CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12370	**Date: November 21, 2023**
	Change Request 13272

Transmittal 12165 issued July 28, 2023, is being rescinded and replaced by Transmittal 12370, dated November 21, 2023, to reflect that the proposed policies have been made final in the CY 2024 MPFS. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 21, 2023. This instruction may now be posted to the Internet.

SUBJECT: Implement Edits to Prevent Payment of Complexity Add-On Code G2211 When Associated Office/Outpatient Evaluation and Management Visit (Codes 99202-99205, 99211-99215) is Reported With Modifier 25

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide instructions to the A/B Medicare Administrative Contractors (MACs) to implement edits to deny payment when an associated Office/Outpatient Evaluation and Management (O/O E/M) visit (codes 99202-99205, 99211-99215) is reported with Modifier 25. This edit will ensure that the add-on code is not improperly paid.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12 / Table of Contents
N	12 / 30 / 30.6.19 / Office/Outpatient Evaluation and Management (O/O E/M) Complexity Add-on Payment (Code G2211)

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions

regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12370	Date: November 21, 2023	Change Request: 13272

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EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to deny payment of Office/Outpatient Evaluation and Management (O/O E/M) visit complexity add-on code G2211 when the associated O/O E/M visit (Codes 99202-99205, 99211-99215) is reported with Modifier 25.

B. Policy: For Calendar Year (CY) 2024, with the end of the Congressionally mandated suspension of payment for O/O E/M visit complexity add-on code G2211, the Centers for Medicare and Medicaid Services (CMS) has finalized a rule to make the code separately payable by assigning the active status indicator to it, effective January 1, 2024. CMS believes that separately identifiable visits occurring on the same day as minor procedures (such as zero-day global procedures) have resources that are sufficiently distinct from the costs associated with furnishing stand-alone office/outpatient E/M visits to warrant different payment (see the CY 2021 Medicare Physician Fee Schedule final rule in the Federal Register (85 FR 84572)). As such, CMS proposed that the O/O E/M visit complexity add-on code G2211 would not be payable when the O/O E/M visit is reported with payment Modifier 25.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13272.1	Effective for dates of service on or after January 1, 2024, contractors shall deny code G2211 on the same date of service as an office/outpatient evaluation and management visit (codes 99202-99205, 99211-99215) reported with Modifier 25, to the same beneficiary. NOTE: For institutional claims	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	this applies to Method II Critical Access Hospital on the same encounter for TOB 85X only.									
13272.2	Contractors shall perform user acceptance testing on G2211 to ensure that our policy not to pay for this code on the same date of service as an office/outpatient evaluation and management visit (codes 99202-99205, 99211-99215) reported with Modifier 25, is being correctly applied.	X	X				X			
13272.3	Contractors shall build in a mechanism or "switch" so that the requirements described in 13272.1 can be turned off if CMS does not finalize this policy.	X	X				X			
13272.4	Effective for dates of service on or after January 1, 2024, contractors shall issue a denial message to practitioners when they do not pay for G2211 as described in 13272.1 using the following messages, with Group Code CO: Claim Adjustment Reason Code P14: The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Remittance Advice Remark Code N20 - Service not payable with other service rendered on the same date. MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13272.5	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Erick Carrera, (410) 786-89 or erick.carrera@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents
(Rev. 12370; Issued: 11-21-23)

Transmittals for Chapter 12

30.6.19 – Office/Outpatient Evaluation and Management (O/O E/M) Complexity Add-on Payment (Code G2211)

(Rev. 12370; Issued: 11-21-23; Effective: 01-01-24; Implementation: 01-02-24)

Starting on January 1, 2024 O/O E/M visit complexity add-on code, G2211 to describe intensity and complexity inherent to O/O E/M visits not accounted for in the valuation of the primary service codes is unbundled and separately payable as an additional payment to the payment for O/O E/M visit primary service codes (99202-99205, 99211-99215).

The full descriptor, refined in the calendar year (CY) 2021 PFS final rule, is 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)). (See the CY 2021 Medicare Physician Fee Schedule final rule in the Federal Register (85 FR 84571)).

The A/B MACs (A & B) shall not pay code G2211 on the same date of service as an office/outpatient evaluation and management visit (codes 99202-99205, 99211-99215) reported with Modifier 25, to the same beneficiary by the same practitioner or nonphysician practitioner.