Introducing the G2211 add-on code

Useful when services are the continuing focal point for a patient's care

ARIA Academy | Coding Brief

About the Author

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Medical coding is crucial to reimbursements in the United States because it ensures that healthcare providers receive proper payment for the services they provide.

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Take advantage of G2211

0.33
Work RVUs

$16.04
CMS Payment Rate

A bright spot in the 2024 Physician Fee Schedule

G2211 by definition

By definition, the G2211 add-on code applies when the visit complexity is 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 a complex condition.

An add-on code, G2211 should be listed separately in addition to codes for office/outpatient evaluation and management visit, new or established.

- Must be used in addition to 99202 to 99205, 99211 to 99215 (Office/Outpatient)
- Can be provided as telehealth

- Not restricted to any specialty
- Can not be used when modifier 25 is appended to E/M code
- Used for Medicare and Medicare Managed Care

Suggested content for documentation

The coding community and healthcare providers continue to seek clear and comprehensive guidance on acceptable documentation for G2211.

The examples provided in CR 13452 are the only practical clues offered by CMS on what they expect of G2211 utilization. Medical coders/auditors advise healthcare providers to have patience as CMS publishes additional guidance and to have internal policies in place to avoid excessive use of the code G2211.

Focal point of care

G2211 applies to care that is the continuing focal point for all of a patient's required services, as reflected in the following examples:

- Updated medication list: prescription dates, dosage changes
- Identifying patient caregivers/healthcare providers and coordination made for patient care
- Maintaining preventative medicine: vaccines, screenings, routine testing, and counselings

Longitudinal relationships

A longitudinal relationship supports coding with G2211. With a longitudinal relationship, clinicians develop relationships with their patients over an extended period of time, as shown by:

- Complete history
- Accurate, updated problem list
- Treatment plans/goals for problem list
- Assessing Social Determinants of Health (SDOH)

Ongoing care related to a single, serious, or complex condition

When ongoing care is related to a single, serious, or complex condition, these services can be reflected in the notes to support use of the G2211 code. These services may include:

- Treatment goals, plan, and frequency of visits
- Monitoring medication and therapy efficacy

Although CMS uses language here to refer to "serious" or "complex" conditions, as of now, these terms have not been defined and are therefore open to a provider's interpretation.

Check your EHR system for tools to help you add G2211 as part of your standard workflow.

Additional Resources

Additional guidance on G2211 was published by CMS on Jan. 18, 2024, in MLN Matters, citing **Change Request (CR) 13473**.

This update includes a paragraph on documentation requirements and highlights medical necessity for the evaluation and management (E/M) visit for the provider to report using G2211.

Excerpt from CMS Manual System CR 13452

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 focal point for all needed services, such as a primary care practitioner, G2211 could be billed. Or, if the practitioner is part of ongoing care for a single, serious and complex condition, e.g. sickle cell disease, then G2211 can be billed.

References

CMS Manual System Pub 100-04 Change Request (CR) 13452 https://www.cms.gov/files/document/r12372cp.pdf

MLN Matters: Edits to Prevent Payment of F2211 Effective Date Jan. 1 2024

CMS Manual System Pub 100-04 Change Request (CR) 13473 https://www.cms.gov/files/document/r12461cp.pdf

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CR 13473 reiterates definitions from **CR 13452**, which went into effect on Jan. 1, 2024. CR 13473 updates the Medicare Claims Processing Manual Chapter 12-Physicians/Nonphysician Practitioners (Rev 12461: Issued 1-18-24). The update can be found in 30.6.7, paragraph F.

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