Jurisdictions J/M Part B Office/Outpatient Evaluation and Management Visit Complexity (HCPCS G2211) Webinar

Kathy Boehm
Senior Provider Relations Representative

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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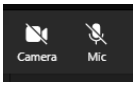

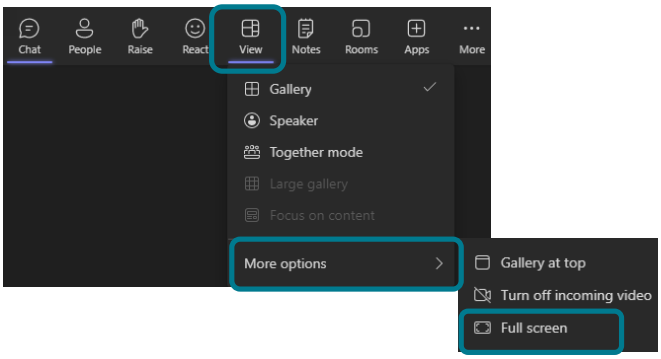

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Agenda

- Definition, Background, and Billing Guidelines
- Resources and Reminders

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Background, Definition, and Billing Guidelines

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HCPCS Code Description

G2211: Short description: Office and Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on Code G2211

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 or outpatient E/M visit, new or established.)

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Background

- Effective January 1, 2024, CMS changed the status of HCPCS code G2211 (Office Outpatient Evaluation Management [O/O E/M] visit complexity add-on code) from a bundled (B) status indicator to an active (A) status indicator
- With a status indicator of A, the code is separately payable as an additional payment to the payment of O/O E/M visit primary service codes to better account for additional resources of visits associated with:
  - **Serving as the continuing focal point for all of the patients' health care services needs; and**
  - **Ongoing medical care related to a patient's single, serious condition, or complex condition**

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Why the New Code?

- CMS indicates, G2211 captures the inherent complexity of the visit that's derived from the longitudinal nature of the practitioner and patient relationship and should be a covered Medicare service
- Code is separately payable (when applicable) for dates of service January 1, 2024, and after
- Patient coinsurance and deductible apply to this code

Why the New Code? Continued

G2211 includes services enabling practitioners to build longitudinal relationships with all patients (not only those patients who have a chronic condition or single, high-risk disease) and to address most patients' health care needs with consistency and continuity over longer periods of time.

MM13473 — How to Use the Office and Outpatient Evaluation and Management Visit Complexity Add-on Code G2211

Who Can Bill HCPCS G2211?

O/O: Outpatient or Office
E/M: Evaluation and Management

- All medical professionals who can bill office and O/O E/M visits (CPT® codes 99202 – 99205, 99211 – 99215), regardless of specialty, may use the code with O/O E/M visits of any level.
  - Questions about denials received when billed by your specialty should be directed to the provider contact center
  - Palmetto GBA just opened this code to podiatrist when all other criteria has been met
  - Palmetto GBA is considering one other provider specialty that is currently restricted at this time

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When to Use G2211

- Think about the relationship between you (performing provider) and the patient
- Consider billing HCPCS code G2211 when all of the criteria is met and:
  - **You're the continuing focal point for all needed services, like a primary care practitioner**
  - **You're giving ongoing care for a single, serious condition or a complex condition, e.g., sickle cell disease or HIV**

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Example 1

- You see the patient as 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.**

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Example 1 Continued

- The complexity that HCPCS 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 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 HCPCS code G2211.

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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 need to weigh these types of factors, the E/M visit is more complex. In this example, you may bill G2211.

When Not to Use HCPCS G2211

O/O: Outpatient or Office
E/M: Evaluation and Management

- The Final Rule finalized that G2211 cannot be billed with an O/O E/M visit that is itself focused on a procedure or other service instead of being focused on longitudinal care for all needed healthcare services, or a single, serious or complex condition
  - **G2211 (Complexity add-on) will be denied when you report an associated O/O E/M visit, codes 99202 – 99205 or 99211 – 99215, with modifier 25 for the same patient by the same practitioner**

- Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule | CMS
- Outpatient-evaluation-and-management-visit-and-modifier.pdf

CMS Received and Responded to Comments on the Proposed Rule Regarding CPT® Modifier – 25

*"We thank commenters for raising these concerns and offering suggestions on how we might refine the policy. First, we are clarifying that modifier **– 25** is reported in instances where the physician or practitioner billing the O/O E/M is the same one who is billing the significant separately identifiable procedure or other service on the same day…."*

Federal Register: CY 2024 Payment Policies Under the Physician Fee Schedule, Section F, 2, A and B

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Key Factors

- Important information used to determine whether or not the add-on code can be billed: the relationship between the practitioner and the patient
- G2211 captures the inherent complexity of the visit that's derived from the longitudinal nature of **the practitioner and patient relationship**
- The practitioner should be:
  - **Serving as the continuing focal point for all of the patients' health care services needs**
  - **Providing ongoing medical care related to a patient's single, serious condition, or complex condition**

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Key Factors Continued

- **Relationship:** CMS clarifies that it is the relationship between the patient and the practitioner for specific types of conditions that is the determining factor of when the add-on code should be billed
- **"Ongoing care"** describes a longitudinal relationship between the practitioner and the patient
  - **"Medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition"**

Reminder of HCPCS Code Description

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 or outpatient E/M visit, new or established.)

Documentation

O/O: Outpatient or Office
E/M: Evaluation and Management

- 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 be reimbursed for the O/O E/M service and the reported add-on code HCPCS code G2211**
  - **Documentation must illustrate the medical necessity of the O/O E/M visit**
- Additional documentation does not need to be submitted with the claim **but** must be retained and available for submission if requested
- 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

Documentation Requirements

- These items could serve as supporting documentation for billing HCPCS code G2211:
  - **Information included in the medical record or in the claim's history for a patient/practitioner combination, such as diagnoses or other documentation to support medical necessity of the O/O E/M service**
  - **The practitioner's assessment and plan for the visit**
  - **Other service codes billed**
  - **What does that "patient-provider" relationship look like in the records?**

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Resources and Reminders

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Reminders

- The most important information used to determine whether the add-on code could be billed is the **relationship between the practitioner and the patient**
- If the practitioner is the focal point for all needed services, such as a primary care practitioner, the HCPCS G2211 add-on code could be billed
- Or, if the practitioner is part of ongoing care for a single, serious **or** complex condition (e.g., sickle cell disease), then the add-on code could be billed
- The add-on code captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship
- HCPCS code G2211 can't be billed when the O/O E/M services is billed with the CPT® modifier 25

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Reminders Continued

- If your provider specialty is receiving denials indicating your specialty is not eligible to bill the new code, contact the provider contact center
- While documentation is not required to be submitted with your claim, you must maintain the necessary documentation and make it available if requested

Unpacking Common Appeal Requests

- Requests to appeal HCPCS code G2211 denials when the claim contained an O/O E/M with the CPT® modifier 25
- Appeal requests for an O/O E/M code (without the CPT® modifier 25), other services, and HCPCS code G2211 billed together. The E/M denied as not paid separately on the same day as another service based on global surgery rules. The providers' appeals are to add the CPT® modifier 25 in an attempt to get all three services paid
- Appeal requests to change diagnosis code when HCPCS code G2211 denied as routine service based on submitted ICD-10

Resources

- MM13272 — G2211 and Modifier 25
- MM13473 — How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211
- MM13452 — CY 2024 Physician Final Rule Summary
- Modifier 25 Fact Sheet

PECOS

- Supports Medicare Provider and Supplier enrollment process
- Allows registered users to securely and electronically submit and manage Medicare enrollment information

Have you updated PECOS?

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FACEBOOK

Follow us on Facebook to learn about upcoming events and ask us general questions

X (TWITTER)

#StayConnected on X for quick access to news and information

YOUTUBE

Go to YouTube for educational videos, tips and strategies

LINKEDIN

LinkedIn is your source for the latest Palmetto GBA news

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Customer Experience Survey

Overall, how satisfied are you with your MAC?

- ☐ Extremely satisfied
- ☐ Somewhat satisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Extremely dissatisfied

How likely are you to recommend our education to a colleague or peer?

Extremely likely

0 1 2 3 4 5 6 7 8 9 10

Not at all likely

Not Satisfied | Satisfied

Survey Link and QR Code

https://tinyurl.com/59rcpztv

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