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Understanding the New Medicare G2211 Code

Guidance from the American College of Rheumatology
Updated: December 6, 2024

For calendar year (CY) 2024, the Centers for Medicare and Medicaid Services (CMS) finalized a new add-on code G2211 for outpatient office visits to acknowledge the complexity of care for services related to ongoing care, for a patient's singular chronic or complex condition. The ACR strongly supported the creation of G2211 and led advocacy efforts for the code to be implemented in 2024.

The Healthcare Common Procedure Code (HCPCS) G2211 is defined as, "Visit complexity inherent to evaluation and management (E/M) 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." This Medicare-specific add-on code is identified primarily for primary care providers and those delivering chronic care to patients, including rheumatology care providers, who meet the coding criteria.

Currently there are no specific documentation or diagnosis requirements from CMS for providers to utilize this new code other than the fact that a longitudinal relationship with the patient must exist. Below are some key questions and answers to provide current guidance for G2211:

Q. When will HCPCS code G2211 be implemented?
A. CMS began reimbursing for code G2211 on January 1, 2024.

Q. Should code G2211 be used only for new patients?
A. No, it is an add-on code that can be listed separately in addition to office/outpatient E/M visits for new or established patients (i.e., codes 99202-99215).

Q. Will code G2211 be covered by other third-party payers?
A. G2211 was created specifically for use on Medicare claims; therefore, there is no guarantee that payers other than Medicare will reimburse for this code.

Q. Can providers bill G2211 with a procedure on the same day as an E/M visit?
A. For calendar year 2025, CMS is allowing providers to be billed modifier -25 when the underlying evaluation and management (E/M) service is performed on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.

Q. Who will decide which condition is complex for G2211 and are there criteria for it?
A. In response to what constitutes a serious or complex condition, CMS has not defined descriptions of a complex patient for G2211 and says no specific diagnosis is required to bill with the add-on code. CMS states, "It does require a continuous and active collaborative plan of care related to an identified health condition – the management of which requires the direction of a practitioner with specialized clinical knowledge, skill, and expertise."

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Q. Can two providers of different specialties bill the add-on code on the same date of service?

A. CMS has provided additional guidance and stated that in this scenario providers will need to consider whether the patient could have an ongoing relationship with a patient care team within a group practice. In such circumstances, if a patient sees another provider in a team-based care practice, and all the billing requirements of G2211 are met, it may be appropriate to report G2211 separately.

Q. Will providers be able to assign an E/M code with G2211 and any of the prolonged service codes?

A. CMS has not addressed the use of G2211 with prolonged codes or given any guidance if the add-on code may or may not be billed on the same day.

Q. Can add-on code G2211 be used with a telehealth visit?

A. CMS added G2211 to the permanent telehealth list, so it is believed that providers should be able to use the code even for an E/M carried out via telehealth.

Q. Are there specific documentation guidelines for G2211?

A. CMS has not specified any additional medical record documentation requirements for reporting the HCPCS code G2211 add-on code. But they have stated that medical reviewers "may use" documentation to confirm the medical necessity of the visit and the patient care relationship. CMS expects that information "in the medical record or in the claim's 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."

Q. What is the reimbursement for G2211?

A. Based on the conversion factor (CF) for 2024 and work relative value units (wRVUs) and national GPCI, the approximate reimbursement will be around **$16.08**. While CMS is proposing to implement G2211, they do caution providers that establishing payment for the add-on code will have redistribution impact, with an increase in revenue for specialties who will use the code more versus a decrease for specialties less involved with outpatient office visits due to the budget neutrality requirement. The ACR strongly advocated for CMS to implement the G2211 add-on code and continues to work to ensure Congress supports safeguarding the resources needed to provide the best and most appropriate treatment for rheumatology patients.

CMS also provided examples of visits for which reporting code G2211 would **not** be appropriate, such as:

- Care furnished by a professional whose relationship with the patient is of a discrete, routine, or time-limited nature (e.g., mole removal or referral for mole removal)
- Counseling related to seasonal allergies
- Initial-onset gastroesophageal reflux disease
- Treatment for a fracture
- Treatment in which comorbidities are either not present or not addressed

- Situations in which the billing professional has not taken responsibility for ongoing medical care for that patient with consistency and continuity over time, or does not plan to take responsibility for subsequent, ongoing medical care for that patient with consistency and continuity over time

For questions or additional information on coding and billing for the new add-on code, contact the ACR practice management team at practice@rheumatology.org.

Coding Scenarios for G2211

Editor's note: *Case vignettes presented are created to illustrate documentation of coding with G2211. They are not intended to represent the full medical record of a case.*

Scenario 1 – Established Patient with rheumatoid arthritis and gout

A 60-year-old established male patient with a history of rheumatoid arthritis and chronic gout of his right ankle and foot, without tophi complains of mild swelling and pain in arms and legs. His pain severity is at a 5 on a 10-point scale and last states the pain lasts for 15–20 minutes while getting dressed.

CPT codes: 99214, G2211

This visit represents an established relationship with whom the provider is providing ongoing longitudinal care related to serious conditions and/or complex conditions.

Scenario 2 – Evaluation for Systemic Lupus Erythematous

A 25-year-old female patient is seen in the office today after her PCP requested a consultation for a possible diagnosis of systemic lupus erythematous (SLE). The patient presents with muscle pain in both legs with a pain level of 8 out 10. She states she has throbbing, usually at the end of the day, that lasts for one to two hours. She is constantly fatigued even when she gets the proper amount of sleep. She complains of hair loss. She states she developed a rash on her cheeks and her right arm, and the rash is worse if she is out in the sun. She says these symptoms began about six months ago. She takes ibuprofen to ease muscle pain. She has no joint pain or swelling, no eye problems, chest pain, respiratory symptoms, or GI or GU problems. She has had no infections and has not traveled. She does not smoke and drinks no alcohol.

Medically appropriate history and examination performed. MDM is a high complexity level visit.

CPT codes: 99205, G2211

This visit represents a new patient relationship with whom the provider will provide ongoing longitudinal care related to the patient's single, serious condition, or complex condition.

Scenario 3 – Established Patient with Osteoarthritis

A 68-year-old female Medicare patient with a diagnosis of primary osteoarthritis of the left knee returns for her third injection in a series of knee injections. She denies fevers or any rashes but complains of a pain in her shoulder due to a fall while playing tennis. The provider completes a medically appropriate history and exam and requests an x-ray. No swelling or redness noted, the patient was advised to take naproxen for pain and to call the office if pain persists. Her left knee was injected with 2 mL of

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hyaluronic acid under aseptic technique without complications. Due to her weight and her fixed left knee flexion of 13º, the injection was performed with ultrasound guidance. A permanent picture of the injection point was added to the patient's medical chart.

CPT codes: 99213-25, 20611-LT

The pain in shoulder is not deemed a long-term chronic condition at this visit. Also, according to CMS guidelines, the outpatient E/M complexity code G2211 is not payable when reported with modifier -25.