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How to Properly Use the G2211 Evaluation and Management Code

By CJ Wolf

Recently, we posted about compliance risks associated with improper Evaluation and Management (E/M) Coding

Well, as of January 1, 2024, there's a new risk in town. Code G2211, which can be added to specific E/M codes under certain circumstances, is now separately reimbursable by Medicare. Because it's so new as a separately reimbursable service, many compliance, coding, and auditing professionals wonder what it's all about.

As a starting point, let's note the code descriptor. It 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)*

Here are a few tips for appropriately reporting this code:

- G2211 is an "add-on" code. By definition, add-on codes cannot be reported alone and typically can only be reported with certain other codes. In the case of G2211, it is allowable to be reported (when all criteria are met) with the office, outpatient evaluation, and management codes from the series 99202-99205 or 99211-99215. In other words, G2211 cannot be reported with the many other E/M code series such as 99281-99285 for emergency department visits or 99304-99310 for nursing facility visits.

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- G2211 cannot be reported when modifier -25 is being appended to an E/M code. The Centers for Medicare and Medicaid Services (CMS) will deny payment for code G2211 on the same date of service as an office or outpatient E/M visit reported with modifier -25 for the same patient by the same physician or nonphysician practitioner.

- The use of this code is about the relationship, not the patient's medical condition. CMS has clarified that the relationship between the patient and the practitioner determines when the add-on code should be billed. The "continuing focal point for all needed health care services" language in the code descriptor describes this relationship.

- Accurate documentation in the medical record is going to be key. The documentation must contain the reason for billing the office/outpatient E/M code, and the visit itself needs to be medically necessary. Compliance, coders, and auditors need to make sure the documentation demonstrates and closely ties to the explanation found in the code descriptor. Other supporting documentation for G2211 may include: information included in the medical record or in the claims' history for a patient/practitioner combination, such as diagnoses; the practitioner's assessment

Since G2211 is being reimbursed separately for the first time in 2024, compliance professionals should be aware of its use. Medical coders and auditors are often the eyes and ears for medical record documentation as it pertains to E/M coding. Keeping up to date on the requirements for compliant reporting of this code is essential. These tips will help, and will provide more comprehensive learning and understanding of the code.

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