

# Understanding the Evaluation and Management Add-on Complexity Code

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## PRACTICE POINTS

- The add-on code G2211 went into effect on January 1, 2024, and can be applied to outpatient evaluation and management visits that fulfill certain criteria.
- This code should be utilized when one is serving as the continuing focal point for all of the patient's health care needs or providing ongoing medical care related to a patient's single, serious or complex condition.

On January 1, 2024, the new add-on complexity code for evaluation and management (E/M) services, G2211, went into effect. Understanding appropriate use of this code and how it can and cannot be utilized is of importance for all physicians. This article discusses the nuances of this code and gives examples of how to effectively incorporate it into practice.

On January 1, 2024, a new add-on complexity code, G2211, was implemented to the documentation of evaluation and management (E/M) visits.<sup>1</sup> Created by the Centers for Medicare & Medicaid Services (CMS), G2211 is defined as “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, or complex condition.”<sup>2</sup> It is an add-on code, meaning that it must be listed with either a new or established outpatient E/M visit.

G2211 originally was introduced in the 2021 Proposed Rule but was delayed via a congressional mandate for 3 years.<sup>1</sup> It originally was estimated that this code would be billed with 90% of all office visit claims, accounting for an approximately \$3.3 billion increase in physician fee schedule spending; however, this estimate was revised

with its reintroduction in the 2024 Final Rule, and it currently is estimated that it will be billed with 38% of all office visit claims.<sup>3,4</sup>

This add-on code was created to capture the inherent complexity of an E/M visit that is derived from the longitudinal nature of the physician-patient relationship and to better account for the additional resources of these outpatient E/M visits.<sup>5</sup> Although these criteria often are met in the setting of an E/M visit within a primary care specialty (eg, family practice, internal medicine, obstetrics/gynecology, pediatrics), this code is not restricted to medical professionals based on specialties. The CMS noted that “the most important information used to determine whether the add-on code could be billed is the relationship between the practitioner and the patient,” specifically if they are fulfilling one of the following roles: “the continuing focal point for all needed health care services” or “ongoing care related to a patient's single, serious and complex condition.”<sup>6</sup>

Of note, further definitions regarding what constitutes a single, serious or complex condition have not yet been provided by CMS. The code should not be utilized when the relationship with the patient is of a discrete, routine, or time-limited nature. The resulting care should be personalized and should result in a comprehensive, longitudinal, and continuous relationship with the patient and should involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.<sup>6</sup>

Herein, 5 examples are provided of scenarios when G2211 might be utilized as well as when it would not be appropriate to bill for this code.

## Example 1

A 48-year-old man (an established patient) with a history of psoriasis and psoriatic arthritis presents to a dermatologist for follow-up. The dermatologist has been managing both conditions for 3 years with methotrexate.

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The patient's disease is well controlled at the current visit, and he presents for follow-up of disease activity and laboratory monitoring every 3 months. The dermatologist continues the patient on methotrexate after reviewing the risks, benefits, and adverse effects and orders a complete blood cell count and comprehensive metabolic panel.

*Would use of G2211 be appropriate for this visit?—Yes,* in this case it would be appropriate to bill for G2211. In this example, the physician is providing longitudinal ongoing medical care related to a patient's single, serious or complex condition—specifically psoriasis and psoriatic arthritis—via managing methotrexate therapy.

### Example 2

Let's alter the previous example slightly: A 48-year-old man (an established patient) with a history of psoriasis and psoriatic arthritis presents to a dermatologist for follow-up. He is being followed by both a dermatologist and a rheumatologist. The patient is on methotrexate, which was prescribed by the rheumatologist, who also conducts the appropriate laboratory monitoring. The patient's skin disease currently is well controlled, and the dermatologist discusses this with the patient and advises that he continue to follow up with rheumatology.

*Would use of G2211 be appropriate for this visit?—No,* in this case it would not be appropriate to utilize G2211. In this example, the dermatologist is providing longitudinal ongoing medical care; however, unlike in the first example, much of the ongoing medical care—in particular the management of the patient's methotrexate therapy—is being performed by the rheumatologist. Therefore, although these conditions are serious or complex, the dermatologist is not the primary manager of treatment, and it would not be appropriate to bill for G2211.

### Example 3

A 35-year-old woman (an established patient) presents to a dermatologist for follow-up of hidradenitis suppurativa. She currently is receiving infliximab infusions that are managed by the dermatologist. At the current presentation, physical examination reveals several persistent active lesions. After discussing possible treatment options, the dermatologist elects to continue infliximab therapy and schedule a deroofing procedure of the persistent areas.

*Would use of G2211 be appropriate for this visit?—Yes,* in this example it would be appropriate to utilize G2211. The patient has hidradenitis suppurativa, which would be considered a single, serious or complex condition. Additionally, the dermatologist is the primary manager of this condition by prescribing infliximab as well as counseling the patient on the appropriateness of procedural interventions and scheduling for these procedures; the dermatologist also is providing ongoing longitudinal care.

### Example 4

Let's alter the previous example slightly: A 35-year-old woman (an established patient) presents to a

dermatologist for follow-up of hidradenitis suppurativa. She currently is receiving infliximab infusions, which are managed by the dermatologist. At the current presentation, physical examination reveals several persistent active lesions. After discussing possible treatment options, the dermatologist elects to perform intralesional triamcinolone injections to active areas during the current visit.

*Would use of G2211 be appropriate for this visit?—No,* in this case it would not be appropriate to bill for G2211. Similar to Example 3, the dermatologist is treating a single, serious and complex condition and is primarily managing the disease and providing longitudinal care; however, in this case the dermatologist also is performing a minor procedure during the visit: injection of intralesional triamcinolone.

Importantly, G2211 cannot be utilized when modifier -25 is being appended to an outpatient E/M visit. Modifier -25 is defined as a "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."<sup>7</sup> Modifier -25 is utilized when a minor procedure is performed by a qualified health care professional on the same day (generally during the same visit) as an E/M visit. Therefore, G2211 cannot be utilized when a minor procedure (eg, a tangential biopsy, punch biopsy, destruction or intralesional injection into skin) is performed during a visit.

### Example 5

A 6-year-old girl presents to a dermatologist for a new rash on the trunk that started 5 days after an upper respiratory infection. The dermatologist evaluates the patient and identifies a blanchable macular eruption on the trunk; the patient is diagnosed with a viral exanthem. Because the patient reported associated pruritus, topical triamcinolone is prescribed.

*Would use of G2211 be appropriate for this visit?—No,* in this case it would not be appropriate to bill for G2211. A viral exanthem would not be considered an ongoing single, serious or complex condition and would be more consistent with a discrete condition; therefore, even though the dermatologist is primarily managing the disease process, it still would not fulfill the criteria necessary to bill for G2211.

### Final Thoughts

G2211 is an add-on code created by the CMS that can be utilized in conjunction with an outpatient E/M visit when certain requirements are fulfilled. Specifically, this code can be utilized when the dermatologist is the primary provider of care for a patient's ongoing single, serious or complex condition or serves as the continuing focal point for all of the patient's health care needs. Understanding the nuances associated with this code are critical for correct billing.

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