

Medicare HCPCS Code G2211 Coding Guidance

Background:

With the release of the Calendar Year (CY) 2024 Medicare Physician Fee Schedule [final rule](#), the Centers for Medicare & Medicaid Services (CMS) finalized policy that allows payment for services described by HCPCS code G2211.

CODE DESCRIPTOR

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).

First proposed by CMS for implementation in CY 2021 and delayed by Congress for three years, HCPCS code G2211 was created to recognize the additional resource costs associated with providing care for a single or multiple complex or serious conditions for which the billing practitioner is or will become the “continuing focal point” for all the care required by the patient or all the care related to the condition(s). The code acknowledges the work and time involved in building a trusting patient-physician relationship and was created to capture work associated with “primary and longitudinal care that has been previously unrecognized and unaccounted for during evaluation and management visits.”

Guidelines for Using G2211:

- G2211 is an add-on code and may only be billed on claims with a new or established outpatient evaluation and management (E/M) service (99202-99215).
- Physicians and advanced practice providers can bill G2211.
- G2211 has been added to the lists of telehealth and audio-only services.
The most important factor in determining when to bill for services captured by G2211 is whether a longitudinal relationship exists or is being developed between the patient and the practitioner. It does not apply when the practitioner’s relationship with the patient is of a discrete, routine, or time-limited nature.
- G2211 may not be used when a procedure is performed on the same day, by the same practitioner, and **modifier -25** (*Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service is appended to the E/M service*) is appended to the E/M service.



- Any practitioner, regardless of specialty may bill for G2211 if medical documentation supports the use of the code.
- Team-based physicians (e.g., transplant teams) and physicians within the same group practice and with the same specialty designation may bill G2211 for the same patient.

G2211 should not be added to every claim billed for office/outpatient E/M services. Documentation and the relationship between the provider and the patient must support the use of the code.

Patients will be responsible for additional deductibles and coinsurance payments when this code is billed under the Medicare program.

Private payers such as Medicaid, Medicare Advantage, and commercial insurance companies are not required to pay for services associated with G2211 and coverage will vary.

Documentation:

- Document the outpatient E/M service, including medical necessity and time spent (if applicable).
- Consistent diagnosis coding is a crucial component of the documentation for G2211. CMS may review documentation in the medical record or claims history that shows the required patient and practitioner relationship, which may be indicated by consistent use of the same diagnosis over time.
- The practitioner's assessment and plan for the visit that includes clear direction and a care plan demonstrating patient return and continued care for the patient and/or condition.
- If the visit is unrelated to the treatment of an ongoing medical issue, the note should indicate that the patient is returning to the practice.
- Other service codes billed.

Clinical Example:

A 67-year-old woman with thyroid cancer is seen for a new patient visit. The endocrinologist examines the patient and develops a care plan to guide her cancer treatment. The appropriate new patient E/M service may be reported along with G2211 when appropriately documented.

Payment for G2211:

Work RVUs	Total RVUs	Estimated Payment
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0.33	0.49	\$16.04*
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**This amount will vary by geographic location and other factors.*