ENDOCRINE SOCIETY
Hormone Science to Health

G2211 Complex Care Code
Q&A Document

- Q: The definition of a high complexity follow-up code is essentially impossible to reach in endocrinology based on complexity, only possible with at least 40 minutes spent on the visit, per a Medicare audit. How can we be sure not to get dinged by Medicare if they don't consider a thyroid nodule or hypothyroidism as a serious condition?
    - A: CMS did not define serious condition and there are no time requirements for use of G2211. When you bill an outpatient evaluation and management (E/M) code, you should determine whether to bill the G2211 add-on code based on the nature of your relationship with the patient. Should you have a long term relationship with the patient or note that you are developing a care plan and will form a longitudinal relationship, you should bill G2211 code along with the outpatient visit.

- Q: Is this also to recognize all of the contact and care that goes on between office visits when there is a serious chronic condition?
    - A: CMS believes that there is work that is not captured by the outpatient E/M codes, associated with the care required when a patient and practitioner have a long-term relationship; the add-on code is meant to capture that work. There are other codes available to bill that may reflect specific work that occurs between visits.

- Q: If care is provided in conjunction with an NP in which case visits are alternatively with NP and MD in the same practice, can this code be used since either provider is not the sole caregiver for the chronic condition?
    - A: Yes, this add-on code can be used when two practitioners—physicians and APPs—in the same practice deliver care to a patient.

- Q: Are commercial plans covering this code? For patients with Medicare as a secondary? The limitation to not use with CGM code $35 is a huge carveout.
    - A: Medicare is the only payer required to reimburse for G codes. At this point, we do not know to what extent other payers (Medicaid, commercial insurers) are reimbursing for it. Many health systems are encouraging practitioners to bill it for all of their patients whenever it applies.

- Q: If an NP chooses not to follow up, would CMS reclaim later?
    - A: The nature of the practitioner and the patient is determinative in billing G2211 with an outpatient E/M service. There is no specific follow-up requirement for the code. CMS is looking for the existence of a care plan being implemented by the

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practitioner and whether the patient returns to see the practitioner or another member of the practice.

- Q: The information I saw specifically excluded treatment for a fracture. Treating someone with osteoporosis and fracture would be ongoing care of a serious condition. Is this excluded the same way insulin was excluded in medical decision making from being "drug therapy requiring intensive monitoring"?
    - A: On its own, treating a fracture may be considered an acute episode, and therefore G2211 cannot be billed. However, if the practitioner has been treating a patient for osteoporosis, and therefore has an ongoing relationship with the patient, G2211 could be billed with an outpatient E/M code when the patient presents with a fracture. The relationship between the practitioner and the patient is determinative.

- Q: Is there a time restriction in between visits that it can be billed again by the same provider?
    - A: There are no time requirements or restrictions associated with the use of G2211.

- Q: Can you bill the code with a single diagnosis, or do you need to associate with multiple diagnoses?
    - A: There is no minimum number of diagnoses required to bill G2211. The relationship between the practitioner and the patient is determinative, not the number of diagnoses.

- Q: Is G2211 applicable to telephone visits? I tried to bill for a telephone visit today and got an error message that it is not applicable.
    - A: G2211 can only be billed with new and established outpatient E/M services: 99202-99205 and 99212-99215. It can be added to a claim when the outpatient E/M service is delivered virtually or by telephone.

- Q: Is obesity considered a serious condition?
    - A: CMS has not defined "serious" conditions. Demonstrating an ongoing practitioner-patient relationship and the development and implementation of a care plan should be considered when determining whether to bill G2211.

- Q: If you see a patient in conjunction with a surgeon (for example, thyroid cancer) and you both order labs, can you use this code?
    - A practitioner who is assuming ongoing care and management for a patient with thyroid cancer can bill G2211 in conjunction with an outpatient E/M code

associated with their cancer care. There is no limit on how many practitioners can bill this code concurrently if the code's requirements are met.

- Q: Do you expect the bill for the patient to go up when this code is billed?
    - A: Patients will be responsible for additional coinsurance for this code when it is billed in conjunction with an outpatient E/M code.

- Q: Do I have to use modifier 25 for this code?
    - A: Modifier 25 is not required when billing G2211 along with an outpatient E/M service.

- Q: How can you bill as complex with 99212, as it is not complex? Can you use with 95251?
    - A: G2211 can only be billed in conjunction with outpatient E/M services, 99202-99205 and 99212-99215). The ongoing relationship or intent to form an ongoing relationship is determinative when determining whether to bill the add-on code, not the outpatient E/M service code level.

- Q: Can a PA use this code?
    - A: Yes, PAs and other advanced practice practitioners can bill for this code.

- Q: If an insurance company denies it now, can this change throughout the year, or if they deny it now should we assume they will deny it for all of 2024?
    - A: Medicare is the only payer required to pay for G2211 and other G codes. Many institutions are recommending that practitioners bill G2211 with all their relevant outpatient E/M services. We recommend that you check with your billing department on how to proceed and what payers other than Medicare may reimburse for the add-on code.

- Q: Should we be adding a standard disclaimer or attestation in our notes to cover that we are addressing complex and longitudinal care?
    - A: CMS may review documentation in the medical record or claims history that shows the required patient and practitioner relationship. The notes should indicate the practitioner's assessment and plan for the visit that includes clear direction and a care plan demonstrating patient return and continued care for the patient and/or condition. If the visit is unrelated to the treatment of an ongoing medical issue, the note should indicate that the patient is returning to the practice.

- Q: Can this code be used for pediatric patients on Medicaid?

- A: We recommend checking with your billing department about whether your state Medicaid program is reimbursing G2211. Medicare is the only payer required to reimburse G2211.

- Q: When is modifier 25 used?
  - A: Modifier 25 is used to indicate that a patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond that associated with another procedure or service being reported by the same physician or other qualified health care professional (QHP) on the same date.

- Q: It seems like we could potentially use this for almost every Medicare patient, is that correct?
  - A: Yes, this can be used in all instances when you have an ongoing relationship with the patient.

- Q: Do any modifiers other than 25 prevent this code from being used?
  - A: No, modifier 25 is the only modifier CMS listed that prevents billing of G2211.

- Q: Does this code need to be linked to a particular diagnosis addressed during the visit, or EM visit as a whole, when we are billing?
  - A: Consistent diagnosis coding is a crucial component of the documentation for G2211 as it demonstrates a longitudinal relationship between the practitioner and the patient. CMS may review documentation in the medical record or claims history that shows the required patient and practitioner relationship, which may be indicated by consistent use of the same diagnosis over time.

- Q: Can we use this code if other services (i.e. ECG) are done at the time of the office visit?
  - A: Other services may be billed with the outpatient E/M code and G2211 if modifier 25 is not required.

- Q: Can you bill this on the final visit with a patient, before you return them to their PCP, if their condition is now well controlled or if they plan to move?
  - A: Yes, this can be billed with the final outpatient E/M services as long as the practitioner and patient have had an ongoing relationship up until this point.

- Q: Do providers earn RVUs when they bill G2211? How many?

Work RVUs	Total RVUs	Estimated Payment
0.33	0.49	$16.04