

October 4, 2023

The Honorable Jason Smith  
Chair, Ways and Means  
United States House of Representatives  
Washington, DC 20515

The Honorable Cathy McMorris Rogers  
Chair, Energy and Commerce  
United States House of Representatives  
Washington, DC 20515

The Honorable Richard Neal  
Ranking Member, Ways and Means  
United States House of Representatives  
Washington, DC 20515

The Honorable Frank Pallone  
Ranking Member, Energy and Commerce  
United States House of Representatives  
Washington, DC 20515

Dear Congressman Smith, Congresswoman McMorris Rogers, Congressman Neal and Congressman Pallone:

On behalf of the undersigned 46 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).<sup>1</sup>

---

<sup>1</sup> 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,<sup>2</sup> 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.<sup>3</sup>

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.<sup>4</sup>

### **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.

<sup>2</sup> See CY 2021 PFS Final Rule Utilization Estimates for EM Add-on Code available at <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1734-f>.

<sup>3</sup> 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%

<sup>4</sup> 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.<sup>5</sup> 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 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  
American Podiatric Medical Association

---

<sup>5</sup> The [AMA RUC](#) and [MedPAC](#) reiterated their opposition to G2211 in their CY 2024 MPFS Proposed Rule comment letters.

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

CC: House Leadership