G2211

CodingIntel
AT THE CORNER OF CODING AND GETTING PAID

Recorded Dec 13, 2023

E/M G2211

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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)

CMS is adopting this code

E/M G2211

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- G2211 is an add-on code to office and other outpatient services, 99202–99215.
- CMS finalized that it may not be reported when modifier 25 is used on the E/M service on a day of a minor procedure.

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G2211

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Use when:

- CMS believes it will be used by primary care and other specialties who treat a single, serious condition or a complex condition with a consistency and continuity over a long period of time. CMS is emphasizing the longitudinal relationship between the practitioner and the patient.

Don't use when:

- "…E/M visit complexity add-on code would not be appropriately reported, such as when the care furnished during the O/O E/M visit is provided by a professional whose relationship with the patient is of a discrete, routine or time-limited nature…"

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"Longitudinal relationship"

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It's simple

- Does the practitioner have or intend to have a long term, ongoing relationship to care for the patient's conditions

What about prolonged care

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CMS doesn't prohibit billing prolonged care when using add-on code G2211

- Remember: prolonged care is about **additional time on the date** of the visit, and only on level 5 visits
- G2211 is for the additional time and **resources used between visits** to manage a care in the long term, calls, staff work, prescription renewals, referrals, etc., allowed on any level visit

CMS believes

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"E/M values still do not account for "for the resource costs associated with primary care and other longitudinal care of complex patients."

"We reiterated our belief that the O/O E/M visit complexity add-on reflects the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M office visit services that enable them 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 a patient's health care needs with consistency and continuity over longer periods of time. "

CMS believes

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"…coding and valuation of O/O E/M services that do not fully distinguish and account for resource costs for primary care and other longitudinal care for complex patients, but specifically for visits associated with longitudinal, non-procedural care when compared to work RVUs for procedural services and visits furnished in association with procedural-based care.

In other words, while many medical professionals rely on procedural codes with work RVUs that account – appropriately -- for their particular expertise and the intensity associated with their overall costs in furnishing care, the expertise of those who rely predominantly on E/M services to report their services is left relatively underrecognized within the previous and current E/M coding and valuation structure."

CMS believes

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"We recognize that many commenters, especially those concerned with budget neutrality- based payment reductions …."

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From the code definition

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"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."

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Don't report

"…visit is provided by a professional whose relationship with the patient is of a discrete, routine, or time-limited nature; such as, but not limited to, a mole removal or referral to a physician for removal of a mole; for treatment of a simple virus; for counseling related to seasonal allergies, initial onset gastroesophageal reflux disease; treatment for a fracture; and where comorbidities are either not present or not addressed, and/or when the billing practitioner has not taken responsibility for ongoing medical care for that particular patient with consistency and continuity over time, or does not plan to take responsibility for subsequent, ongoing medical care for that particular patient with consistency and continuity over time."

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Documentation: CMS is silent on this now

Verification will likely be based on

- Claims
- Diagnosis codes
- Specialty designation

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G2211

- Use with codes 99202—99215
- Have or intend to have a long term, on-going relationship with the patient
- Primary care: focal point for all needed services
- Other, non-procedural care: ongoing care for a single, serious condition or complex condition

Thank you

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