REVIEWS IN UROLOGY

Coding Corner: Healthcare Common Procedure Coding System Code G2211, Visit Complexity Inherent to Evaluation and Management

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Introduction

For this issue, we reviewed the Healthcare Common Procedure Coding System (HCPCS) level 2 code G2211. Though the code has existed for a few years, Medicare began reimbursing physicians for reporting the code in January 2024. The code is used to describe the complexity of an evaluation and management (E&M) visit associated with an ongoing, longitudinal care relationship, focusing on a circumstance rather than a specific service. The circumstance described in this code differs from the prolonged services described by *Current Procedural Terminology (CPT)* codes 99358 through 99418; the case management services described by *CPT* codes 99366 through 99368; and the chronic care management services described by *CPT* codes 99490, 99491, and 99437 through 99489:

> ***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).*
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> *—Source: CMS Manual System Pub 100-04 Medicare Claims Processing (https://www.cms.gov/files/document/r12461cp.pdf)*

Healthcare Common Procedure Coding System code G2211 is a crucial component of medical billing in that it acknowledges the complexities of managing the health of patients with severe or complex conditions. As health care shifts toward value-based care models, understanding the nuances of such billing enhancements becomes critical for specialists, including urologists.

The definition of HCPCS code G2211 encompasses visit complexity inherent to E&M services. It is associated with medical care, which is the focal point of all necessary health care services. It also applies to medical care services that are part of ongoing care for a patient's single, serious, or complex condition. Notably, G2211 is an

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add-on code listed as an addition to a new or established outpatient's office E&M visit.

The Evolution of HCPCS Code G2211

When it was released in 2021, HCPCS code G2211 was expected to be used extensively, across all Medicare specialties. Estimates initially suggested nearly a 3% drop in the conversion factor for that year.

Following its announcement of the proposed rule, Medicare received extensive feedback, much of it negative and from surgical specialties. Though the rule was designed to provide additional revenue for primary care, this development came at the expense of surgical fields, leading to considerable debate among disciplines.

Despite these challenges, the code was included in the final rule, signaling Medicare's intention to proceed with its implementation. In a last-minute decision, though, the US Congress intervened and postponed the implementation of HCPCS G2211 until January 1, 2024. Since its introduction, this code has been incorporated into HCPCS but was barred from active use until the beginning of 2024.

The Evolved Code G2211 Prioritizes Clinician-Patient Relationships

There have been subtle yet notable shifts in the focus of code G2211 since its conception and planned implementation in 2021. The design of the code initially targeted practice expenses experienced mostly by primary care clinicians caring for patients with long-term, chronic conditions. Revisions leading up to the code's enactment in 2024, though, suggested a pivot away from a practice expense. Code G2211 now functions as an academic and intellectual code, building relationships between and among the health care team, the practice, and the patient. This focus on building relationships recognizes that specialists, not just primary care clinicians, provide integrated long-term care. It was also determined that HCPCS G2211 could not be billed if an E&M code was used with modifier 25.

One of Medicare's strategic objectives is enhancing chronic care management in a manner that reduces hospital admissions, historically the most substantial cost factor in health care. This objective aligns with insights from early initiatives in value-based care, demonstrating that substantial cost savings are achieved by keeping patients out of expensive care facilities. The implementation of G2211 aligns with this objective by incentivizing physicians to invest more time in building relationships with their patients through a modest increase in E&M reimbursement codes. As such, patients will ideally be more likely to contact their physician directly for issues that might otherwise lead them to the emergency department.

This shift in focus is particularly relevant for specialists such as urologists.

SUMMARY OF MAIN POINTS

- Code G2211 should be used in an outpatient office setting only.
- Code G2211 should be used as an add-on code with *CPT* codes 99202 through 99215 for office or other outpatient services.
- Do not report the code when using modifier 25 with the E&M code.
- Clinicians must have an ongoing relationship with their patients to use code G2211; the point of the code is to improve care management and health outcomes.
- The clinician should be the primary health care professional for the ongoing or chronic condition for which the patient is seen at this E&M visit.
- Conditions and diagnoses that may be relevant to the use of this code (case dependent; list not intended to be all inclusive) include prostate, bladder, kidney, and ureteral cancer; BPH; urinary incontinence; recurrent urinary tract infection; and recurrent nephrolithiasis or urolithiasis.

ABBREVIATIONS

BPH	benign prostatic hyperplasia
CPT	*Current Procedural Terminology*
E&M	evaluation and management
HCPCS	Healthcare Common Procedure Coding System

As outlined in the final rule, building a trusting relationship is crucial; patients with such connections are more likely to experience better health outcomes. They are more inclined to contact their clinician with health concerns, adhere to treatment recommendations, and engage more fully with their health care plan. This inherent value of G2211 emphasizes its contrast with scenarios in which patients receive care from unfamiliar clinicians in urgent care settings, in which the absence of a relationship may hinder treatment adherence and trust. The code's revised interpretation highlights how sustained relationships can enhance adherence to medical and surgical therapies.

Medicare has substantially reinforced both this approach and the value of an established patient-clinician relationship. The program has specified that even if a patient's new health concern is unrelated to their chronic condition, use of HCPCS code G2211 remains justified. For example, a urologist managing a patient's prostate cancer would still apply code G2211 when addressing unrelated issues, such as flank pain. This process is predicated on the belief that advice from a trusted health care professional is more likely to be followed even for conditions that may not require long-term management. Medicare, recognizing the trust between patient and clinician, therefore encourages continuity in patient care across different health issues within the same specialty.

When a specialty clinician such as a urologist is treating an acute condition, they are more likely to provide better recommendations than would a clinician who does not see the patient regularly. They have an established rapport with the patient and understand how to treat the acute condition in the larger context of a chronic condition.

The Appropriate Use of Code G2211

It's important to note that this code is intended for office use only, not in an ambulatory surgical center or hospital setting, even if the clinician sees the same patients in different settings. This code is used as an add-on during an office-based E&M service.

In urology, the most straightforward applications of HCPCS code G2211 involve cancer care, including bladder, kidney, and prostate cancers. These conditions fit within the code's framework. The code is also pertinent to benign prostatic hyperplasia (BPH), urinary incontinence, and recurrent conditions such as urinary tract infections and kidney stones. These are everyday issues for urologists for which ongoing advice and care are crucial to maintaining patient health; thus, they are well suited to the application of code G2211.

Urinary concerns such as urinary urgency and incontinence substantially affect a patient's quality of life and self-worth. These chronic conditions align perfectly with the intent behind code G2211. The examples from the Centers for Medicare & Medicaid Services illustrate that our patient management strategies are in complete alignment with this code's intended use.

There are situations, however, in which G2211 might not be appropriate in the urology outpatient setting. An illustrative example in which G2211 does not apply can be seen in an initial gastroenterology visit for gastroesophageal reflux disease, in which symptoms may hint at a long-term care scenario, but the diagnostic and follow-up relationship is not established in a manner consistent with G2211's requirements. A similar situation in urology occurs during a patient's initial visit for a nonrecurrent urinary tract infection or an isolated episode of gross hematuria. Although symptoms are present, there is neither an established chronic disease state nor planned coordination of ongoing care. The same principle applies to cases such as acute, singular kidney stones, in which the treatment goal is immediate resolution rather than long-term management.

Knowing when to apply HCPCS code G2211 is not always cut and dry, as in the case of second opinions. Patients who are seen for second opinions and who are unlikely to be seen again would not meet the requirements to bill for code G2211. When a patient who has requested a second opinion states a

preference for the clinician who provided the second opinion, however, the G2211 code would apply. In these situations, asking the patient whether they will be returning to their initial clinician is reasonable. Though it may not be detrimental to occasionally miss the opportunity to apply code G2211, doing so frequently could become problematic.

Reimbursement of Code G2211

Reimbursement strategies and ensuring adequate compensation are crucial in medical practice management. The annual adjustment of the conversion factor by Medicare, which is designed to be budget neutral, had major implications at the beginning of 2024. A 3.3% reduction in the conversion factor was expected, influenced partly by the introduction of HCPCS code G2211, which accounted for approximately a percentage point of this reduction. Legislative adjustments through the Consolidated Appropriations Act mitigated this impact, revising the cut to approximately 1.67%.[1] Despite this adjustment, a substantial portion of the reduction is attributed to code G2211.

This add-on code, particularly given the volume of applicable patients within urology, serves as a mechanism to recoup some of the financial losses associated with the conversion factor reduction. Code G2211 currently offers a reimbursement of approximately $16.05 per applicable office visit under Medicare Part B.[2] This revenue stream is vital, especially considering that no corresponding increases in the conversion factor have been observed over the years, even as operational costs have continued to rise. When all factors are considered, this code effectively returns reimbursement to 2023 levels.

It is important to note that in addition to Medicare, several private payers and Medicare Advantage plans have begun to recognize this code. Though this recognition is not yet universal, it is crucial because it affects the broader applicability of HCPCS code G2211 across insurance platforms, enhancing the financial sustainability of practices that heavily engage with these patient demographics.

Medicare has established specific rules for the use of code G2211 to incentivize practices to focus on long-term, high-quality care. Understanding and adhering to these regulations is important not only in terms of compliance but also because they are critical measures when it comes to improving patient care. Proper reporting and documentation are critical as they ensure that practices are prepared for potential audits and are capitalizing on the opportunities G2211 provides to enhance reimbursement and patient outcomes.

Consistent and correct application of HCPCS code G2211 ensures that the code's benefits are fully realized, supporting its overarching goal of advancing health care quality through improved patient relationships and care continuity.

Documentation and Team Guidance for Code G2211

Effectively documenting patient-clinician relationships is crucial. In practice, many clinicians adeptly record the essence of these relationships without explicitly labeling them as such. Through comprehensive history taking and physical examinations, the care provided to patients with chronic conditions is often well documented. Although not all clinicians opt to add specific statements about their care relationships, those who do believe it enhances their protection against potential audits. This methodological variance reflects the personal style and legal cautiousness of each clinician.

The challenge extends to how auditing teams are instructed to interpret such documentation. As review practices have evolved, the clinical narrative typically offers clear evidence of ongoing care, particularly when plans for follow-up visits are documented. Ambiguities arise, though, in scenarios such as a clinician advising a patient with a recurrent health concern such as BPH or kidney stones to "call if problems arise." This phrasing may not sufficiently demonstrate the clinician's intent to maintain a long-term care relationship. To address this gap, we've

started implementing guidelines to ensure that documentation reflects a continuous care intention, such as noting ongoing management plans for BPH during visits for related symptoms such as flank pain. These documentation practices are crucial for establishing a clear and defendable patient care trajectory in medical records.

It is easier to justify or explain elements of patient care to an auditor if those elements are clearly documented, so it is better to include such information in the patient's medical notes if there is any uncertainty. This additional information is not overdocumentation; instead, it ensures that the documentation accurately reflects the work performed and the existing relationship between the clinician and the patient.

Modifier 25 and Code G2211

Understanding the relationship between modifier 25 and HCPCS code G2211 is vital to the code's correct application. In urology, for instance, scenarios often arise in which a patient may undergo a same-day cystoscopy or receive an intramuscular injection of a cancer medication, necessitating the use of modifier 25. It is important to note, however, that when modifier 25 is used, G2211 cannot also be applied. This restriction was implemented to prevent overcompensation because the clinician is fully compensated for the E&M visit and any additional procedures that day by the modifier.

The decision to restrict code G2211 in cases in which modifier 25 is used stems from Medicare's efforts to balance the budget impact of this new coding process. The logic, detailed in the *Federal Register*,[3] articulates that if an E&M service and a related procedure are billed on the same day, the comprehensive care is sufficiently accounted for, negating the need for additional G2211 compensation. Though not universally popular, this approach reflects a compromise intended to maintain the financial integrity of health care reimbursement systems.

This approach may seem restrictive, but it is crucial to adhere to these guidelines because they align with broader aims to enhance patient care through well-structured reimbursement strategies. Adherence ensures that high-quality care is provided and documented, fulfilling the dual goals of patient satisfaction and clinician compliance with Medicare standards.

Since the introduction of HCPCS code G2211, private insurers have responded in a variety of ways. Some have aligned their policies with Medicare, while others have fluctuated, initially denying but later accepting G2211 claims. This variety of responses highlights the need for ongoing vigilance in practice management to ensure that changes in billing practices are closely monitored and appropriately adjusted. Medicare may issue further guidance, however, so staying informed on policy updates is essential for all health care professionals.

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