COSMOS
Navigate the Compliance Universe

# Report on Medicare Compliance Volume 33, Number 32. September 09, 2024
# CMS Sheds Light on G2211 Billing in New FAQs; 'No Magic Language' for Documentation

By Nina Youngstrom

In new guidance, CMS sheds light on when it's appropriate to bill for the complexity add-on code G2211 (or not), and in the process, has lent support to team-based care.[1] But CMS doesn't say much about documentation requirements for the add-on code in its new FAQs.

G2211 was activated in the 2024 Medicare Physician Fee Schedule (MPFS) rule. According to the rule, physicians and nonphysician practitioners are permitted to bill G2211 with their office or outpatient evaluation and management (E/M) visits (99202-99205 and 99211-99215) if 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." While the ongoing care must describe "a longitudinal relationship between the practitioner and the patient," a new patient visit can be billed with G2211 if it's the anticipated start of a longitudinal relationship.

Although the FAQs don't define "longitudinal relationship," they address other questions that have been floating around this year. "They have specifically delineated when it is not appropriate to use the code," said Martie Ross, a principal with PYA. The most significant demarcation line is between a one-time visit and an ongoing relationship or the prospect of one. "That's the test," she said.

But the FAQs provide "no magic language" that physicians should use to support the additional reimbursement from the add-on code, Ross said. "CMS auditors won't be looking for specific language within the visit for which G2211 is billed," she explained. "Instead, they're looking for the longitudinal record." For new patients, however, CMS expects to see documentation of the intent to establish a longitudinal relationship, which should be more specific, Ross said.

CMS noted it hasn't gone beyond the code definition in saying what should be in the medical records. "Our medical reviewers may use the medical record documentation to confirm the medical necessity of the visit and the patient care relationship as appropriate. We would expect that information included in the medical record or in the claims history for a patient/practitioner combination, such as diagnoses, the practitioner's assessment and medical plan of care, and/or other codes reported could serve as supporting documentation for billing HCPCS code G2211."

## Come One, Come (Almost) All

Ronald Hirsch, M.D., vice president of R1 RCM, appreciates when CMS clarifies the "nuances that come to light" with new codes and policies. The FAQs are useful for both providers and Medicare administrative contractors (MACs) who probably will audit claims with G2211. "The alternative, having each MAC develop their own rules, as we see with local coverage determinations, is not optimal," he said.

CMS has spelled out, for example, that physicians may use G2211 for services provided in outpatient hospital settings. "HCPCS code G2211 is separately payable to the billing physician or practitioner in both facility and non-facility settings and is not limited to any physician specialties," the FAQs state.

Copyright © 2024 by Society of Corporate Compliance and Ethics (SCCE) & Health Care Compliance Association (HCCA). No claim to original US Government works. All rights reserved. Usage is governed under this website's Terms of Use.

That may come as a surprise to some practitioners. “It was initially thought that G2211 was only applicable for patients seen in the office setting,” Hirsch explained. “But this clarification from CMS that G2211 can be used for certain hospital visits is financially significant for providers. Both hospitalists and specialists have a large volume of hospital visits to patients classified as outpatients where the appropriate E/M visit codes 99202-99215 fall into those eligible for use of G2211.”

Because there aren’t additional documentation requirements, Hirsch said it’s worth the extra effort for the billing staff to review the FAQs and develop a process to add the code when applicable. Reimbursement for G2211 is about $16.31 (the national payment rate)—an extra 10%-17% that more than compensates for proposed 2025 E/M payment cuts, he noted.

## ‘They Like Team-Based Care’

As the FAQs reinforce, CMS is encouraging use of the add-on code, Ross said. It’s a way to even the reimbursement playing field between E/M services and procedures. Auditors probably won’t nitpick the reporting of the code except when it’s used with a new patient visit because it’s based on a longitudinal relationship. “You would have to look at the history of the patient. It doesn’t sound easy to audit,” Ross noted. Audits could focus, however, on whether physicians tacked on G2211 for a patient who was seen for a one-time problem (e.g., mole removal).

The FAQs also evince CMS’s support for team-based care. CMS addresses whether physicians and practitioners would “have an ongoing relationship with a patient care team within the group practice that includes more than one physician or practitioner. We understand it is possible that team-based care practices may also serve as the continuing focal point for all needed services or provide ongoing care for a single, serious condition or a complex condition. In such circumstances when a patient sees another physician or practitioner in a team-based care practice, and if all other requirements of HCPCS code G2211 are met, it may be appropriate to report HCPCS code G2211.”

It's significant that G2211 doesn’t attach to a single National Provider Identifier, Ross said. “CMS policy has been pretty clear,” she noted. “They like team-based care.” Even when services are provided incident-to the physician, a group practice is permitted to bill G2211. “The language is general in the FAQs, but what they’re saying is, if it’s team-based care, it’s not ‘my patient. It’s our patient.’ It’s the practice’s patient and the patient can see any of the doctors.”

CMS steered clear of defining “longitudinal” relationships beyond what’s already on record, although the FAQs essentially explained what doesn’t count as a longitudinal relationship: “HCPCS code G2211 is not appropriate when the billing practitioner has not taken responsibility for ongoing medical care for a given 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.”

CMS was more forthcoming about the expectations of longitudinal relationships in a January open door forum, Ross said.[2] She would have liked to see more in the FAQs because applying the concept may not be that easy in real-world situations.

## A Wider Berth for Modifier 25

The FAQs reiterate that CMS plans to tweak its policy on the use of modifier 25 with G2211. Although this year CMS denies payment of the add-on code when claims have E/M visits with modifier 25, CMS has proposed in the 2025 MPFS rule to pay for G2211 when it’s reported by the same practitioner on the same day as an annual wellness visit, vaccine administration or any Medicare Part B preventive service provided in the office or

Copyright © 2024 by Society of Corporate Compliance and Ethics (SCCE) & Health Care Compliance Association (HCCA). No claim to original US Government works. All rights reserved. Usage is governed under this website’s Terms of Use.

outpatient setting.

Unfortunately, the FAQs didn't address G2211 in the context of urgent care, Ross said. This matters because it's becoming more common for primary care practices to open urgent care centers next door and staff them mainly with NPPs. Often, the patient is a stranger when they show up at the urgent care center, although the primary care practice hopes to establish a long-term patient relationship, she explained. Still unanswered is whether that's accomplished when the first encounter is at the urgent care center.

The FAQs did confirm a few things. For example, "no specific diagnosis is required for HCPCS code G2211 to be billed." Also, CMS doesn't pay rural health clinics and federally qualified health centers for G2211 because services described by the add-on code are bundled into their encounter-based rate.

Contact Ross at mross@pyapc.com and Hirsch at rhirsch@r1rcm.com.

1 Centers for Medicare & Medicaid Services, "Frequently Asked Questions (FAQs) About Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-On HCPCS Code G2211," accessed September 5, 2024, https://go.cms.gov/3AMkRCa.
2 Nina Youngstrom, "Key G2211 Definition Is in 'Eye of the Beholder,' Complicating Compliance; FAQs Are Coming," *Report on Medicare Compliance* 33, no. 12 (April 1, 2024), https://bit.ly/3yWvIJc.

**This publication is only available to subscribers. To view all documents, please log in or purchase access.**

Purchase Login

Copyright © 2024 by Society of Corporate Compliance and Ethics (SCCE) & Health Care Compliance Association (HCCA). No claim to original US Government works. All rights reserved. Usage is governed under this website's Terms of Use.