**G2211 Information Sheet**

**Excerpts from the** [**2024 PFS Final Rule**](https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other) **(pages 78973-78974):**

We are finalizing changing the status of HCPCS code G2211 to make it separately payable by assigning it an ‘‘active’’ status indicator, effective January 1, 2024, as proposed.

Specifically, this add-on code is intended to characterize the base service (that is, O/O E/M visits) based on the kind of care being furnished (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) to better account for the inherent complexity of these visits that would otherwise be unaccounted for.

We note that the application of the add-on code is not based on the characteristics of particular patients (even though the rationale for valuing the code is based on recognizing the typical complexity of patient needs) but rather the relationship between the patient and the practitioner.

We clarify that it is the *relationship* between the patient and the practitioner that is the determining factor of when the add-on code should be billed. First, 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. For example, 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.

The second part of the add-on code also describes a *relationship* between the practitioner and patient, but for specific types of conditions. The add-on code describes ‘‘medical care services that are part of ongoing care related to a patient’s single, serious condition or a complex condition.’’ Again, the ‘‘ongoing care’’ describes a longitudinal relationship between the practitioner and the patient. In comparison to the previous example, though, this is specifically in reference to a single, serious condition or a complex condition. For example, 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.

We also note unequivocally that this code is not restricted to medical professionals based on particular specialties. Instead, it should be used by medical professionals, regardless of specialty, with O/O E/M visits (other than those reported with the –25 modifier) 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. We reiterate that when physicians and other practitioners provide care that serves as the continuing focal point for all needed healthcare services, they should report the inherent complexity add-on code along with all reasonable and necessary O/O E/M visits (not reported with the –25 modifier).

**Other**

2024 Medicare Reimbursement in North Carolina = $15.49

From MLN Matters Number: [MM13272](https://www.cms.gov/files/document/mm13272-edits-prevent-payment-g2211-office/outpatient-evaluation-and-management-visit-and-modifier.pdf)

Make sure your billing staff knows about complexity add-on code G2211:

• Medicare pays separately starting January 1, 2024

• We don’t pay when you report an associated O/O E/M visit with modifier 25

• We don’t pay Method II Critical Access Hospitals on the same encounter for type of bill 85X

**Info from: Fact Sheet:** [**Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits – Fact Sheet (cms.gov)**](https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf)

ADD-ON CODE FOR VISIT COMPLEXITY

Medicare established payment for 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, or complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)).

The Consolidated Appropriations Act delays PFS payment for this code until January 1, CY 2024 or later. Practitioners may report this code for qualifying visits furnished on or after January 1, 2021, although we assigned a PFS payment status indicator of “B” (Bundled) until 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.

• Reporting is not restricted based on specialty, but certain specialties will likely furnish these types of visits more than other specialties. HCPCS code G2211 may be reported with any visit level.

• Example 1: In the context of primary care, HCPCS code G2211 could recognize the resources inherent in holistic, patient-centered care that integrates the treatment of illness or injury, management of acute and chronic health conditions, and coordination of specialty care in a collaborative relationship with the clinical care team.

• Example 2: In the context of specialty care, HCPCS code G2211 could recognize the resources inherent in engaging the patient in a continuous and active collaborative plan of care related to an identified health condition the management of which requires the direction of a clinician with specialized clinical knowledge, skill and experience. Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals.

**Other Resources:**

[G2211: Coding Tips | AAFP](https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/evaluation-management/G2211-what-it-is-and-how-to-use-it.html)