E-BRIEF SERIES

Healthicity

Mastering G2211: Strategies for Effective Documentation and Billing

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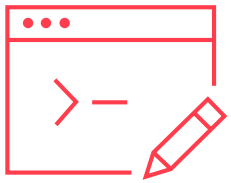
2024 brought a lot of changes to the medical coding and reimbursement world. In January, we highlighted some of the changes in our New Year, New Coding Changes webinar.

Some of the most frequently asked questions during that webinar were about HCPCS code G2211, when to report it and required documentation. Though the code was not brand new in 2024, it would be the first time Medicare would reimburse the service separately. Previously, the code was in a status of not separately reimbursable. But as of January 1, 2024, its Medicare, national payment rate is $16.05.



The codes full description reads:

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)

A lot of medical coders and auditors are asking, "What does this code mean?" Some are confused about the first phrase, "Visit complexity inherent to evaluation and management." They may ask themselves, if it is inherent to the evaluation and management (E/M), why is it reported separately?

The CMS Physician Fee Schedule Final Rule has a lengthy discussion about the purpose, intent, expected use of and many other questions and responses related to the G2211code. For those looking for deeper details, read pages 78968-78975 in the final rule here: https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

But to summarize, CMS believes that this code should reflect the time, intensity, and practice expense resources involved when practitioners furnish the kinds of office, outpatient 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.

Interestingly though, the code is not restricted only to primary care specialties. CMS has provided a couple patient encounter examples where it might be appropriate to report G2211. Both of these examples, along with other guidance for using this code, can be found in Medicare's MLN Matters (MM) 13473 here: **https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf**

EXAMPLE 1:

A patient sees you, their primary care practitioner, for sinus congestion. You may suggest conservative treatment or antibiotics for a sinus infection. You decide on the course of action and the best way to communicate the recommendations to the patient in the visit. How the recommendations are communicated is important in that it not only affects the patient's health outcomes for this visit, but it also can help build an effective and trusting longitudinal relationship between you and the patient. This is key so you can continue to help them meet their primary health care needs. The complexity that code G2211 captures isn't in the clinical condition – the sinus congestion. 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 an important cognitive effort of using the longitudinal doctor-patient relationship itself in the diagnosis and treatment plan. These factors, even for a simple condition like sinus congestion, make the entire interaction inherently complex. In this example, you may bill G2211.

EXAMPLE 2:

A patient with HIV has an office visit with you, their infectious disease physician. The patient tells you they've missed several doses of HIV medication in the last month because you're part of their ongoing care and have earned their trust over time. You tell them it's important not to miss doses of HIV medication, while making the patient feel safe and comfortable sharing information like this with you in the future. If you didn't have this ongoing relationship with the patient and the patient didn't share this with you, you may have decided to change their HIV medicine to another with greater side effects, even when there was no issue with the original medication. Because you're part of ongoing care for a single, serious condition or a complex condition such as HIV, and have to weigh these types of factors, the E/M visit is more complex. In this example, you may bill G2211.

CMS is careful to point out that use of the code should not be based on the characteristics of particular patients, but rather the relationship between the patient and practitioner.

Specifically, they write in the final rule that has been previously referenced:

"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. First, the "continuing focal point for all needed health care services" describes a relationship between the patient and the practitioner, when the practitioner is the continuing focal point for all health care services that the patient needs."

There are restrictions on the use of G2211. For example, it is an "add on" code, which means it can never be reported alone. However, it is also not allowed to be reported with just any code. When the circumstances meet the coding definition and requirements, G2211 is only to be used as an add on code with an E/M code from the ranges 99202-99205 or 99211-99215. In addition, this code is not to be reported in an encounter where modifier -25 is being used. CMS, in the MM 13473, states "*we'll deny payment for code G2211 on the same date of service as an O/O E/M visit (codes 99202-99205, 99211-99215) reported with modifier 25, for the same patient by the same physician or nonphysician practitioner.*"

As coders and auditors already know, documentation in the medical record will be essential for supporting reporting of this code. Again, from MM 13473, CMS provides the following guidance as it relates to documentation:

You must document the reason for billing the O/O E/M visit. The visits themselves would need to be medically reasonable and necessary for the practitioner to report G2211. In addition, the documentation would need to illustrate medical necessity of the O/O E/M visit. We haven't required additional documentation. Our medical reviewers may use the medical record documentation to confirm the medical necessity of the visit and accuracy of the documentation of the time you spent. These items could serve as supporting documentation for billing code G2211:

- *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*

CONCLUSION:

It is no doubt that use of this code, its volume, and the medical specialties reporting it most frequently will be monitored by CMS and enforcement agencies. As the history of medical coding and auditing has shown, it is likely that future government audits and settlements will guide future guidance for coders, auditors, and practitioners on what exactly they should, and should not do related to code G2211.

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CJ Wolf is a highly regarded healthcare professional with more than 20 years of experience in revenue cycle management, practice management, compliance, coding, billing, auditing, and client services. He is a nationally recognized compliance thought leader who has published numerous articles and resources and has been featured at national conferences and events.

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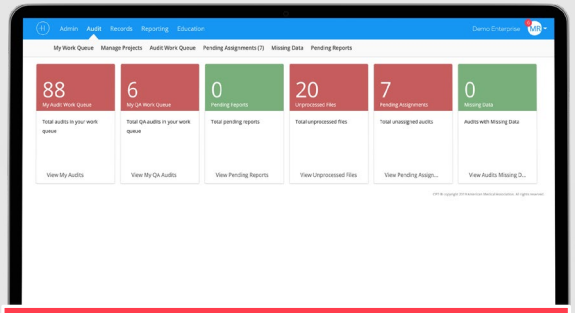

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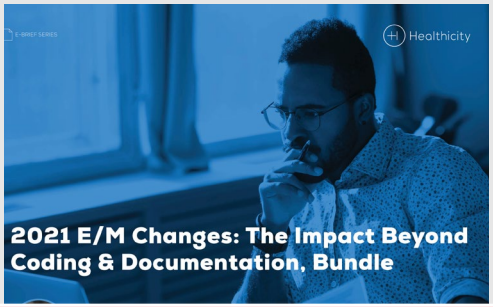

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