that approximately 90 percent of the budget neutrality adjustment for CY 2024 is attributable to G2211, with all other proposed valuation changes making up the other 10 percent.¹¹ This reduction would still create concerning implications for physician practices and their ability to provide patient care services, especially in today's high inflationary period. This could particularly affect physicians, including primary care physicians, practicing in rural and underserved areas who perform minor procedures and other services, such as imaging, that will see reductions in reimbursement to pay for G2211.
- **Implementing G2211 is also expected to introduce disruptions to the resource-based RVUs of E/M services.** Implementing G2211 would lead to varying payments for E/M services based on the specialty of the provider delivering the service, as CMS has made assumptions regarding which providers will likely report this non-resource-based code at the expected billing rate. Consequently, CMS would establish a payment policy that rewards certain providers with higher compensation for the same level of work, creating an unfunded bonus without a specific validated resource that can be clearly defined or audited. In contrast, every code within the Medicare PFS has a well-defined and validated work definition, allowing for audit. Unfortunately, code G2211 fails to meet these criteria, and approving payment for this code would disrupt the relative resource-based RVUs of E/M services and the integrity of the entire Medicare PFS. Per Medicare statute,

¹¹ Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs: CY 2024 Physician Fee Schedule Proposed Rule. July 13, 2023. <https://www.federalregister.gov/public-inspection/2023-14624/medicare-and-medicare-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other>.

CMS is prohibited from paying physicians differently for the same work, and the “Secretary may not vary the . . . number of relative value units for a physician’s service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.”¹²

Given these serious problems, we strongly urge CMS not to implement G2211. The policy basis for this code no longer exists. It is disingenuous for CMS to continue to put forth unconvincing rationales in its rulemaking over the years to account for why G2211 — a code that is not resource-based, is not validated, and is duplicative of other services — should be implemented. G2211 was a stop-gap measure to make certain specialties whole when first proposed in 2018. It is no longer justified given the many other codes that have been revised and/or newly established that provide additional validated resource-based reimbursement for ongoing patient care. Finally, the consequences of implementing this code are grim — many physician practices would be harmed, thereby serving as a potential detriment to their ability to deliver timely, affordable, high-quality care to their patients.

Thank you for considering our recommendations. We would be pleased to discuss this matter further. In the meantime, if you have any questions or need additional information, please contact Vinita Mujumdar at vmujumdar@facs.org.

Sincerely,

American College of Surgeons
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Obstetricians and Gynecologists
American Orthopaedic Foot & Ankle Society
American Society of Metabolic and Bariatric Surgery
American Society for Surgery of the Hand Professional Organization
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Society of Colon & Rectal Surgeons
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urogynecologic Society
American Urological Association
Congress of Neurological Surgeons
Society for Vascular Surgery
The Society of Thoracic Surgeons

¹² Medicare Physician Fee Schedule, 42 U.S. Code §1395w-4(c)(6) (2022).