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September 7, 2023

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1784-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically via www.regulations.gov

Subject: CMS-1784-P 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 American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons in the United States, we appreciate the opportunity to comment on the payment and quality provisions of the above-referenced notice of proposed rulemaking.

EXECUTIVE SUMMARY

CODING AND REIMBURSEMENT ISSUES

Conversion Factor

The AANS and the CNS are deeply concerned about the overall decrease in the Calendar Year (CY) 2024 conversion factor. CMS proposes a nearly 3.5% reduction in the 2024 conversion factor (CF) for all physicians. The estimated 2024 conversion factor will be \$32.7476, down \$1.1396 compared to 2023. These cuts stem from the budget neutrality adjustment related to the new G2211 office visit add-on code for complex services and a reduction in the temporary increase to CF provided by Congress in the omnibus spending bill. Unfortunately, these cuts come as practice costs continue to rise. CMS projects the increase in the Medicare Economic Index (MEI) for 2024 will be 4.5%. We urge CMS to take all possible actions to provide a positive update to the Medicare conversion factor in 2024, including halting the G2211 code, which is duplicative and unnecessary in light of revisions to the E/M coding system.

Global Surgical Codes

The AANS and the CNS urge CMS to immediately increase the 10- and 90-day global codes to reflect the proportionate increase in value for evaluation and management (E/M) codes to maintain the relativity of the fee schedule and comply with the Medicare statute prohibiting specialty payment differentials.

Medicare Economic Index

The AANS and the CNS are pleased that CMS plans to delay any change in the Medicare Economic Index (MEI) until the American Medical Association's (AMA) Physician Practice Information (PPI) Survey cost data collection work is completed and thoroughly reviewed.

Evaluation and Management Codes

- **“Add-on” Code for Complex Patients.** As noted above, CMS proposes implementing a separate add-on code and payment for enhanced visit complexity, G2211. The AANS and the CNS oppose the implementation of this code, as it is unnecessary and inappropriate. CMS should permanently halt the implementation of the G2211 code. At the very least, rather than making any utilization assumptions — which are speculative at best — CMS should track G2211 code utilization before making additional cuts to the CF.
- **Split/Shared Visits.** The proposed rule defines split (or shared) E/M visits as visits provided in a facility setting by a physician and a nonphysician provider in the same group and delays for one year, the requirement that the practitioner who provides the substantive portion of the visit would bill for the visit. The AANS and the CNS are pleased with the continued delay in implementation and urge CMS to rescind the proposal permanently.

Practice Expense (PE) Relative Value Units (RVUs)

The AANS and the CNS support the AMA PPI Survey and are pleased that CMS has agreed to delay changes in the MEI until the survey is complete and results can be analyzed.

CMS Valuation of Specific Codes

- **CMS Acceptance of RUC-Recommended Values.** The AANS and the CNS appreciate the agency's acceptance of 91% of RUC-passed values, which are based on valid, clinically relevant information that preserves relativity. We believe the RUC is the entity best positioned to provide recommendations to CMS on resource inputs for work, PE and professional liability valuations and to establish values for E/M and other physicians' services.
- **Total Disc Arthroplasty (TDA) codes.** The AANS and the CNS urge CMS to accept the RUC-recommended values for the Total Disc Arthroplasty (TDA) CPT code 22860.
- **Potentially Misvalued Procedure.** The AANS and the CNS urge CMS not to price sacroiliac joint arthrodesis procedure CPT code 27279 in the non-facility/office setting.

Telehealth

- **Deep Brain Stimulation (CPT codes 95970, 95983, 95984).** The AANS and the CNS disagree with the CMS proposal to limit these codes to the Medicare Telehealth Services List with a planned expiration at the end of CY 2024. Given safeguards in the devices, we believe these procedures should be added to the telehealth list permanently to allow them to be performed remotely.

QUALITY ISSUES

Quality Payment Program (QPP)

- Overall, the AANS and CNS believe that the Quality Payment Program (QPP), in its current form, fails to adequately measure clinical quality for specialists, such as neurosurgeons. We refer CMS to

the comment letters submitted by the Alliance of Specialty Medicine and the Physician Clinical Registry Coalition (PCRC), which reflect our views on various issues related to the QPP.

- **Merit-Based Incentive Payment System (MIPS) Value Pathways (MVP).** Although we do not believe that MVPs adequately address the numerous problems plaguing MIPS, our members find it increasingly challenging to participate in traditional MIPS, where many cannot even identify six relevant measures that will not put them at risk for a penalty due to scoring caps. While we ideally would like to see CMS adopt the MVP framework's reduced reporting requirements across all of MIPS, in the absence of such a policy, we request that CMS expand opportunities for specialists, like neurosurgeons, to have the option to participate through an MVP if appropriate for their practice.
- **MIPS Quality Measures.** We urge CMS to preserve quality measure #128: Body Mass Index (BMI) Screening as a standalone measure rather than incorporating it into a primary care-focused composite measure so it is still available to specialists such as neurosurgeons.
- **Cost Measures.** The AANS and CNS have ongoing concerns about the Low Back Pain episode-based cost measure. We urge CMS to remove neurosurgeons and orthopedic surgeons from the list of eligible specialties for attribution to the measure, which is intended to evaluate non-operative, chronic care. We also urge CMS to work more closely with specialties to incorporate clinical quality data from registries into its analyses of physician cost.
- **Promoting Interoperability.** The AANS and CNS oppose CMS' proposal to increase the minimum Promoting Interoperability performance period from 90 to 180 days. We also oppose the agency's proposal to require a "yes" response for the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) measure to comply with the Promoting Interoperability category due to the administrative burden of complying with this measure.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Program

The AANS and CNS strongly support CMS applying a hard pause to the AUC program and rescinding the current program regulations.

DETAILED COMMENTS

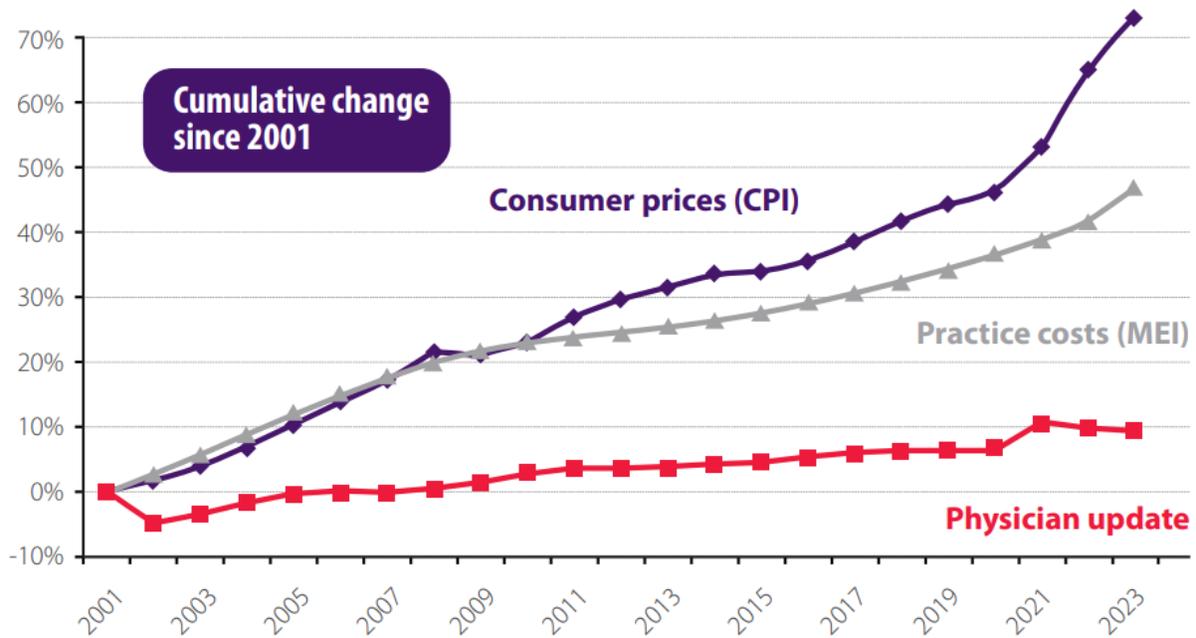
CODING AND REIMBURSEMENT ISSUES

Conversion Factor

The CY 2024 Medicare conversion factor is proposed to be reduced by 3.36 percent from \$33.8872 to \$32.7476. These cuts result from a -1.25 percent reduction in the temporary update to the conversion factor under current law and a negative budget neutrality adjustment stemming in large part from the adoption of an office visit add-on code, discussed below. Unfortunately, these cuts coincide with the ongoing growth in the cost to practice medicine as CMS projects a 4.5 percent MEI increase for 2024.

The AANS and the CNS echo the comments of the AMA, the Alliance of Specialty Medicine, the American College of Surgeons (ACS) and many other medical specialty societies expressing our deep concern regarding the overall decrease in the CY 2024 conversion factor. At a time when physicians face continued challenges from the aftermath of the COVID-19 pandemic and steep inflation, a cut in the conversion factor is particularly distressing. The cut in the conversion factor comes mainly from the budget neutrality adjustment related to the new G2211 office visit add-on code for complex services. Implementation of this code was postponed for three years in the Consolidated Appropriations Act, 2021 and a reduction in the temporary increase to CF provided by Congress in the omnibus spending bill.

Medicare physician payment cuts are unsustainable as practice costs continue to rise. The cost of running a medical practice increased 47% between 2001 and 2023, as measured by the MEI. As measured by the Consumer Price Index, economy-wide inflation is even higher, rising 73% over this period, with recent inflation at levels not seen since the 1980s. Thus, when adjusted for inflation in practice costs, Medicare physician pay declined 26% from 2001 to 2023.



With the MEI estimated at 4.5%, *any* cuts are inappropriate, but they are significantly problematic given this steep inflation in practice costs. **The AANS and the CNS urge CMS to take all possible actions to provide a positive update to the Medicare conversion factor in 2024, including permanently halting the implementation of the G2211 code. At the very least, rather than making any utilization assumptions — which are speculative at best — CMS should track G2211 code utilization before making additional cuts to the CF.**

Global Surgical Codes

The AANS and the CNS, the ACS, the AMA, the RUC and virtually all other medical specialty societies have urged CMS to apply E/M office visit increases to the visits bundled into global surgery payment. The surgical specialties participated in the RUC survey, and their data were the same as, and often greater than, primary care and other specialties. CMS has emphasized the robust survey utilized in the valuation of E/M office visits, and this survey demonstrates what the law requires: all physicians should receive the same payment for the same service. For 2024, CMS proposes updating the work RVUs and work times of maternity procedures with an “MMM” global period to reflect any relevant E/M updates associated with the MMM global period. However, CMS continues to stay silent on the issue of incorporating E/M increases into the global surgical periods.

In 2021, CMS took an unprecedented step and decided not to apply the increased values in the RVU of the E/M services to the CPT codes in the global surgical package. However, E/M services comprise up to 40% of the RVU for any particular CPT code. By not increasing the values of the E/M portion of the global surgical codes, those codes are now untethered from the valuation of the E/M services. The result is a loss of relativity within the fee schedule. For the first time since the advent of the Resource-based Relative Value Scale, CMS has unilaterally decided to pay physicians of different specialties dissimilar rates for the same work, violating the Medicare statute.

The AANS and the CNS continue to urge CMS to apply the RUC-recommended changes to the E/M component of the 10- and 90-day global surgery codes to maintain the relativity of the fee schedule and to comply with the Medicare law's prohibition on specialty payment differentials.

Medicare Economic Index

In the 2023 Medicare Physician Fee Schedule (MPFS Final Rule), CMS finalized its plan to update MEI weights for the different cost components of the MEI for CY 2023. However, CMS also noted that it postponed implementing the MEI changes until sometime in the future, noting the need for continued public comment due to the significant impact on physician payments. If the MEI weights are implemented in a budget-neutral manner, overall physician work payment would be cut by 7%, and malpractice payments would be reduced several fold. These significant shifts are due to a substantial error in the agency's analysis of the U.S. Census Bureau's Service Annual Survey, which omitted nearly 200,000 facility-based physicians. After correcting this significant omission, the physician work MEI weight would increase instead, and malpractice values would experience a much smaller reduction.

In the 2024 proposed rule, CMS announced it would postpone implementing the updated MEI weights until the AMA completes a national study on physician practice expenses. The AANS the CNS are encouraging neurosurgeons to participate in the AMA's PPI survey, which will provide more than 10,000 physician practices with the opportunity to share their practice cost data and the number of direct patient care hours provided by physicians and qualified healthcare professionals. A coalition of other nonphysician provider organizations is also working with Mathematica to administer a similar study of their professions. These surveys will be in the field through April 2024. Data would be shared with CMS in early 2025 for the 2026 MPFS rulemaking process. **We support the agency's decision not to implement MEI changes until after thoroughly analyzing the AMA PPI survey data.**

Evaluation and Management Code Issues

- **“Add-on” Code for Complex Patients.** As noted above, CMS proposes implementing a separate add-on code and payment for enhanced visit complexity of primary care and longitudinal care of complex patients. G2211 would generally apply to outpatient office visits as an additional payment, recognizing the costs clinicians may incur when longitudinally treating a patient's single, serious or complex chronic condition. CMS has lowered the estimated utilization assumption of the add-on code from 90% in its 2021 rule to 38% when initially implemented in 2024 and 54% once the code has been fully adopted.

Unfortunately, although the utilization assumption has been cut in half, the add-on code will still lead to an additional across-the-board cut to the CF due to Medicare's budget neutrality requirements. We urge CMS not to implement this code. It is unnecessary and inadvisable for the following reasons:

- There is no longer a valid justification for G2211 because, under the new office or outpatient E/M coding structure, physicians can 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 MPFS.

- Implementing G2211 will introduce disruptions to the resource-based RVUs of E/M services under the MPFS.

The AANS and the CNS joined 17 surgical specialty societies in a July 26, 2023, letter (appended herein) to CMS providing greater detail on the history of the G2211 code and the reason its use is inappropriate. **We urge the agency to permanently halt the implementation of the G2211 code. At the very least, rather than making any utilization assumptions — which are speculative at best — CMS should track G2211 code utilization before making additional cuts to the CF.**

- **Split/Shared E/M Visits.** We are pleased that CMS again plans to postpone its proposal for “Split or Shared” E/M visits provided in a facility setting by a physician and a nonphysician provider in the same group. Two years ago, CMS proposed to allow only the practitioner who provides the substantive portion by time to bill for the visit. We continue to oppose the restriction. We appreciate that the agency has delayed changes in this policy until 2025, allowing clinicians who furnish split (or shared) visits to continue to have a choice of history, physical exam, medical decision making (MDM) or time spent to define the substantive portion instead of using only total time to determine the substantive portion. In the meantime, the AMA CPT Editorial Panel has strengthened the guidance for reporting split/shared visits using MDM, and this information will be included in the 2024 CPT publication. **We hope that CMS will find this guidance helpful and urge the agency to rescind its plan to change the policy in 2025.**

Telehealth Provisions and Inflation Reduction Act Implementation

CMS proposes implementing several telehealth-related provisions of the Consolidated Appropriations Act, 2023, in effect until Dec. 31, 2024. Specifically of interest to neurosurgery, CMS proposes not to add Deep Brain Stimulation (DBS) analysis and programming CPT codes 95970, 95983 and 95984 to the list of codes with permanent telehealth status. However, CMS proposes keeping these services on the list for 2024. We disagree with the agency’s plan not to grant permanent telehealth status to these codes.

CMS proposes adding these codes to the Medicare Telehealth Services List through the end of 2024 and has asked for comments on patient safety concerns and whether the services are appropriate for inclusion beyond 2024. The AANS and the CNS disagree with the agency’s proposal not to permanently add CPT codes 95970, 95983, and 95984 to the Medicare telehealth list. CMS justifies this proposal with several unfounded reservations about these services when performed via telehealth. These CPT codes describe the electronic analysis (CPT code 95970) of implanted brain neurostimulator pulse generators/transmitters, as well as the first 15 minutes (CPT code 95983) and each additional 15 minutes (CPT code 95984) of brain neurostimulator programming. CMS expresses concern about whether the connection between the implanted device and the analysis/calibration equipment (the neurostimulator programmer) can be done remotely. However, systems have been used successfully for over a year and a half, allowing for a stable, secure 2-way telehealth connection for brain stimulator pulse generator programming. These systems route through a secure HIPAA-compliant server and allow the managing physician to remotely control all essential functions of the patient device while providing real-time audio and video for patient assessment and feedback.

Moreover, CMS is concerned about patient safety if the programming is incorrect or another problem occurs. These are valid concerns that have been addressed in the development and deployment of existing remote brain neurostimulator programming systems. These systems ensure the patient controller has a “safe” program (set of stimulation parameters). If there is an interruption in the remote connection, the device automatically reverts to this “safe” program so that the patient is not left with a potentially problematic set of programming parameters. **The AANS and the CNS believe that the successful track record of these remote programming systems is safe and reliable, thus meriting the inclusion of CPT codes 95970, 95983 and 95984 on the Medicare Telehealth Services List.**

Practice Expense RVUs

As stated above, the AANS and the CNS support the AMA’s PPI Survey and have encouraged our members to participate if contacted. The survey is underway, and we are pleased that CMS has agreed to pause using other cost data sources in the physician payment system until the AMA survey is complete. We agree that using the most current data is paramount, especially for setting the MEI.

CMS Valuation of Specific Codes

The AANS and the CNS were pleased to see that CMS has adopted a higher percentage, 91%, of RUC-recommended values than in recent years. **However, we would ask the agency to increase the work RVUs for the total disc arthroplasty CPT code 22860.**

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	6.88	7.50

In September 2021, the CPT Editorial Panel revised code 22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar* and created Category I code 22860 to describe *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)* to replace Category III code 0163T which described the same add on procedure.

The code family is very low volume and involves a -62 modifier as two surgeons — an access surgeon and a spine surgeon — act as co-surgeons to perform the initial interspace and the second interspace total disc arthroplasty, as necessary. Generally, cervical disc arthroplasty is widely used and accepted over the anterior total disc arthroplasty approach that this code family describes.

The AANS and the CNS joined other spine specialty societies to survey CPT codes 22857 and 22860 for the January 2022 RUC meeting. In reviewing the survey responses for code 22857, the specialties noted, and the RUC concurred that the collected data for the previous meeting was inaccurate. Therefore, the codes were resurveyed for the April 2022 RUC meeting with a targeted survey tool that was vetted and approved by the RUC Research Subcommittee.

- **22857.** We are pleased that CMS accepted the RUC recommended work RVU and practice expense inputs for CPT code 22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar* (work RVU = 27.13, 173 minutes intra-service time, and 537 minutes total time). **Again, we are pleased that CMS has accepted the RUC-recommended reaffirmation for CPT code 22857. We urge CMS to consider the relationship between this code and the new CPT code 22860 to maintain relativity within the code family and payment schedule.**
- **22860.** For CPT code 22860, CMS disagrees with the RUC recommended work RVU of 7.50 and proposes a work RVU of 6.88, which reflects the survey 25th percentile of surgeons with experience

who perform total disc arthroplasty. CMS suggests that the RUC recommended work RVU falls on the high end of 46 ZZZ codes with an intra-service time of 60 minutes and that a work RVU of 6.88 is more relative among those services. CMS states that a work RVU of 6.88 is still appropriately supported by RUC key reference service codes 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50, 45 minutes intra-service and 50 minutes total time) given that describes an anterior approach and 22208 *Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 9.66, 120 minutes intra-service and 135 minutes total time). CMS further states that CPT code 22226 *Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.03, 60 minutes intra-service and total time), which represents an anterior approach, and CPT code 22216 *Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)* (work RVU = 6.03, 60 minutes intra-service and total time), which represents a posterior or posterolateral approach, are both valued at 6.03 work RVUs.

We disagree with CMS's relativity comparison with the RUC key reference services. Key reference survey codes 22552 and 22208 appropriately bracket the surveyed code and demonstrate the relativity of the RVU, intra-service time, and intensity of similar surgical spine add-on codes. For example, the recommended work RVU of 7.50 for the surveyed code establishes a value slightly greater than the key reference code 22552. The top key reference service code is also an anterior approach. However, it requires less time and survey respondents indicated that the surveyed code is 91% somewhat more and 9% much more intense than the key reference service.

Further, the surveyed code has an appropriately lower work RVU than the second key reference 22208, a posterior or posterolateral approach typically performed by a single surgeon. Survey respondents indicated that the surveyed code is 33% somewhat more and 50% much more intense/complex than the second key reference service, which describes a less complex posterior approach. Given the lower intra-service time of the surveyed code, albeit with higher complexity when compared to the second key reference code, the RUC recommended work RVU of 7.50 is appropriate.

Additionally, it is important to note that exposure of the second interspace is more technically difficult than the initial interspace, given the proximity to the iliac vessels, especially if the surgeons are accessing superior lumbar vertebrate levels, which is typical for this procedure. Therefore, the intra-service time of the add-on code is almost a third of the base code, demonstrating the added complexity of the time spent exposing the second interspace, performing the discectomy and cautiously positioning the new prosthetic disc. The RUC recommended work RVU is commensurate with the work required to perform this add-on service.

Further, we disagree with the CMS comparison to CPT codes 22216 and 22226, given that they were valued over 25 years ago and did not meet the survey threshold of 30 respondents. As the total disc arthroplasty procedures have evolved, the AANS, the CNS and other spine specialty societies stated, and the RUC concurred, that the intensity and complexity of the service increases when performing spine procedures via an anterior approach. Codes 22216 and 22226 may not have accounted for this differential in work when they were valued. Both CMS comparison codes fail to recognize the intensity of a total disc arthroplasty of a second interspace compared to an osteotomy of the spine. Therefore, the recently surveyed total disc arthroplasty code, which describes an anterior approach, adequately reflects the work required to perform this procedure at the median survey percentile.

We disagree with the CMS assessment of the 46 ZZZ codes with an intra-service of 60 minutes. Based on the ample evidence from 31 surgeons that the surveyed procedure is highly intense and complex, the RUC recommended median percentile work RVU of 7.50, and related intensity falls appropriately toward the higher end of the relative services based on these factors. **Therefore, we urge CMS to accept a work RVU of 7.50 for CPT code 22860.**

Potentially Misvalued Codes—CPT Code 27279

CMS received a comment nominating CPT code 27279 (*Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device*) as misvalued. Specifically, the commenter is asking CMS to price the service in the non-facility setting in addition to the facility setting. CMS has expressed concerns about whether this 90-day surgical service can be safely and effectively furnished in the non-facility/office setting (for example, in an office-based surgical suite). **We agree with the agency's concern and urge CMS not to price CPT code 27279 in a non-facility/office setting.**

QUALITY ISSUES

Quality Payment Program

Overall, the AANS and CNS believe that the QPP in its current form fails to adequately measure clinical quality for specialists, such as neurosurgeons. We are eager to work with CMS and Congress to fundamentally reform this program so that it more meaningfully promotes higher-value care for neurosurgical patients.

We refer CMS to the comment letter submitted by the Alliance of Specialty Medicine, which reflects our feedback on numerous proposed QPP policies, including:

- MIPS Value Pathways
- The MIPS performance threshold
- Data completeness thresholds for the Quality category
- Public reporting of cost measures
- Proposed updates to the targeted review process
- Public reporting of utilization data
- Updates related to the determination of Qualifying Participants (QPs) in Advanced Alternative Payment Models (APMs)
- Proposal to rescind the Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Program

We also refer CMS to the comment letter submitted by the PCRC, which reflects our views regarding qualified clinical data registry proposals.

Below, we offer comments on some additional proposals related to MIPS.

- **MVPs.** Although we do not believe that MVPs adequately address the numerous problems plaguing MIPS, our members find it increasingly challenging to participate in traditional MIPS, where many cannot even identify six relevant measures that will not put them at risk for a penalty due to scoring caps. While we ideally would like to see CMS adopt the MVP framework's reduced reporting requirements across all of MIPS, in the absence of such a policy, we request that CMS expand opportunities for specialists, like neurosurgeons, to have the option to participate through an MVP if appropriate for their practice.

To broaden the clinical applicability of this MVP and make it more relevant to spine surgeons, we request that CMS consider adding the following other MIPS CQMs to this MVP and removing the title's reference to "rehabilitative support":

- + 039: Screening for osteoporosis
- + 126: Diabetic peripheral neuropathy - neurological evaluation
- + 134: Screening for depression and follow-up plan
- + 178: Functional status assessment for RA patients
- + 226: Tobacco screening and cessation
- + 418: Osteoporosis management in women with fracture
- + 461: Leg pain after lumbar surgery
- + 471: Functional status after lumbar surgery

- **Quality Category.** CMS proposes to adopt a Preventive Care and Wellness Composite measure, which includes seven component measures. Some of these component measures, such as #128: Body Mass Index (BMI) Screening, are currently standalone MIPS quality measures but are being proposed for removal as standalone measures and would only be available as part of the larger composite. **If CMS finalizes this composite measure, we urge the agency to preserve the BMI as a standalone measure available to specialists such as neurosurgeons.** There are currently few MIPS measures relevant to neurosurgeons, and many, particularly spine surgeons, consider it valuable for a significant portion of their patients. Our members report that the BMI measure is important as it:

- + Encourages them to take the time to talk to their patients about obesity;
- + Impacts spine health and risk of surgery;
- + Helps patients set goals for their weight and weight loss strategies, including relative contributions of nutrition versus exercise and resources for improving their diet; and
- + Provides an opportunity to encourage patients to follow up with their primary care physicians.

The agency's proposal to remove this measure suggests that these discussions are suddenly useless to specialists and their patients. BMI very much impacts spine care decision-making, and when there is a tangible consequence to obesity, such as painful spinal deterioration or being ineligible for surgery, this is a discrete and time-sensitive motivating factor for patients to address what is otherwise a nebulous, chronic issue that otherwise might have been deferred.

- **Cost Category.** CMS proposes to adopt a new Low Back Pain episode-based cost measure for 2024. Neurosurgeons participated in the Acumen Wave 4 workgroup that developed this measure. While we appreciate being included in the development process, we are concerned about this measure. Most importantly, we are worried that non-operative patients could be attributed to neurosurgeons under this chronic condition measure. This is a fundamental flaw of the measure because it judges a surgeon's performance outside their principal role.

Back pain is widespread, and more than 90% of patients do not receive surgical care, so why should this measure attribute surgeons the costs of managing non-surgical patients with back pain? Performance measures are only valid if they measure what a clinician is actually doing. Surgeons do surgery, and measuring non-surgical orders and referrals tells patients and other clinicians nothing meaningful about a surgeon. It is as arbitrary as evaluating an internal medicine physician on lumbar spine fusions. While we recognize that Acumen attempted to include subgroups and other adjustments to ensure more clinically accurate comparisons, we are still concerned that if neurosurgeon A tells the patient, "You're non-surgical, I can't do anything for you," and neurosurgeon B says "surgery isn't indicated, but let's try PT, injections, etc.," then neurosurgeon B will be penalized for being more costly while providing higher-quality care to address the patient's concerns.

Again, this is arbitrary and reduces the measure’s validity and meaning. Holding surgeons accountable for the Low Back Pain measure also fails to account for the fact that there is already a Lumbar Fusion episode-based cost measure in the program that more accurately focuses on the services provided by surgeons. **We continue to urge CMS to remove neurosurgeons and orthopedic surgeons from the list of eligible specialties for attribution to the Low Back Pain measure, intended to evaluate non-operative, chronic care.** CMS’ proposal to include the Low Back Pain cost measure in the musculoskeletal MVP, primarily geared towards primary care and rehabilitation, is further evidence that this measure is inappropriate for surgeons.

We also remind CMS that since the initiation of this project, there has been no progress made on linking episode-based cost measures to quality or looking beyond claims data when evaluating a clinician’s overall value. If quality is not directly factored into the value equation, then these cost measures could have the unintended consequence of disincentivizing appropriate care that is evidence-based and that accounts for patient preferences. **We strongly urge Acumen to work with CMS and clinician stakeholders to build algorithms and/or incorporate clinical data sources, such as registry data, and to develop methodologies that allow CMS to understand the bigger picture and account for the appropriateness and quality of care when evaluating cost.**

CMS examined the reliability of the five proposed episode-based measures in this rule and presented the percentage of tax identification numbers (TINs) and TIN/National Provider Identifiers that meet the 0.4 reliability threshold at the proposed case minimum of 20 for each measure. These findings are summarized in the table below. **The AANS and CNS are concerned that fewer than 100% of eligible clinicians and groups met CMS’ reliability threshold of 0.4 under the Low Back Pain measure. If CMS continues to rely on such a low reliability standard, it should at least require that all eligible clinicians and groups meet it before a measure is ready for implementation.**

TABLE 44: Percent of TINs and TIN/NPIs that Meet 0.4 Reliability Threshold and TIN and TIN/NPI Mean Reliability

Measure name (case minimum)	% TINs meeting 0.4 reliability threshold	Mean reliability for TINs	% TIN/NPIs meeting 0.4 reliability threshold	Mean reliability for TIN/NPIs
Depression	99.62%	0.87	98.61%	0.80
Emergency Medicine	100.00%	0.91	100.00%	0.78
Heart Failure	91.81%	0.68	86.79%	0.60
Low Back Pain	96.27%	0.75	95.66%	0.73
Psychoses and Related Conditions	100.00%	0.83	100.00%	0.86

- **Promoting Interoperability.** CMS proposes requiring a continuous 180-day performance period for the Promoting Interoperability performance category beginning with the CY 2024 performance period/2026 MIPS payment year rather than the current 90-day requirement.

The AANS and CNS oppose CMS’ proposal to increase the minimum Promoting Interoperability performance period. This proposal will increase the administrative burden on already strained practices while doing little to improve the quality of patient care. This performance category is already the most challenging for clinicians to comply with from an administrative perspective, particularly for practices (i.e., single TINs) that span various settings (e.g., hospitals and physician offices) or are located across different geographic locations, which also could result in only a portion of the practice participating in a regional APM. Currently, practices do not stop collecting Promoting Interoperability measure data at the 90-day mark. The collection of these data is

embedded into the workflow throughout the year. As such, arbitrarily expanding this performance period will only put added pressure on practices to monitor compliance without a commensurate positive impact on patient outcomes.

CMS also proposes to modify the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) measure beginning with the CY 2024 performance period/2026 MIPS payment year such that only a “yes” response on the attestation will constitute completion of this measure and a “no” response will result in a score of zero for the whole Promoting Interoperability performance category. CMS previously adopted the SAFER Guides measure under the Promoting Interoperability performance category beginning with the CY 2022 performance period. Currently, clinicians must attest to whether they have conducted an annual self-assessment using the High Priority Practices SAFER Guide at any point during the calendar year with one “yes/no” attestation statement. Clinicians must complete this attestation but are not scored based on their answer.

The AANS and CNS also strongly oppose CMS’ proposal to require a “yes” response for this measure to comply with the Promoting Interoperability category. Neurosurgical practices report that this measure takes an enormous amount of time to review and complete, involving significant clinical staff time, which is currently at a premium due to staff shortages. Even when EHR vendors have provided guidance on this measure, it must still be tailored to the specific practice/specialty, which is time-consuming and results in diverting attention from the patient to these administrative activities.

The Promoting Interoperability was established to promote patient engagement and electronic exchange of information using certified electronic health record technology (CEHRT). However, according to the Office of the National Coordinator for Health Information Technology, as of 2021, nearly 4 in 5 office-based physicians (78%) and nearly all non-federal acute care hospitals (96%) adopted a certified EHR.¹ The widespread adoption of CEHRT raises questions about the ongoing utility of this category.

Appropriate Use Criteria for Advanced Diagnostic Imaging Program

CMS proposes to pause the implementation of the Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services program and to rescind the current AUC program regulations. Despite numerous attempts by CMS to implement this program, which was established under the Protecting Access to Medicare Act, it has been plagued with operational issues that have resulted in continual delays. In this rule, CMS acknowledges that it has exhausted all reasonable options for fully operationalizing the program consistent with the statutory provisions to require real-time claims-based reporting to collect information on AUC consultation and imaging patterns for advanced diagnostic imaging services, which was intended to inform outlier identification and prior authorization. CMS does not propose a time frame within which implementation efforts may recommence. However, the agency states that it will continue to identify a workable implementation approach and proposes to adopt any such approach through subsequent rulemaking.

The AANS and CNS strongly support CMS applying a hard pause to the AUC program and rescinding the current program regulations. The AUC Program has been fraught with implementation challenges since its enactment and, in the intervening time, has grown outdated — particularly with the subsequent enactment of the Medicare Access and CHIP Reauthorization Act MACRA and the rise of new health care payment and delivery models that hold clinicians responsible for health care resource use, such as APMs and MIPS. We appreciate CMS’ recognizing these challenges and look forward to working with CMS to further the goals of this program in an alternative manner.

¹ <https://www.healthit.gov/data/quickstats/national-trends-hospital-and-physician-adoption-electronic-health-records>

CONCLUSION

The AANS and the CNS appreciate the opportunity to provide feedback on these coding, payment and quality provisions in the CY 2024 Medicare PFS proposed rule. We are particularly concerned about the inappropriate and unnecessary proposal to implement the G2211 office visit add-on code for complex services and the agency's failure to incorporate the increased E/M office visit work into the 10- and 90-day global surgical codes. We urge CMS to take all necessary steps to prevent Medicare payment reductions and to work with the medical community and Congress to fix this broken system.

Thank you for considering our comments. We appreciate the expertise, hard work and dedication of CMS leaders and staff. We look forward to collaborating on these and other policy matters to ensure timely patient access to quality care.

Sincerely,



Anthony L. Asher, MD, President
American Association of Neurological Surgeons



Elad I. Levy, MD, President
Congress of Neurological Surgeons

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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	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).