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Reporting code G2211 may increase payment for services that focus on maintaining patient relationships

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When it comes to code sets in health care, Current Procedural Terminology (CPT) and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) are talked about the most. The Healthcare Common Procedure Coding System (HCPCS) usually is mentioned only in relation to reporting medication and supplies.

However, it's important for physicians and other health care professionals to be aware of this code set, especially the codes used for reporting professional services that aren't supported by CPT codes.

HCPCS codes are designed and maintained by the Centers for Medicare & Medicaid Services (CMS). Although any health plan can recognize and pay for these codes, they are used more commonly by Medicare and Medicaid.

Office or other outpatient E/M visit complexity

The CMS developed code **G2211** in 2020 for implementation on Jan. 1, 2021: 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 (add-on code, list separately in addition to office/outpatient E/M visit, new or established patient).

The aim of G2211 is to identify the increased level of complexity in two types of relationships. The first is a medical home, which involves establishing a long-lasting relationship with a patient for the purpose of

providing primary medical care. The second is subspecialty care, which involves providing ongoing care focused on a single, serious condition or a complex condition such as asthma or diabetes mellitus.

G2211 is reported in addition to office and other outpatient E/M services. This add-on code is not based on the characteristics of particular visits, but rather on the relationship between the patient and the physician or other qualified health care professional (QHP). Pediatric physicians and QHPs should report the code if it is appropriate, as it may increase payment for services that focus on building and maintaining long-term relationships with patients.

However, not all insurance companies or Medicaid plans pay for the code yet, which provides an opportunity for advocacy by AAP chapters and their pediatric councils, and the Payer Advocacy Advisory Committee. On the national level, the AAP is in communication with large commercial payers to advocate for coverage and payment of G2211.

In 2023, the CMS announced its intention to cover Medicare benefits for code G2211 for services provided on or after Jan. 1, 2024. Medicare has limitations on the reporting of G2211. The code cannot be reported with an E/M service if modifier 25 (significant and separately identifiable E/M service) is applied to the related E/M code. This means that physicians and QHPs cannot report G2211 if they also perform immunization and medication administration or minor procedures on the same date as the related E/M service.

Vignette 1

A primary care physician serves as the medical home for a patient who seeks treatment for otitis media. In addition to addressing the presenting problem and the patient's overall health status, the physician reviews and addresses gaps in recommended preventive care during the visit.

The physician reports the office E/M service code and G2211. As described by the CMS, the complexity captured by code G2211 is not due to the clinical condition itself (otitis media) but to the cognitive load of the continued responsibility of being the focal point for all of this patient's health care needs.

Vignette 2

During a follow-up appointment, a cardiologist examines an adolescent who has an atrial septal defect. The patient is not experiencing any symptoms. The cardiologist counsels the patient and parents on symptoms that should prompt them to seek immediate medical care or call the office, and addresses the patient’s and parents’ concerns and questions. The cardiologist then reports an office E/M code and G2211.

Key points

- Code G2211 can be reported for any office or other outpatient E/M visit level (i.e., **99202-99215**), except when another service is provided on the same date and modifier 25 is added to the E/M code.
- The total relative value unit assigned to G2211 is 0.49. The national payment rate in 2024 is $16.04.
- Code G2211 can be reported by any primary care clinician or pediatric specialist, including members of the same group practice who treat the same patient.
- Code G2211 captures the complexity of a patient's visit that is part of maintaining an ongoing patient relationship, either for overall health care needs or care for a single, serious condition or complex condition.

Resources

- AAP fact sheet on code G2211 including FAQs

- Information from the CMS on how to use code G2211