CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12620	**Date: May 2, 2024**
	Change Request 13534

SUBJECT: Primary Care First (PCF) Model: Updated Appendix B - Prohibited Healthcare Common Procedure Coding System (HCPCS) Codes

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide updates to the list of Primary Care First (PCF) Appendix B Prohibited HCPCS codes, which are specified under CR 11896. The updated Appendix B will apply to related PCF CMS CRs including: CR 11419, CR 11896, and CR 11911. Of note, HCPCS code G2211 (Add-On Code for Prolonged E&M with direct patient contact) is being removed from Appendix B so participants can bill this code and receive payment as per the Physician Fee Schedule final rule, effective January 1, 2024. Contractors shall utilize the updated Appendix B provided in the attachment to this CR. Additionally, contractors shall go back to reprocess and accept claims for HCPCS code G2211 received on or after January 1, 2024, from Primary Care First participants, adding payments as necessary.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 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
N/A	N/A

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:

Demonstrations

Attachment - Demonstrations

Pub. 100-19	Transmittal: 12620	Date: May 2, 2024	Change Request: 13534

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EFFECTIVE DATE: January 1, 2024
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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to provide updates to the list of Primary Care First (PCF) Appendix B Prohibited HCPCS codes, which are specified under CR 11896. The updated Appendix B will apply to related PCF CMS CRs including: CR 11419, CR 11896, and CR 11911. Of note, HCPCS add-on code G2211 (Add-On Code for Prolonged E&M with direct patient contact) is being removed from Appendix B so PCF participants can bill this code and receive payment as per the Physician Fee Schedule final rule, effective January 1, 2024. Contractors shall utilize the updated Appendix B provided in the attachment to this CR. Additionally, contractors shall reprocess and accept claims for HCPCS add-on code G2211 received on or after January 1, 2024, from Primary Care First participants, adding payments as necessary.

Primary Care First (PCF) Model

The PCF model tests whether financial risk and performance-based payments that reward primary care practitioners for actionable outcomes will reduce total Medicare expenditures, preserve or enhance quality of care, and improve patient health outcomes. PCF incentivizes providers to reduce hospital utilization and total cost of care by offering the opportunity to earn significant performance-based payment adjustments based on their performance.

This CR will allow PCF participants to bill the new Prolonged E&M complexity add-on code G2211 to ensure they have equal opportunity to benefit from the intended primary care revenue boost from this complexity code. As such, this CR contains an updated PCF Appendix B: Prohibited Codes list.

Evaluation and Management (E/M) Visits Complexity Add-on HCPCS Code G2211

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, CMS finalized changing the status of code G2211 to make it separately payable by assigning it an "active" status indicator, effective January 1, 2024. 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" 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. Add-on code G2211 may be submitted with E/M Office or Outpatient (O/O) visits, 99202-99215.

B. Policy: Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) authorizes the Center for Medicare & Medicaid Innovation (CMMI) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program spending while maintaining or improving the quality of beneficiaries' care.

CMMI has made the policy decision to remove the new HCPCS code G2211: "Prolonged E&M with direct patient contact" from the list of prohibited codes in Appendix B. This will allow PCF participants to be able to bill this code FFS and receive payment as per the Physician Fee Schedule final rule. The reason for this change is to allow PCF participants have equal opportunity to benefit from the intended primary care revenue boost from this complexity code. G2211 was included in the CY 2024 Physician Fee Schedule as a novel code (in effect January 2, 2024) for primary care outpatient visits. In the PCF Payment and Attribution Methodologies paper, Code G2211 is not included as a PCF Flat Visit Fee HCPCS code, nor is it one of the HCPCS codes on the prohibited list for PCF.

As such, this CR will update the current PCF Appendix B Prohibited HCPCS Codes by deleting the HCPCS code G2211 so claims will no longer be denied as a noncovered charge. The code's description is 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, or complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)."

Contractors are to accept claims containing this new add-on code in accordance with its effective date. Claims reprocessing will need to occur for claims with G2211 from on or after January 1, 2024, until the implementation date of this CR in October 2024. Medicare contractors shall therefore implement the systems and/or local-contractor-level changes needed for processing claims with the new code should it appear on a Medicare claim, adding payments as necessary.

Please note that changes to Appendix B will override any business requirements from any related PCF CRs, including:

- CMS CR 11419 - Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 1: Provider, Beneficiary and Procedure Code Files to Support Model Implementation
- CMS CR 11896 - Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 2: FFS Payments and Other Claims-Based Adjustments
- CMS CR 11911 - Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 3: IURs and Edits for Non-Sequential Claims

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13534.1	CWF shall end date the original Appendix B referenced in the PCF SIP Payment Implementation CR with December 31, 2023, and utilize the updated PCF Appendix B Prohibited HCPCS Codes provided in the attachment to this CR for related PCF model CRs effective January 1, 2024.								X	
13534.1.1	CWF shall update the PCF Prohibited HCPCS Codes list (Appendix B). The following code must be removed from Appendix B: E/M Visits Complexity Add-on HCPCS Code G2211.								X	
13534.2	Contractors shall reprocess and accept claims for HCPCS complexity add-on code G2211 for claims with dates of service on or after January 1, 2024.		X							
13534.2.1	Contractors shall reprocess claims with Date of Service (DOS) on or after January 1, 2024, containing HCPCS add-on code G2211 for PCF model participants within 60 days.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

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: 1

Primary Care First (PCF)
Appendix B

Prohibited HCPCS Codes

HCPCS Codes	Service Type
99487	Chronic Care Management
99489	Chronic Care Management
99490	Chronic Care Management
99491	Chronic Care Management
99339	Home Care
99340	Home Care
G2212	Prolonged Evaluation & Management
99439	Chronic Care Management