

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12461	Date: January 18, 2024
	Change Request 13473

SUBJECT: Guidance for the Implementation of the Office and Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on Code G2211

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update guidance on the office and outpatient (O/O) evaluation and management (E/M) visit complexity add-on code G2211.

This code is not restricted to medical professionals based on specialties. Instead, it should be used by medical professionals, regardless of specialty, with O/O E/M visits of any level (other than those reported with the -25 modifier, see 30.6.19 – Office/Outpatient Evaluation and Management (O/O E/M) Complexity Add-on Payment (Code G2211)) for care that serves 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. The most important information used to determine whether the add-on code could be billed is the relationship between the practitioner and the patient. If the practitioner is the continuing focal point for all needed health care services, such as a primary care practitioner, the add-on code G2211 could be billed. Or, if the practitioner is furnishing ongoing care related to a patient's single, serious and complex condition, e.g., sickle cell disease, HIV, then the add-on code G2211 could be billed. The add-on code G2211 captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.

EFFECTIVE DATE: January 1, 2024

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: February 19, 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	12/30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99202 - 99215)

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

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EFFECTIVE DATE: January 1, 2024

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: February 19, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update guidance on the office and outpatient (O/O) evaluation and management (E/M) visit complexity add-on code G2211.

For CY 2024, with the end of the Congressionally mandated suspension of payment for O/O E/M visit complexity add-on code G2211, CMS is finalizing changing the status of code G2211 to make it separately payable by assigning it an "active" status indicator, effective January 1, 2024. Add-on code G2211 includes services that enable practitioners to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single, high-risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time.

B. Policy: O/O E/M visit complexity add-on code G2211 is not restricted to medical professionals based on specialties. Instead, it should be used by medical professionals, regardless of specialty, with O/O E/M visits of any level (other than those reported with the -25 modifier, see 30.6.19 – Office/Outpatient Evaluation and Management (O/O E/M) Complexity Add-on Payment (Code G2211)) for care that serves 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.

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. The "continuing focal point for all needed health care services" describes a relationship between the patient and the practitioner when the practitioner is the continuing focal point for all health care services that the patient needs.

The most important information used to determine whether the add-on code could be billed is the relationship between the practitioner and the patient. If the practitioner is the continuing focal point for all needed health care services, such as a primary care practitioner, the add-on code G2211 could be billed. Or, if the practitioner is furnishing ongoing care for a single, serious condition or a complex condition, e.g., sickle cell disease, HIV, then the add-on code G2211 could be billed. The add-on code G2211 captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC		H H H	M A C	D M E	Shared-System Maintainers			Other
		A	B				F I S S	M C S	V M S	
13473.1	Contractors shall make note of the changes to Pub 100-04 Sect 30.6.7.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC			H H H	M A C	D M E	C E D I
		A	B	F I S S				
13473.2	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

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. 12461; Issued:01-18-24)

Transmittals for Chapter 12

30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99202 - 99215)

(Rev. 12461; Issued:01-18-24; Effective:01-01-24 Implementation: 02-19-24)

A. Definition of New Patient for Selection of E/M Visit Code

Interpret the phrase “new patient” to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

B. Office/Outpatient E/M Visits Provided on Same Day for Unrelated Problems

As for all other E/M services except where specifically noted, the Medicare Administrative Contractors (MACs) may not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office, off campus-outpatient hospital, or on campus-outpatient hospital setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

C. Office/Outpatient or Emergency Department E/M Visit on Day of Admission to Nursing Facility

MACs may not pay a physician for an emergency department visit or an office visit **and** a comprehensive nursing facility assessment on the same day. Bundle E/M visits on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician (see section on Nursing Facility Services below).

D. Drug Administration Services and E/M Visits Billed on Same Day of Service

MACs must advise physicians that CPT code 99211 cannot be paid if it is billed with a drug administration service such as a chemotherapy or nonchemotherapy drug infusion code (effective January 1, 2004). This drug administration policy was expanded in the Physician Fee Schedule Final Rule, November 15, 2004, to also include a therapeutic or diagnostic injection code (effective January 1, 2005). Therefore, when a medically necessary, significant and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of these drug administration services, the appropriate E/M CPT code should be reported with modifier -25. Documentation should support the level of E/M service billed. For an E/M service provided on the same day, a different diagnosis is not required.

E. Prolonged Office/Outpatient E/M Visits

When the practitioner selects office/outpatient E/M visit level using time, the practitioner reports prolonged office/outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office/outpatient E/M services). See Prolonged Services section for additional information.

F. Add-On Code for Office/Outpatient E/M Visit Complexity

Beginning January 1, 2021, Medicare established HCPCS add-on code G2211 describing visit complexity inherent to office/outpatient E/M visits 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.

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)).

The Consolidated Appropriations Act, 2021 delayed PFS payment for this code until January 1, CY 2024 or later. *Effective January 1, 2024, Medicare is changing the status of HCPCS code G2211 to make it separately payable by assigning it an "active" status indicator.*

- HCPCS code G2211 includes services that enable practitioners to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single, high-risk disease) and to address the majority of patients' 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. *The "continuing focal point for all needed health care services" and "part of ongoing care related to a patient's single, serious condition or a complex condition" describe relationships between the patient and the practitioner.*

- Reporting is not restricted based on specialty. HCPCS code G2211 may be reported with any visit level. *HCPCS code G2211 may not be reported with an O/O E/M visit reported with Modifier -25. See 30.6.19 – Office/Outpatient Evaluation and Management (O/O E/M) Complexity Add-on Payment (Code G2211).*

- *Example 1: A patient has a primary care practitioner that is the continuing focal point for all health care services, and the patient sees this practitioner to be evaluated for sinus congestion. The inherent complexity that this code (G2211) captures is not in the clinical condition itself—sinus congestion—but rather the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. There is previously unrecognized but important cognitive effort of utilizing the longitudinal relationship itself in the diagnosis and treatment plan and weighing the factors that affect a longitudinal doctor patient relationship. In this example, the primary care practitioner could recommend conservative treatment or prescription of antibiotics. If the practitioner recommends conservative treatment and no new prescriptions, some patients may think that the doctor is not taking the patient's concerns seriously and it could erode the trust placed in that practitioner. In turn, an eroded primary care practitioner/ patient relationship may make it less likely that the patient would follow that practitioner's advice on a needed vaccination at the next visit. The primary care practitioner must decide—what course of action and choice of words in the visit itself, would lead to the best health outcome in this single visit, while simultaneously building up an effective, trusting longitudinal relationship with this patient for all of their primary health care needs. Weighing these various factors, even for a seemingly simple condition like sinus congestion, makes the entire interaction inherently complex, and it is this complexity in the relationship between the doctor and patient that this code captures.*

• *Example 2: a patient with HIV has an office visit with their infectious disease physician, who is part of ongoing care. The patient with HIV admits to the infectious disease physician that there have been several missed doses of HIV medication in the last month. The infectious disease physician has to weigh their response during the visit—the intonation in their voice, the choice of words—to not only communicate clearly that it is important to not miss doses of HIV medication, but also to create a sense of safety for the patient in sharing information like this in the future. If the interaction goes poorly, it could erode the sense of trust built up over time, and the patient may be less likely to share their medication adherence shortcomings in the future. If the patient isn't forthright about their medication adherence, it may lead to the infectious disease physician switching HIV medicines to another with greater side effects, even when there was no issue with the original medication. It is because the infectious disease physician is part of ongoing care, and has to weigh these types of factors, that the E/M visit becomes inherently more complex and the practitioner bills this code (G2211). Even though the infectious disease doctor may not be the focal point for all services, such as in the previous example, HIV is a single, serious condition, and/or a complex condition, and so as long as the relationship between the infectious disease physician and patient is ongoing, this E/M visit could be billed with the add-on.*

The most important information used to determine whether or not the add-on code could be billed is the relationship between the practitioner and the patient. If the practitioner is the focal point for all needed services, such as a primary care practitioner, the HCPCS G2211 add-on code could be billed. Or, if the practitioner is part of ongoing care for a single, serious condition or a complex condition, e.g., sickle cell disease, then the add-on code could be billed. The add-on code captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.

G. Medical Review When Practitioners Use Time to Select Visit Level

Our reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit.