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How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211

Related CR Release Date: January 18, 2024	**MLN Matters Number:** MM13473 Revised
Effective Date: January 1, 2024 & January 1, 2025	**Related Change Request (CR) Numbers:** CR 13473 & CR 13705
Implementation Date: February 19, 2024 & January 6, 2025	**Related CR Transmittal Numbers:** R12461CP & R13015OTN
Related CR Title: Guidance for the Implementation of the Office and Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on Code G2211	

What's Changed: We added information on how to use G2211 with modifier 25 for certain Medicare Part B services starting January 1, 2025 (pages 2, 3 & 4). We also added the CR 13705 effective & implementation dates, transmittal number, and link. Substantive content changes are in dark red.

Affected Providers

- Hospitals
- Physicians
- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

All medical professionals who can bill office and outpatient (O/O) evaluation and management (E/M) visits (CPT codes 99202-99205, 99211-99215), regardless of specialty, may use the code with O/O E/M visits of any level. We don't restrict G2211 to medical professionals based on specialties.

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Action Needed

Make sure your billing staff knows about:

- Correct use of HCPCS code G2211 and modifier 25
- Documentation requirements for G2211
- Patient coinsurance and deductible
- How to use G2211 with modifier 25 for certain Part B services

Background

CR 13473 Changes – Effective January 1, 2024

CR 13473 updates guidance on the O/O E/M visit complexity add-on code G2211. Starting January 1, 2024, CMS will change the status of G2211. We'll assign it an "active" status indicator to make it separately payable as an additional payment to the payment of O/O E/M visit base service codes to better account for the additional resources of visits associated with:

- Serving as the continuing focal point for all the patients' health care services needs
- Ongoing medical care related to a patient's single, serious condition or complex condition

G2211 captures the inherent complexity of the visit that's derived from the longitudinal nature of the practitioner and patient relationship.

When To Bill G2211

Don't report G2211 without reporting an associated O/O E/M visit, the base service code. Think about the relationship between you and the patient when deciding to bill G2211. Bill G2211 if:

- You're the continuing focal point for all needed services, like a primary care practitioner
- You're giving ongoing care for a single, serious condition or a complex condition, like sickle cell disease or HIV

Example 1: A patient sees you, their primary care practitioner, for sinus congestion. You may suggest conservative treatment or antibiotics for a sinus infection. You decide on the course of action and the best way to communicate the recommendations to the patient in the visit. How you communicate the recommendations is important in that it not only affects the patient's health outcomes for this visit, but it also can help build an effective and trusting longitudinal relationship between you and the patient. This is key so you can continue to help them meet their primary health care needs.

The complexity that code G2211 captures isn't in the clinical condition – the sinus congestion. The complexity is in the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. There's important cognitive effort of using the longitudinal doctor-patient relationship itself in the diagnosis and treatment plan. These factors, even for a simple condition like sinus congestion, make the entire interaction inherently complex. In this example, you may bill G2211.

Example 2: A patient with HIV has an office visit with you, their infectious disease physician. The patient tells you they've missed several doses of HIV medication in the last month because you're part of their ongoing care and have earned their trust over time. You tell them it's important not to miss doses of HIV medication, while making the patient feel safe and comfortable sharing information like this with you in the future.

If you didn't have this ongoing relationship with the patient and the patient didn't share this with you, you may have decided to change their HIV medicine to another with greater side effects, even when there was no issue with the original medication. Because you're part of ongoing care for a single, serious condition or a complex condition such as HIV, and must weigh these types of factors, the E/M visit is more complex. In this example, you may bill G2211.

G2211 and Modifier 25

G2211 isn't payable when you report the associated O/O E/M visit with modifier 25, except in certain cases starting January 1, 2025.

You can add modifier 25 to an E/M CPT code to show the E/M service is significant and separately identifiable from other services you report on the same date of service. Medicare Claims Processing Manual, Chapter 12, section 30.6.6 says you can only use modifier 25 on E/M claims and only when the same practitioner provides the services to the same patient on the same day as another procedure or other service. However, this doesn't apply to G2211.

Per MLN Matters Article MM13272, we deny payment for code G2211 on the same date of service as an O/O E/M visit (codes 99202-99205, 99211-99215) reported with modifier 25, for the same patient by the same physician or non-physician practitioner on the same day.

Documentation Requirements

You must document the reason for billing the O/O E/M visit. The visits themselves would need to be medically reasonable and necessary for the practitioner to report G2211. Also, the documentation would need to illustrate medical necessity of the O/O E/M visit. We haven't required additional documentation. Our medical reviewers may use the medical record documentation to confirm the medical necessity of the visit and accuracy of the documentation of the time you spent. These items could serve as supporting documentation for billing code G2211:

- Information included in the medical record or in the claims history for a patient/practitioner combination, such as diagnoses
- The practitioner's assessment and plan for the visit
- Other service codes billed

Patient Coinsurance and Deductible

We pay for G2211 using the Physician Fee Schedule, and patient coinsurance and deductible applies.

CR 13705 Changes – Effective January 1, 2025

Starting January 1, 2025:

- G2211 is payable even if you report the base code with modifier 25 only when the service or other procedure requiring the reporting of modifier 25 is an allowed Part B service. See Attachment 1 of CR 13705 for the list of allowed services. These services include:
  - Part B preventive services
  - Immunization administrations
  - Annual Wellness Visits
- Method II Critical Access Hospitals must use type of bill 85X (revenue codes 096x, 097x, or 098x).

More Information

We issued CRs 13473 & 13705 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
December 26, 2024	We added information on how to use G2211 with modifier 25 for certain Part B services starting January 1, 2025 (pages 2, 3 & 4). We also added the CR 13705 effective & implementation dates, transmittal number, and link.
January 18, 2024	Initial article released.