CASE STUDY

G2211 Decoding

A potential disruptor of 2024 compensation

By Kelsi O'Brien, MHSA

It has been three years since the changes in work relative value units (wRVUs) for outpatient (OP) evaluation and management (E/M) codes disrupted benchmarks and compensation models nationwide. It may feel as though medical groups have finally settled into their new normal with more volume (thus, more wRVUs) and right-sized conversion factors that promote financially sustainable compensation models, but not so fast. The delayed implementation of a single add-on code could mean groups are in for another round of disruption.

Background and Context

G2211 is an add-on code that should be listed separately and billed in addition to office/outpatient E/M visits (new or established). The code should be used when the "complexity inherent to evaluation and management associated with medical care services serves as the continuing focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition," according to the Centers for Medicare & Medicaid Services (CMS).

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Figure 1

The Impact of an Additional 400 wRVUs

Family Medicine	# of Providers	50th Percentile	55th Percentile	60th Percentile	65th Percentile
National Clinical Productivity – wRVU	9,005	5,923	6,138	6,335	6,597

AMGA 2023 Medical Group Compensation and Productivity Survey

Difference 423

Any specialty could potentially utilize this code with their OP E/M services as long as the service does not include a 25 modifier. The code carries an RVU weight of 0.49 and a wRVU weight of 0.33. Based on the current CMS conversion factor of $33.29, reimbursement would equate to $16.30. CMS has indicated that they expect 38% of all OP E/M services to qualify for use of the code initially, and when fully implemented, as much as 54%.

Utilization Criteria

Medicare Learning Network notes that the G2211 code should be used when the visit enables practitioners to build longitudinal relationships with patients (that is, not only those patients who have a chronic condition or single, high-risk disease) and to address the majority of patients' healthcare needs with consistency and continuity over long periods of time.

Provided examples of appropriate use are management of sinus congestion and medication management for a patient with HIV. Examples of inappropriate use that have been provided are mole removal or referral to a physician for removal of a mole, treatment of a simple virus, counseling related to seasonal allergies, or initial onset of gastroesophageal reflux disease. It is too early to identify any trends in denials related to documentation or diagnosis, but it is certainly a matter worth monitoring.

Reimbursement

One of the big questions that comes with implementation of a new code, especially a G-code, is whether commercial insurers will recognize and pay the code. Codes that are payer-specific create challenges for medical groups and/or billing optimization. A recent AMGA-conducted online poll noted that Cigna, United, and Humana have all paid for the code on claims submitted. Some groups reported that commercial insurers were denying the code due to unrecognition, but that after a correction in their system, claims could be resubmitted and would be paid in full.

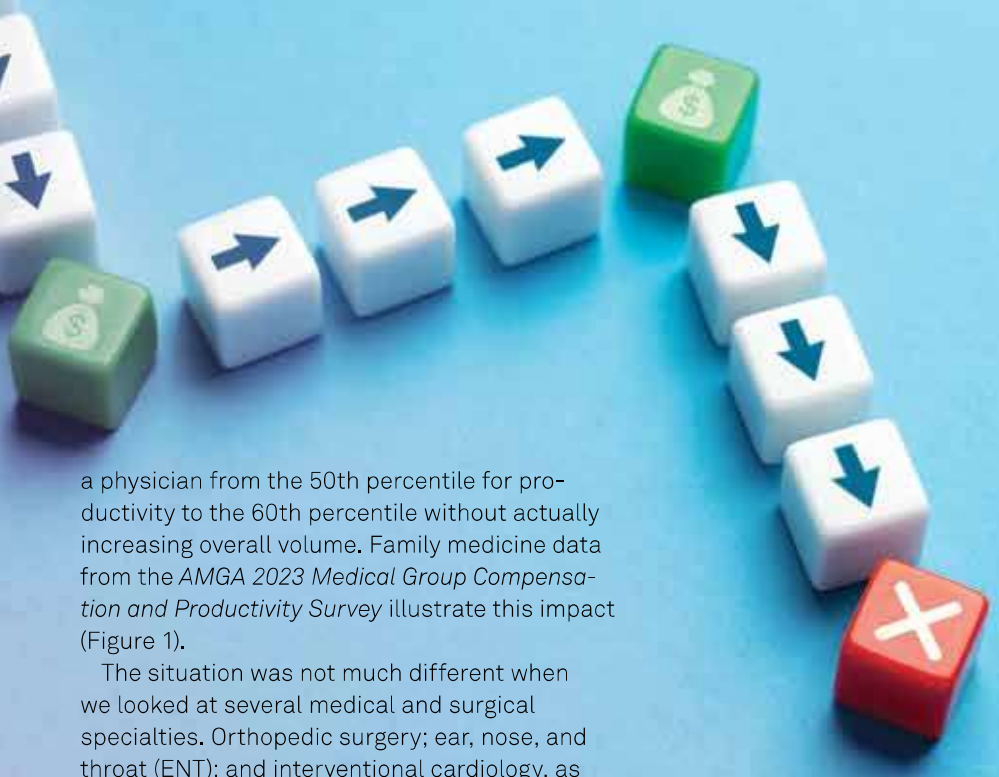
The challenge physician enterprises will face is that when the code is added, the provider will receive credit for the additional wRVUs. With more than 65% of physicians on productivity-based compensation plans, paying physicians based on wRVUs that are not reimbursed is a problem, and paying based on an increased number of wRVUs at existing compensation rates could also be a problem.

Impact on Productivity

At face value, G2211 seems rather inconspicuous. How much impact could a code worth 0.33 wRVUs really have? We sought to answer that exact question through an extensive case study with a large multispecialty group located in the Midwest. We found that this code could be incredibly disruptive during the next two years.

Starting with primary care, we looked at a cohort of roughly 200 family and internal medicine physicians. We found that 70% of the wRVUs generated in 2023 were the result of an OP E/M service, or alternatively, 40% of all codes billed would potentially qualify for the addition of G2211. If we assume that 50% of all OP E/M services now include the G2211, that would result in roughly 400 additional wRVUs for each family medicine physician and 300 wRVUs for each internal medicine physician.

Still not convinced of the impact? In family medicine, the addition of 400 wRVUs would take



a physician from the 50th percentile for productivity to the 60th percentile without actually increasing overall volume. Family medicine data from the *AMGA 2023 Medical Group Compensation and Productivity Survey* illustrate this impact (Figure 1).

The situation was not much different when we looked at several medical and surgical specialties. Orthopedic surgery; ear, nose, and throat (ENT); and interventional cardiology, as examples, all have the potential for 300 or more additional wRVUs per physician, which will have varying degrees of impact on their productivity percentiles. Medical groups will be left asking themselves: Is provider productivity truly increasing, or are the physicians just effectively utilizing the G2211 add-on? Survey data reflecting the increased volume associated with this code will not be available until July 2025 at the earliest.

Compensation Implications

If you are still not concerned, you will want to pay attention to this next section.

A common approach to physician compensation is tier-based productivity. A sample plan illustrates the payment per wRVU increasing with higher productivity, a common market approach utilized by groups nationwide (Figure 2). Under this model, if providers are increasing their productivity, they could potentially earn a higher payment per wRVU.

Even if we assume that groups are being reimbursed every time they bill the G2211, a payment of $52.04 per wRVU will increase the deficit associated with provider compensation (Figure 3).

As a part of our analysis, we also calculated the actual impact to physician compensation in ENT, assuming the compensation per wRVU was static at the median of $67.04 per the AMGA survey. The additional 300 wRVUs would result in an extra $20,000 in compensation per full-time physician. In a system for which Medicare is the primary payer, compensation will outpace reimbursement two to one. Under a commercial-dominant payer system, if rates are negotiated at 200% of Medicare, compensation and reimbursement will break even at best.

Keep in mind that this assumes all payers are acknowledging and paying on G2211. If the code is not paid, the lost revenue is at least $15,000 per physician, further magnifying the loss.

Figure 2

A Sample Plan In Which Payment per wRVU Increases With Higher Productivity

1	0–54th Percentile wRVU Productivity	45% Percentile Conversion Factor	Individual Compensation
2	55th–64th percentile wRVU productivity	50% percentile conversion factor	100% wRVUs × conversion factor = total potential compensation
3	64th–99th percentile wRVU productivity	55% percentile conversion factor	10% FTE adjusted value-based at-risk compensation incentive derived from compensation above

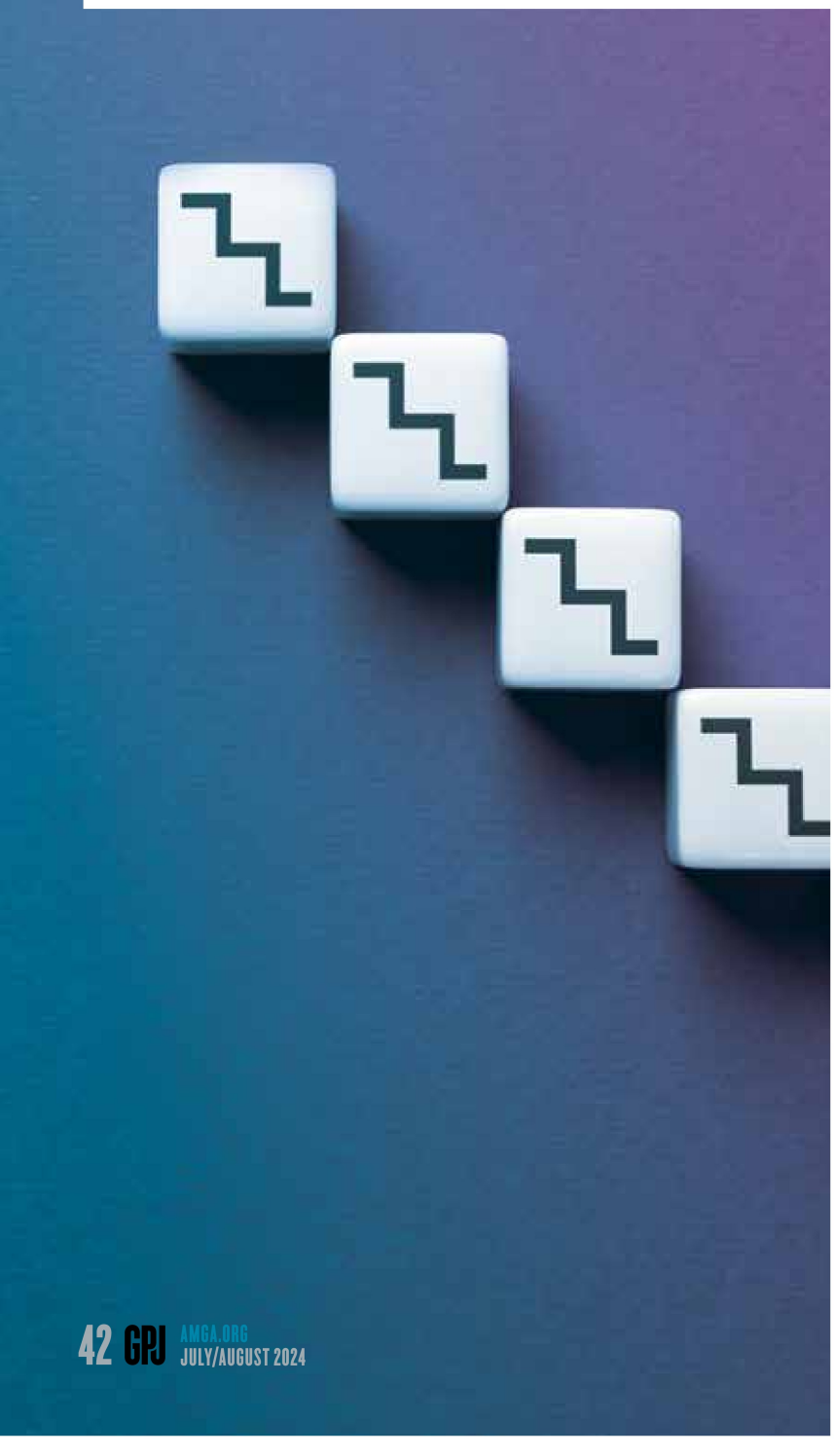
Andrii Yalanskyi/Getty Images

Figure 3

AMGA 2023 Medical Group Compensation and Productivity Survey Results for Compensation per wRVU

Family Medicine	45th Percentile	50th Percentile	55th Percentile
National Clinical Productivity Ratio – Compensation per wRVU	$48.99	$50.58	$52.04

AMGA 2023 Medical Group Compensation and Productivity Survey



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Recommendations and Next Steps

After reviewing the full scope of use and impact, groups have several options for addressing the situation:

- **Option 1:** First is the wait-and-see approach, removing the wRVUs from provider productivity reporting attributed to the code and monitoring reimbursement. With this approach, we recommend evaluating the additional revenue earned at the end of the year and paying out a portion of the collections. Groups risk provider dissatisfaction or lagging behind competitors with this approach, but it is the fiscally conservative option.
- **Option 2:** The second choice would be to run a sensitivity analysis for the provider specialty compliment and payer mix within your organization and determine a modified payment per wRVU and adjusted volume reporting that shows true volume increase versus the G-code volume. This particular approach requires consistent and constant monitoring, as use and reimbursement of the code could fluctuate.
- **Option 3:** The third and final option is to let the reimbursement and compensation play out without modification. The result will undoubtedly be richer compensation, but with the right payer model, it could be the right choice.

No matter which option you choose, we strongly recommend educating and engaging your provider compensation committee and developing reporting that tracks the impact on both compensation and revenue. National surveys will reflect the impact of this code in 2025, and this certainly is not the only market disruptor, but physician enterprises will want to keep an eye on G2211. GPJ

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