THOMAS J. WEIDA, MD, FAAFP, AND JANE A. WEIDA, MD, FAAFP

G2211: Simply Getting Paid for Complexity

A majority of family medicine visits should qualify for the visit complexity add-on code. Here's how to start using it in your practice.

ABOUT THE AUTHORS

Dr. Thomas Weida is chief medical officer, associate dean for clinical affairs, and professor at the University of Alabama College of Community Health Sciences. He is also a member of the American Medical Association's Relative Value Scale Update Committee (RUC). Dr. Jane Weida is immediate past chair of the Department of Family, Internal, and Rural Medicine and professor at the University of Alabama College of Community Health Sciences. She is also a member of the Medical Association of the State of Alabama's Board of Censors, the Alabama Department of Public Health Board of Directors, and the Alabama Board of Medical Examiners. Author disclosures: no relevant financial relationships.

Editor's note: The Centers for Medicare & Medicaid Services has not yet provided written guidance for certain aspects of code G2211, as noted in the article. We will update the online version of this article as more details become available.

Primary care is unique in that it is based on an ongoing relationship with patients. Effective Jan. 1, 2024, traditional Medicare (and some Medicare Advantage plans) will recognize the value of that relationship by reimbursing for HCPCS code G2211, which clinicians can add on to an office/outpatient visit evaluation and management (E/M) code. G2211 documents that the longitudinal relationship has complexity beyond that captured in the work of standard E/M codes. This complexity exists for chronic care and even some acute care visits. The deciding factor is the continuing relationship between the clinician and the patient.

DEFINITION OF G2211

The Centers for Medicare & Medicaid Services (CMS) defines G2211 as follows:

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.)[1]

There are two aspects to this definition. The first part underscores that the basis for G2211 is *not* the patient's clinical condition but the clinician's continued responsibility for the patient. The second part acknowledges that an ongoing relationship may exist for a single, serious condition or a complex condition even if the clinician is not the focal point for *all* services; CMS provides the example of a patient with HIV who receives ongoing care from an infectious disease doctor.[2]

USING G2211

G2211 may only be added to a new or established patient office/outpatient visit E/M code (99202-99205 or 99211-99215). It may be added whether medical decision making or time is used to select the level of service. G2211 may be used for either chronic care visits (with no minimum number of chronic conditions needed to qualify) or acute visits as long as a longitudinal relationship exists or will exist with the patient. Therefore, a new patient visit can qualify when the patient will be establishing with the clinician as their medical home, and an acute care visit with an established patient can qualify if the clinician's practice serves as the continuing focal point for all needed health care services.

CMS has not required any additional documentation to support code G2211. However, if there might be any doubt about the longitudinal patient relationship (or intent to provide longitudinal care), it may be helpful to demonstrate it in the visit note. Particularly for acute problems, documenting the longitudinal relationship's impact on the acute visit could be helpful. For example, the assessment and plan could read as follows: *Influenza A, X prescribed, call if not improved in X days; make an appointment to return for influenza immunization in about 2 weeks; next visit as needed for new or worsening problem, already scheduled annual wellness visit.*

G2211 may also be used in instances where a "patient's overall, ongoing care is being managed, monitored, and/or observed by a specialist for a particular disease condition."[1] G2211 is an add-on code to the E/M visit, and modifier 25 does not need to be added to the E/M code. (In fact, G2211 cannot be billed if the visit requires modifier 25; see the exclusions section on page 8.) G2211 can be billed with an office visit E/M service provided via telehealth.

> The basis for G2211 is *not* the patient's clinical condition but the clinician's continued responsibility for the patient.

EXAMPLES WHERE G2211 WOULD QUALIFY

A 65-year-old established patient on Medicare whom you have been treating for diabetes, hypertension, and hyperlipidemia presents to your office for a routine check. You order an A1C, comprehensive metabolic panel, lipid panel, and urine for microalbumin, and you adjust the patient's blood pressure medication. This would qualify for a 99214 E/M code as well as the G2211 add-on code because you have an ongoing relationship with the patient.

A 72-year-old patient on Medicare who is new to the practice visits your office to establish ongoing care and also has sinus congestion. This would qualify for an appropriate E/M code as well as the G2211 add-on code. In this example, "the complexity that code G2211 captures isn't in the clinical condition — the sinus congestion.

KEY POINTS

- CMS created the new G2211 add-on code to recognize that the longitudinal relationship with a patient has complexity beyond that captured in the work of standard E/M codes.
- Code G2211 can be added to office/outpatient E/M visits (99202-99205 or 99211-99215) based on the clinician's continued responsibility for the patient, not based on the patient's clinical condition.
- Additionally, even if the clinician is not the focal point for *all* services for the patient, an ongoing relationship may exist for a "single, serious condition or a complex condition," justifying use of G2211.

The complexity is in the cognitive load of the continued responsibility of being the focal point for all needed services for this patient."[3] The intent to establish ongoing care for this new patient suffices.

A 68-year-old established patient who sees you yearly for a Medicare annual wellness visit and periodically for acute problems presents at this visit with complaint of a cough and concern for influenza. You order a rapid test for influenza and recommend influenza vaccination after the patient recovers from this illness and each season thereafter. This would qualify for an appropriate E/M code as well as the G2211 add-on code because you serve as the continuing focal point for all of the patient's health care.

An endocrinologist has been managing a Medicare patient's uncontrolled diabetes and complications for years, and the patient returns for a recheck. This would qualify for an appropriate E/M code as well as the G2211 add-on code because the physician has an ongoing relationship with the patient that involves care of a "single, serious condition or a complex condition" (diabetes, in this instance).

G2211 DOs AND DON'Ts

Do use G2211 for:

- ✓ Office/outpatient E/M visits (99202-99205 or 99211-99215) if you are the "continuing focal point for all needed health care services" for the patient, whether the condition is acute or chronic. (If you are not the continuing focal point, use G2211 only if you provide ongoing care for a serious or complex condition.)

Don't use G2211 for:

- ✗ Non-office E/M visits,
- ✗ Urgent care center visits (i.e., one-off visits),
- ✗ Transitional care management visits,
- ✗ Medicare annual wellness visits,
- ✗ Visits requiring modifier 25 (i.e., services that when reported on the same date as an office/outpatient E/M service necessitate adding modifier 25 to the E/M code). Examples:
  - Annual wellness visit (G0438-G0439),
  - Injection of medication (96372),
  - Spirometry, inhalation treatment, or other pulmonary function services (94010-94799),
  - Osteopathic manipulative therapy (98925-98929),
  - Annual alcohol misuse screening (G0442),
  - Annual depression screening (G0444),
  - High-intensity behavioral counseling to prevent sexually transmitted infection (G0445),
  - Annual, face-to-face intensive behavioral therapy for cardiovascular disease (G0446),
  - Face-to-face behavioral counseling for obesity (G0447).

EXCLUSIONS

CMS will not pay for G2211 when the E/M service is reported with modifier 25 (significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service).[4] The intent was to exclude G2211 from instances where minor procedures are performed on the same date as an office visit, which often occurs outside of primary care and does not reflect the visit complexity and ongoing relationship otherwise envisioned by G2211. In those instances, CMS considers the additional work and complexity to be part of the procedure code. Unfortunately, the unintended effect of CMS's decision is to exclude the use of G2211 in primary care when modifier 25 is applicable, such as medication administration (e.g., 96372) or spirometry (e.g., 94010 or 94060) in addition to an E/M service. CMS may make additional clarifications on this issue in upcoming rules as they monitor the use of G2211 and have further discussions with interested parties.

Because G2211 may only be reported in addition to office/outpatient E/M visits (99202-99215), it cannot be attached to Medicare annual wellness visits or transitional care management visits. Complexity is already factored into the work and codes for these visits. G2211 also cannot be added to any non-office-visit E/M codes, such as inpatient, emergency department, nursing home, or home visit codes. G2211 would not be appropriate for most urgent care center visits, given the one-off nature of those encounters.

Additionally, CMS considers G2211 to be inappropriate when the 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" — unless comorbidities are present or addressed, or unless the clinician has taken (or plans to take) responsibility

for ongoing care for the patient.[5]

CMS has not clarified in writing whether G2211 can be billed by a physician covering for a colleague who is the patient's ongoing source of care or by a nonphysician provider billing for an acute visit with a patient whose ongoing physician is in the same practice. However, based on statements from CMS staff at a Jan. 24, 2024, Open Door Forum, CMS seems inclined to think of clinicians in the same specialty and same group interchangeably for purposes of reporting G2211. (We will update the online version of this article when CMS publishes more guidance.)

EXAMPLES WHERE G2211 WOULD NOT QUALIFY

A 65-year-old established patient on Medicare whom you have been treating for diabetes, hypertension, and hyperlipidemia presents to your office for a routine check. You order an A1C, comprehensive metabolic panel, lipid panel, and urine for microalbumin, and you adjust the patient's blood pressure medication. You also order injection of a medication reported with 96372. This would qualify for a 99214 but would not qualify for G2211 because adding the injection code, 96372, requires that you add modifier 25 to the E/M code.

A 67-year-old Medicare patient sees you for a subsequent Medicare annual wellness visit. G2211 cannot be added because the proper code for this visit is G0439, a HCPCS code, which is not one of the applicable E/M codes. If you had provided the annual wellness visit in addition to an office/outpatient E/M service, modifier 25 would have been required, which would also disqualify the visit for code G2211.

A 70-year-old Medicare patient sees a gastroenterologist for a screening colonoscopy exam without expectation of an ongoing relationship. G2211 cannot be added as there is no ongoing relationship established (or expected to be established).

USE IN FAMILY MEDICINE RESIDENCY PROGRAMS

Unlike many other specialty residency programs, where patients may see different residents but the same attending physician who is established with the patient and bills for the visit, family medicine patients may see the same resident but have multiple attending physicians who bill for the visits. G2211 is not included in the primary care exception, so that would suggest that in order to use this code for visits that normally qualify for the primary care exception (straightforward and low complexity medical decision making), the attending physician would also need to see the patient. CMS has offered no written guidance in this area. However, at the Jan. 24 Open Door Forum, CMS staff suggested that guidance may be forthcoming allowing G2211 to be billed with E/M services on the primary care exception list if the resident is serving as the focal point for the patient's care.

> CMS will not pay for G2211 when the E/M service is reported with modifier 25.

Until specific guidance is released, given the intent of CMS to recognize the value of the longitudinal relationship between the physician and patient, the following billing practices seem appropriate. If the patient sees the resident who usually provides their care, then it would seem appropriate to use G2211. This would apply to continuity of care issues or acute issues where ongoing care influences the decision-making. If a resident doesn't usually see the patient for care but is seeing the patient for a continuity-type visit, it would seem appropriate to use G2211, as billing would be submitted under one Tax Identification Number (TIN) for the residency practice. Additionally, this would fulfill the intent of the longitudinal relationship for the practice. It would be important for the resident to document the ongoing relationship they have with the patient or the impact the patient's total health has on the current issue. The attending physician would also need to see the patient and document appropriately. Again, this is simply what seems appropriate given the intent of the code, but we look forward to guidance from CMS. ➤

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.

PAYMENT

Medicare's national payment amount for G2211 is $16.05; the actual allowance will vary geographically. This value will be subject to the patient's deductible and coinsurance. A Medicare patient often has a 20% coinsurance; therefore, if this code reimburses $16, the patient will be responsible for $3.20. Practices should be prepared to explain to patients what this additional charge is.

CMS estimates that practices will use G2211 with more than half of office/outpatient E/M services once physicians become familiar with the code. So, assuming you provide 20 visits per day, 200 days per year, and half of your visits qualify for the new code, it could bring in $32,080 per year. Some Medicare Advantage plans may pay for this code, while others may consider the work to already be included in capitation rates or other services paid to the practice. Private insurers' coverage of G2211 will also vary because it is not a CPT code, but a Medicare HCPCS code. Each individual insurer sets its own payment policy, just as each state sets its own Medicaid payment policy.

OVERALL, IT'S A WIN

Although limited by legislative actions and budget neutrality, CMS is recognizing the contribution primary care (and other longitudinal care that consists primarily of E/M services) makes to the overall management of Medicare patients. The visit complexity add-on code, G2211, will be valuable for family physicians. Given that Medicare will be paying less per visit in 2024 because the Medicare RVU conversion factor has decreased by $1.14 per RVU, adding this new code will provide a positive net payment for office/outpatient E/M visits. Practices should check the payment policies of their Medicare Advantage plans and private insurers to determine whether they will be paying for this code. FPM

1. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. 88 FR 78970. https://www.federalregister.gov/d/2023-24184/p-1379

2. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. 88 FR 78974. https://www.federalregister.gov/d/2023-24184/p-1397

3. How to use the office & outpatient evaluation and management visit complexity add-on code G2211. *MLN Matters*, 13473. Jan. 18, 2024.

4. Current Procedural Terminology 2024 Professional Edition. American Medical Association. Appendix A:971.

5. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. 88 FR 78971. https://www.federalregister.gov/d/2023-24184/p-1385