Using the New CMS G2211 Code

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Beginning January 1, 2024, there is a new G code that can be used for Medicare claims. In the 2024 Final Physician Fee Schedule Rules, G2211 can now be used as an add-on code to Evaluation and Management Services (E&M) but only in certain cases. At this time, G2211 CANNOT be reported with 92002-92014 codes. While CMS is rather vague about the details of when this code can be utilized, there are some general guidelines for the G2211 applications.

> **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 does not make any restrictions on which specialties can utilize this new code. In the MedLearn Article MM13473, CMS states that G2211 can be used by any provider who can bill E&M Codes. This code is an add-on code to account for the additional resources required for those primary care providers who coordinate all of a patient's health care services needs. As well, the G2211 code can be used to account for the "inherent complexity of [visits] … derived from the longitudinal nature of the practitioner and patient relationship" for providers who continue rendering medical care for any patient's single, serious condition, or complex condition. Further CMS states: "The complexity is in the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. There's important cognitive effort of using the longitudinal doctor-patient relationship itself in the diagnosis and treatment plan. These factors, even for a simple condition …make the entire interaction inherently complex." CMS makes it clear that the patient condition itself does not necessarily indicate how complex the care might be in reality.

For eye care providers, the G2211 should be used when the care of the patient requires ongoing and continued monitoring of serious condition such as glaucoma, AMD, or other conditions that requiring long term monitoring and care considerations. Typically, this code would not be used for acute care conditions expected to resolve such as acute infections. And remember that G2211 cannot be reported with General Ophthalmologic Examination codes 92002-92014.

There are a few other factors of which to be aware.

1. CMS will NOT reimburse G2211 if paired with any CPT® that is not considered an E&M Code (99202-99215, 92002-92014) such as OCT, Fundus photos, Visual Fields, any surgical procedures
2. The G2211 code cannot be billed with any procedure along with an E&M Code with the Modifier -25 attached. CMS explains this decision with the following statement: "Separately identifiable visits occurring on the same day as minor procedures, such as zero-day global procedures, have resources sufficiently distinct from the costs associated with providing stand-alone [E&M] visits to justify different payment. "

The documentation for the E&M code should demonstrate both the medical necessity and the E&M code choice; however, there are no additional documentation requirement for the G2211 code to be used (MM13272). CMS states that auditors will use the following when determining if the G2211 was properly applied.

- Medical record documentation demonstrating the medical necessity and E&M code choice
- Information included in the medical record or in the claims history for a patient/practitioner combination, such as diagnoses
- The practitioner's assessment and plan for the visit
- Other service codes billed

The normal patient copayments and deductibles will apply to the G2211. Novitas reimbursement for participating providers is $15.21 for 2024.

When deciding whether to use the add-on code G2211 along with an E&M code (not with 92002-92014) consider your long-term relationship with the patient as well as the implications, morbidity and mortality of the patient's condition. Ensure your documentation supports your care of the patient which should NOT be routine and/or time-limited in nature. Another Resource here and here. Happy Coding…