G2211

CMS will pay for add-on code G2211, effective 1-1-2024.

- G2211 (definition below) is an add-on code to office and other outpatient services, 99202–99215.
- CMS believes it will be used by primary care and other specialties who treat a single, serious condition or a complex condition with a consistency and continuity over a long period of time. CMS is *emphasizing* the longitudinal relationship between the practitioner and the patient.
- Providers billing the add-on code are expected to provide longitudinal care to the patient.
  - Providers who do not intend to have an ongoing longitudinal relationship with the patient (e.g., urgent care, consultants, second opinions, etc.) should not bill G2211.
- Bill G2211 in conjunction with an office or other outpatient evaluation and management (E/M) service.
- Add-on code G2211 may be billed with telehealth services.
- Do not bill G2211 when the E/M service is reported with modifier 25 for a procedure rendered by the same provider.
- Do not bill G2211 when chronic/complex conditions are documented but not considered or addressed in the evaluation/management of the patient.

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)*

Stay within the guardrails
CMS did not assign utilization or frequency limits for the code, but that isn't permission to add it to every visit. "I also want to throw a caution flag out there. You have to make sure that, again, you're meeting all of the criteria for the base [E/M] for this to be applicable," Shickle explained.

"You have to think about the relationship between … the provider and the patient," she emphasized and encouraged practices to review the examples CMS created for physicians and qualified health care professionals (*see resource, below*).

Whether the treating practitioner oversees all the patient's care or treats one serious or complex condition, "[CMS's] guidance on utilizing this code is emphasizing the importance of the longitudinal relationship," Shickle said.

Base documentation standards on auditor expectations.

Use Medicare's guidance on what auditors want to see when you create a template or build a compliance policy for G2211, Shickle advised.

Here are the types of information auditors will look for in your charts, and that you should see when you conduct an internal review:

- Medical necessity of the primary E/M code.
- Accuracy of the documentation for the E/M code, making clear whether it was coded based on medical decision-making (MDM) or time.
- "Things in your record to substantiate the longitudinal relationship," Shickle added, providing more details about what auditors might be looking for:
    - Overall claims data.
    - The diagnosis or diagnoses for the visit.
    - Your assessment and plan for the visit.
    - Other service codes that you may be billing at the same time.

The documentation for each visit that includes G2211 should tell the complete story of the patient/provider relationship and the additional work the provider performed. When that information isn't there, don't add G2211 to the visit.

You should also remind staff that reporting the E/M code with modifier **25** (significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) will automatically trigger a denial, Shickle warned.

2 more questions and answers for training

Question: *Urgent care clinics report codes 99202-99215. Can clinic providers report G2211?*

Answer: No. "If you think about it, those are visits or situations where those providers are not really forming those longitudinal relationships with their patients. And they're not taking responsibility for overall care. So, if you can't demonstrate that in the patient's medical record then, adding the codes would not be appropriate," Shickle said.

Question: *Can providers of different specialties within a multispecialty practice report G2211 for the same patient?*

Answer: "According to the CMS rules, the answer for that is yes," Shickle said. "Meeting the criteria, making sure that the relationship is there, making sure those providers are responsible for the overall medical care for those patients for those conditions [is key]." As is solid documentation, Shickle explained. "But in those types of scenarios, I think it's absolutely appropriate," she concluded.

Resource

• How to use the office & outpatient evaluation and management visit complexity add-on code G2211: *www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf*

G0136

CMS (Centers for Medicare & Medicaid Services) estimates that approximately 50% of an individual's health is directly related to social determinants of health (SDOH).

In broad terms, SDOH is "economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context, which includes factors like housing, food and nutrition access, and transportation needs" (CMS Final Rule, p. 344).

CMS has established a code for the assessment of SDOH:
G0136 -- Administration of a standardized evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.

- Not a screening service but an assessment tool (not to be done on all Medicare patients as screening)
- Triggered by provider believing the patient has SDOH needs that are interfering with the diagnosis or treatment of a condition
- Can be done on the day of an E/M service (office visit) excluding 99211 (nurse visit)
- May be done at Medicare annual wellness visit (initial or subsequent but not Welcome to Medicare)
- No cost to the patient if done at Medicare annual wellness visit
- May be completed at hospital discharge visits, however, CMS expects follow-up visits (outpatient or TCM) to try and meet identified SDOH needs
- Must document the SDOH needs in the record; diagnosis codes for these are in ICD-10 categories Z55-Z65 (include in top 12 visit diagnoses so they reach the payer)

Examples of SDOH Diagnosis Codes (not a comprehensive list):
Z550 Illiteracy and low-level literacy
Z551 Schooling unavailable and unattainable
Z552 Failed school examinations
Z553 Underachievement in school
Z554 Educational maladjustment and discord with teachers and classmates
Z555 Less than a high school diploma
Z556 Problems related to health literacy
Z558 Other problems related to education and literacy
Z559 Problems related to education and literacy, unspecified
Z560 Unemployment, unspecified
Z561 Change of job
Z562 Threat of job loss
Z563 Stressful work schedule
Z564 Discord with boss and workmates
Z565 Uncongenial work environment
Z566 Other physical and mental strain related to work
Z5681 Sexual harassment on the job
Z5682 Military deployment status
Z5689 Other problems related to employment
Z569 Unspecified problems related to employment
Z570 Occupational exposure to noise
Z571 Occupational exposure to radiation
Z572 Occupational exposure to dust
Z5731 Occupational exposure to environmental tobacco smoke
Z5739 Occupational exposure to other air contaminants
Z574 Occupational exposure to toxic agents in agriculture

Z575 Occupational exposure to toxic agents in other industries
Z576 Occupational exposure to extreme temperature
Z577 Occupational exposure to vibration
Z578 Occupational exposure to other risk factors
Z579 Occupational exposure to unspecified risk factor
Z586 Inadequate drinking-water supply
Z5881 Basic services unavailable in physical environment
Z5889 Other problems related to physical environment
Z5900 Homelessness unspecified
Z5901 Sheltered homelessness
Z5902 Unsheltered homelessness
Z5910 Inadequate housing, unspecified
Z5911 Inadequate housing environmental temperature
Z5912 Inadequate housing utilities
Z5919 Other inadequate housing

"An SDOH risk assessment without appropriate follow-up for identified needs would serve little purpose." CMS Final Rule, p. 346
"We continue to believe that follow-up or referral is an important aspect of following up on findings from an SDOH risk assessment."

Further information can be found on pages 5 and 6 of MLN booklet.
https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

G0447

Obesity Behavioral Therapy Counseling – Face to Face behavioral counseling for obesity 15 minutes.

Frequency: (Up to 22 visits in a 12 month period)

First Month: 1 face to face visit every week

Months 2-6: 1 face to face visit every other week

Months 7-12: 1 face to face visit every month if patient meets criteria

Cover patients with Obesity (BMI greater than or equal to 30 kg per meter squared)

Proper documentation is important when billing for this code. Documentation should look similar to below.

"15 minutes spent with patient discussing lifestyle modifications and diet to affect weight loss. Discussed healthy diet as well as low-fat, low-cholesterol diet. Reviewed Plant Based diet with patient. Discussed exercise options with attention to patient's abilities. Encourage walking at least 45 minutes 5 days a week if physically able. Reviewed healthy options with less sugars and carbohydrates. Encouraged smaller meals at evening meal. All questions answered to patient's satisfaction today."

Further information, including policy for use of G0447, can be found at :
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R142NCD.pdf