# Frequently Asked Questions (FAQs) About Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-On HCPCS Code G2211

Healthcare Common Procedure Coding System (HCPCS) code *G2211 (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 condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established))*.

## Q1: When can I report HCPCS code G2211?

A: All medical professionals who can bill Medicare for office/outpatient (O/O) evaluation and management (E/M) visits (i.e., Current Procedural Terminology (CPT) codes 99202-99205, 99211-99215) may report the HCPCS code G2211 add-on code to O/O E/M base codes. HCPCS code G2211 may not be reported without reporting an O/O E/M base code visit, i.e., CPT codes 99202-99205, 99211-99215. HCPCS code G2211 captures the inherent complexity of the O/O E/M visit that is derived from the longitudinal nature of the practitioner and patient relationship. (CY 2024 physician fee schedule (PFS) final rule, 88 FR 78818, 78970)

Think about the relationship between you and the patient when deciding whether to bill HCPCS code G2211, including whether:

- You're the continuing focal point for all needed services, like a primary care practitioner (CY 2024 PFS final rule, 88 FR 78818, 78973-78974),
- You're providing ongoing care for a single, serious condition or a complex condition (e.g., sickle cell disease) (CY 2024 PFS final rule, 88 FR 78974).

There are many visits with new or established patients where the O/O E/M visit complexity add-on code would not be appropriately reported, such as when the care furnished during the O/O E/M visit is provided by a professional whose relationship with the patient is of a discrete, routine, or time-limited nature; such as, but not limited to, a mole removal or referral to a physician for removal of a mole; for treatment of a simple virus; for counseling related to seasonal allergies, initial onset gastroesophageal reflux disease; treatment for a fracture; and where comorbidities are either not present or not addressed, and/or when the billing practitioner has not taken responsibility for ongoing medical care for that particular patient with consistency and continuity over time, or does not plan to take responsibility for subsequent, ongoing medical care for that particular patient with consistency and continuity over time (CY 2024 PFS final rule, 88 FR 78971).

## Q2: In what office and outpatient settings can HCPCS code G2211 be billed?

A: All rules for reporting O/O E/M services (i.e., CPT codes 99202-99205, 99211-99215) apply to billing HCPCS code G2211. Continue to use the codes in this family to report E/M services you provide to a

patient in the office or other outpatient facility. HCPCS code G2211 is separately payable to the billing physician or practitioner in both facility and non-facility settings and is not limited to any physician specialties.
HCPCS code G2211 cannot be billed with code sets for other E/M services (e.g., hospital inpatient, emergency department, home or residence, and nursing facility).

## Q3: Can HCPCS code G2211 be billed when my patient sees another physician or practitioner in my group practice instead of me, including colleagues in the same specialty as me?

A: In this scenario, physicians and practitioners might consider whether the patient could have an ongoing relationship with a patient care team within the group practice that includes more than one physician or practitioner. We understand it is possible that team-based care practices may also serve as the continuing focal point for all needed services or provide ongoing care for a single, serious condition or a complex condition. In such circumstances when a patient sees another physician or practitioner in a team-based care practice, and if all other requirements of HCPCS code G2211 are met, it may be appropriate to report HCPCS code G2211.

## Q4: Is it appropriate to bill HCPCS code G2211 using the Primary Care Exception

A: Physicians can bill under the primary care exception for lower-level O/O E/M services provided by resident physicians in certain primary care training settings. Physicians bill for these services by attaching the GE modifier to their claims for O/O E/M visits described by CPT codes 99202-99203 & 99211-99213. The temporary policy we put in place during the COVID-19 Public Health Emergency to permit physicians to bill under the primary care exception for O/O E/M level 4-5 visits (99204-99205, 99214-99215) is no longer in effect. The HCPCS code G2211 add-on code can be billed for services furnished under the primary care exception if the criteria for billing HCPCS code G2211 are met.

## Q5: Can HCPCS code G2211 be billed in an FQHC or RHC?

A: We generally pay Rural Health Clinic (RHC)s and Federally Qualified Health Center (FQHCs) an encounter-based rate. The service described by HCPCS add-on code HCPCS code G2211 is bundled into the RHC all-inclusive rate or FQHC prospective payment system payment rate along with the service described by the O/O E/M base code with which HCPCS code G2211 would be billed. There is no separate payment made to an FQHC or RHC for HCPCS code G2211.

## Q6: Is HCPCS code G2211 denied when modifier-25 is on the claim for any service?

A: As finalized in the CY 2024 PFS final rule (88 FR 78974-78975) and summarized in MLN Matters Article MM13272, we'll deny payment for HCPCS code G2211 reported for an O/O E/M visit (CPT codes 99202-99205, 99211-99215) that has been reported with Modifier -25, on the same date of service, for the same patient, by the same physician or nonphysician practitioner. For the CY 2025 PFS, in response to practitioners' concerns, we are proposing to allow payment of HCPCS code G2211 when the O/O E/M

base code is reported by the same practitioner on the same day as an AWV, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting (89 FR 61696-61697).

## Q7: What must be documented for HCPCS code G2211? What does a billing/treating practitioner state in the patient record for the medical necessity of reporting HCPCS code G2211?

A: We have not specified any additional medical record documentation requirements for reporting the HCPCS code G2211 add-on code. Our medical reviewers may use the medical record documentation to confirm the medical necessity of the visit and the patient care relationship as appropriate. We would expect that information included in the medical record or in the claims history for a patient/practitioner combination, such as diagnoses, the practitioner's assessment and medical plan of care, and/or other codes reported could serve as supporting documentation for billing HCPCS code G2211. Practitioners should consult their Medicare Administrative Contractor (MAC) regarding documentation requirements related to the underlying O/O E/M visit. Practitioners should also consult the Evaluation and Management Services Guide, MLN006764 August 2023.

## Q8: What constitutes a serious or complex condition? What diagnosis must be used?

A: No specific diagnosis is required for HCPCS code G2211 to be billed. For the billing practitioner, it would be appropriate to report a health condition that is a single, serious condition and/or a complex condition for which the billing practitioner is engaging the patient in a continuous and active collaborative plan of care related to an identified health condition—the management of which requires the direction of a practitioner with specialized clinical knowledge, skill, and experience. Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals.

We provide several examples to clarify the use of HCPCS code G2211 in the context of specialty care. For example, HCPCS code G2211 could be billed by an infectious disease physician who is part of ongoing care for a patient with HIV (a single, serious condition and/or complex condition), or a practitioner who is part- of ongoing care for a patient with sickle cell disease.

## Q9: What is the definition of "longitudinal"? Does it matter if the patient comes in once a year, every other year, or every 5 years, as long as the patient has selected that physician as their primary care doctor and who they call when they need care?

A: The add-on code HCPCS code G2211 captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship. Therefore, HCPCS code G2211 is not appropriate when the billing practitioner has not taken responsibility for ongoing medical care for a given patient with consistency and continuity over time, or does not plan to take responsibility for subsequent, ongoing medical care for that particular patient with consistency and continuity over time. No specific definition is provided for "longitudinal" for HCPCS code G2211 to be billed. As long as the practitioner-patient relationship aligns with Q1 above, HCPCS code G2211 can be billed to recognize the services that enable practitioners to build longitudinal relationships with their patient and address the

majority of patient's health care needs with consistency and continuity over longer periods of time. This includes furnishing services to patients on an ongoing basis that result in care that is personalized to the patient. The services result in a comprehensive, longitudinal, and continuous relationship with the patient and involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.

## Q10: Does patient cost-sharing apply to HCPCS code G2211?

A: Yes, the usual Part B patient coinsurance and deductible applies when HCPCS code G2211 is billed.

## Q11: Can HCPCS code G2211 be reported during the same service period as care management services? Or, are these considered duplicative?

A: HCPCS code G2211 may be billed during the same service period as care management services. We do not believe HCPCS code G2211 necessarily would be duplicative of care management services since the concept of inherent complexity better recognizes the professional work that occurs during the visit, while the care management codes generally recognize services that happen outside of the visit.

## Q12: Where can I find additional information?

A: These FAQs draw on policies for HCPCS code G2211 finalized in the CY 2024 PFS final rule (CY 2024 PFS final rule, 88 FR 78818) available at https://www.govinfo.gov/content/pkg/FR-2023-11-16/pdf/2023-24184.pdf). For additional information, we refer readers to that final rule and to the Medicare Learning Network (MLN) Matters Articles MM13272 at https://www.cms.gov/files/document/mm13272-edits-prevent-payment-g2211-office/outpatient-evaluation-and-management-visit-and-modifier.pdf and MM13473 available at https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf.