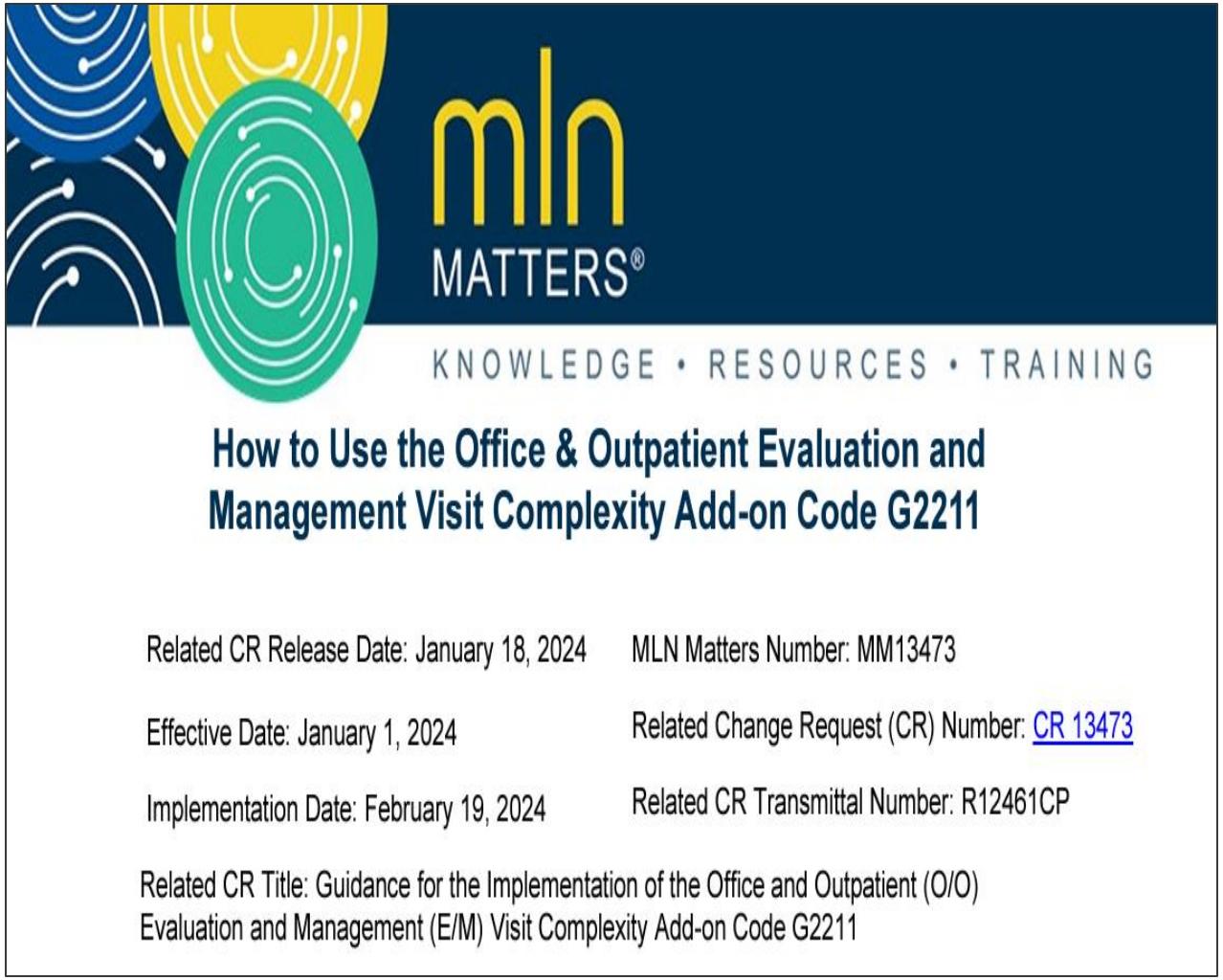
Coding Training and Education Material

Complexity Add On G2211

What is G2211?

CMS Definition

- Effective 1/18/2024 G2211 is considered payable by CMS and serves as the continuing focal point for all patient's health care needs.
- Ongoing medical care related to a patients single, serious condition or complex condition.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How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211

Related CR Release Date: January 18, 2024

Effective Date: January 1, 2024

Implementation Date: February 19, 2024

MLN Matters Number: MM13473

Related Change Request (CR) Number: CR 13473

Related CR Transmittal Number: R12461CP

Related CR Title: Guidance for the Implementation of the Office and Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on Code G2211

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When Do I use G2211

CMS Coding Guidance

- Think about the relationship between you and the patient when deciding to bill G2211.
- Bill G2211 if:
  - 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, like sickle cell disease or HIV

When Do I use G2211

CMS Coding Guidance Case Example

- A patient sees you, 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.
- The complexity that 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 G2211.**

When Do I use G2211

CMS Documentation Guidance

- You must document the reason for billing the O/O E/M visit and visits need to be medically reasonable and necessary for the practitioner to report G2211. CMS doesn’t require additional documentation.
- Our 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.
- These items could serve as supporting documentation for billing code G2211:
  - Information included in the medical record or in the claim's history for a patient/practitioner combination, such as diagnoses
  - The practitioner’s assessment and plan for the visit
  - Other service codes billed Patient Coinsurance and Deductible

A1C Screening Order Set

Billing for A1C during Annual Wellness

Hemoglobin A1C on Screening

Medicare covers blood glucose (blood sugar) laboratory test screenings (including the Hemoglobin A1C test, and other tests with or without a carbohydrate challenge) if a patient is at risk for developing diabetes. Coverage is limited to 2 test per 12 months, once every six months.

Qualified screenings risk factors:

- High blood pressure (hypertension) **ICD 10 [I10 -I1A.0]**
- History of abnormal cholesterol and triglyceride levels (dyslipidemia) **ICD 10 [E78-E78.01]**
- Obesity **ICD 10 [E66- E66.9]**
- History of high blood sugar **ICD 10 [R73, Z86.39]**

Part B also covers these screenings if 2 or more of these conditions apply:

- 65 or older
- Family history of diabetes (parents or siblings). **ICD 10 [Z83.3]**
- History of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than 9 pounds. **ICD 10 [Z86.32]**

https://www.medicare.gov/coverage/diabetes-screenings

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STI Screening Policy

STI Testing Policy Guidelines

Reimbursement for Infectious agent detection by nucleic acid assays for the detection of Sexually Transmitted Infections

Plans will reimburse for the following services for Sexually Transmitted Infections (STIs) in men and women:

- Single Tests:
  - 87491 Chlamydia *(closes the quality measure- can not be billed with either of the codes below and creates a denial and reconciliation issue that could increase cost for your office)*
  - 87591 Gonorrhea
  - 87661 Trichomonas vaginalis
- Comprehensive Test:
  - 87801 Infectious agent, multiple organisms (closes the quality measure)

Procedure code 87801 is a more comprehensive, multiple organism code for infectious agent detection by nucleic acid***. Effective 8/1/2020, when any two or more of the single test codes (87491, 87591, and/or 87661) are billed separately for the same provider and the same date of service, the reimbursement will be based on the rate for 87801,*** which is the more comprehensive multiple organism's code.

Regardless of the units billed for a single code, payment will be made based on a single unit of 87801.

Modifier -25

Modifier 25 with Separately Reported Services

- The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service.
- The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided.
- This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.
- As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

EVALUATION AND MANAGEMENT MODIFIER 25

- 25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.**

- Reflects that the day of a minor surgical procedure, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual operative and postoperative care associated with the procedure that was performed.

- The term "separately identifiable service" means an additional service that is not part of the surgery or procedure. The E&M service must require additional history, exam, knowledge, skill, work, time, and risk above and beyond that of the surgery or procedure and its pre- and post-procedure components. Moreover, the E&M service should be able to stand alone from the same-day procedure.

E&M Standard Documentation Requirements

E&M Standard Documentation Requirements

Office or Outpatient E/M Visits

- Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
- Assessment, clinical impression, or diagnosis
- Medical plan of care
- If you don’t document the date, legible name of the observer and your rationale for ordering diagnostic and other services, it should be easily inferred
- Past and present diagnoses should be accessible to you or the consulting physician
- You should identify appropriate health risk factors
- You should document the patient’s progress, response to and changes in treatment, and revision of diagnosis
- Documentation in the medical record should report the diagnosis and treatment codes you report on the health insurance claim form or billing statement

reference:
Medicare Evaluation and Management Services Guide

E&M Standard Documentation Requirements

Office or Outpatient E/M Visits

Chief Complaint:
A CC is a short statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient's own words, like patient complains of upset stomach, aching joints, and fatigue. The medical record should clearly show the CC.

History of Present Illness:
HPI is the portion of the E/M history component that describes the patient's current illness. HPI covers development of the illness from the first sign or symptom to the current time. This includes location, quality, severity, timing, context, modifying factors, and associated signs and symptoms with a significant relationship to the presenting problem or problems

Review of Systems:
(ROS), is the part of an E/M history that involves asking about body systems to identify past and present signs and symptoms. A series of questions helps define the problem, clarify the differential diagnosis, identify testing needed, and provide baseline data about body systems related to treatment options.

History and Exam:
Medically appropriate patient past, family, and/or medical history with examination findings pertaining to the visit. This includes a record of the patient's vitals with at least 3 measurements. Height, weight, temperature, blood pressure, etc.

Assessment and Plan:
Statement of the examination/visit findings that reviews the number and complexity of the problem or problems the provider addresses during the encounter. This will include any tests ordered, test results, procedures or treatment performed, treatment planned, medical decision making, and follow up care recommendation.

Accessing Quarterly Vaccine/ Drug Allowances

Vaccine/ Drug Allowances

Quarterly Updates

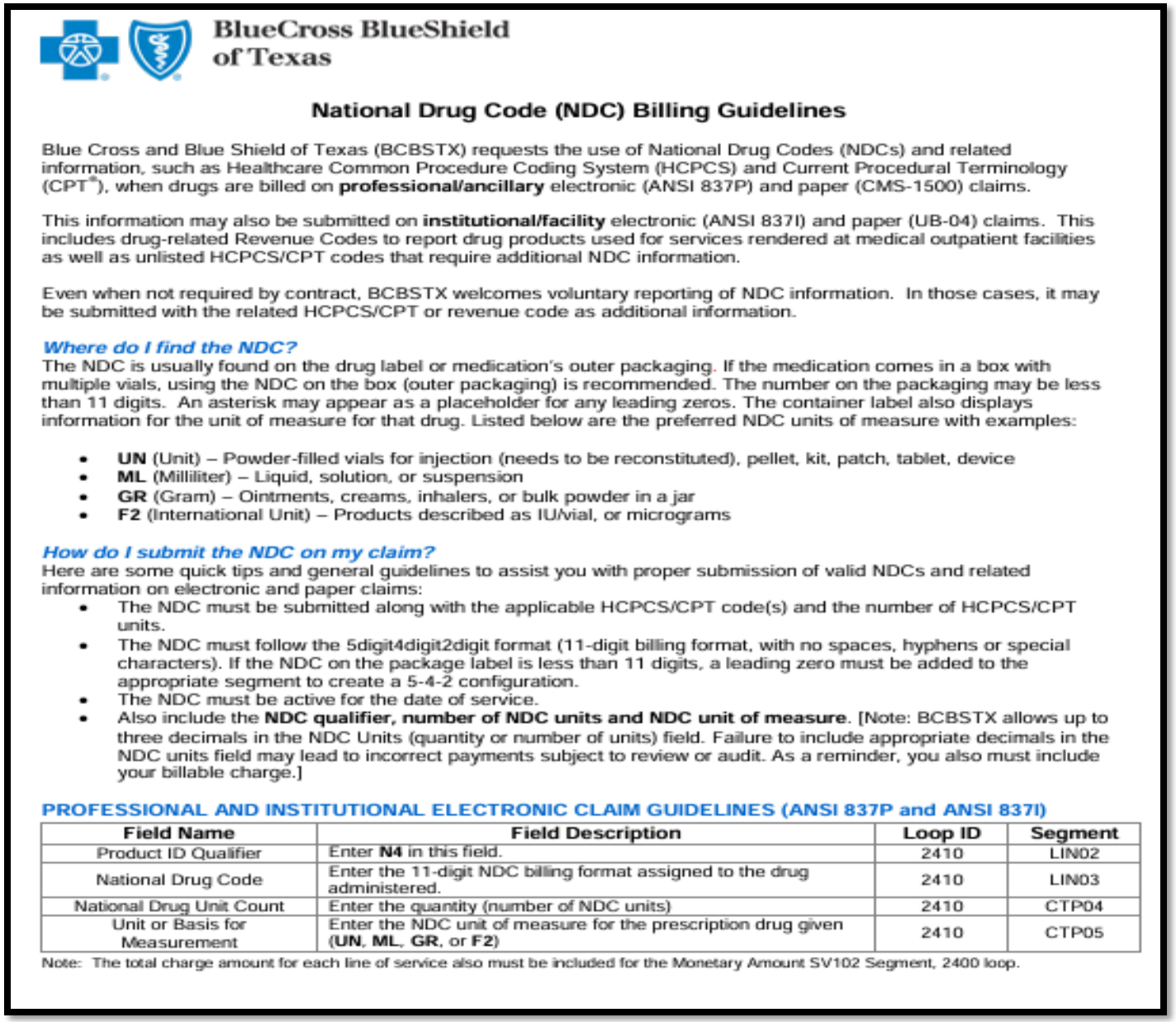
- Vaccine and Drugs allowances are updated quarterly by most health plans. Access to the updated allowance schedules for drugs and vaccines can be found here using the links below, including current reimbursement for flu vaccines.

- CMS: Vaccine Pricing | CMS
- BCBS: 2024 NDC Schedules | Blue Cross and Blue Shield of Texas (bcbstx.com)
- UHC: https://secure.uhcprovider.com/#/feeschedulelookup
- Aetna: https://apps.availity.com/public/apps/home/#!/loadApp?appUrl=%2Fweb%2Fpve%2Fcarmelo%2F%23%2F%3Fid%3DrJgFeF0PPN%26cacheBust%3D1723555439
- Cigna: https://cignaforhcp.cigna.com/app/my-practice/fee-schedule/view

Vaccine Allowances

Why we should Update Vaccines Allowances Quarterly

- Did you know that BCBS requires the use of an NDC when billing for the vaccines and drugs. Doing this allows them to increase the allowed amount for the vaccine based on the actual price of the medication.
- If you are not currently including the NDC with your vaccine charges you may be leaving money on the table. Please see the attached instructions to get your system updated today.
- Additional resources can be found here: BlueCross BlueShield Billing with NDC Codes Overview.
- Please check to make sure you charge amount is higher than the highest contract allowance to make sure your claims are not underpaid.



BlueCross BlueShield of Texas

National Drug Code (NDC) Billing Guidelines

Blue Cross and Blue Shield of Texas (BCBSTX) requests the use of National Drug Codes (NDCs) and related information, such as Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT®), when drugs are billed on **professional/ancillary** electronic (ANSI 837P) and paper (CMS-1500) claims.

This information may also be submitted on **institutional/facility** electronic (ANSI 837I) and paper (UB-04) claims. This includes drug-related Revenue Codes to report drug products used for services rendered at medical outpatient facilities as well as unlisted HCPCS/CPT codes that require additional NDC information.

Even when not required by contract, BCBSTX welcomes voluntary reporting of NDC information. In those cases, it may be submitted with the related HCPCS/CPT or revenue code as additional information.

Where do I find the NDC?

The NDC is usually found on the drug label or medication's outer packaging. If the medication comes in a box with multiple vials, using the NDC on the box (outer packaging) is recommended. The number on the packaging may be less than 11 digits. An asterisk may appear as a placeholder for any leading zeros. The container label also displays information for the unit of measure for that drug. Listed below are the preferred NDC units of measure with examples:

- **UN** (Unit) – Powder-filled vials for injection (needs to be reconstituted), pellet, kit, patch, tablet, device
- **ML** (Milliliter) – Liquid, solution, or suspension
- **GR** (Gram) – Ointments, creams, inhalers, or bulk powder in a jar
- **F2** (International Unit) – Products described as IU/vial, or micrograms

How do I submit the NDC on my claim?

Here are some quick tips and general guidelines to assist you with proper submission of valid NDCs and related information on electronic and paper claims:

- The NDC must be submitted along with the applicable HCPCS/CPT code(s) and the number of HCPCS/CPT units.
- The NDC must follow the 5digit4digit2digit format (11-digit billing format, with no spaces, hyphens or special characters). If the NDC on the package label is less than 11 digits, a leading zero must be added to the appropriate segment to create a 5-4-2 configuration.
- The NDC must be active for the date of service.
- Also include the **NDC qualifier, number of NDC units and NDC unit of measure**. [Note: BCBSTX allows up to three decimals in the NDC Units (quantity or number of units) field. Failure to include appropriate decimals in the NDC units field may lead to incorrect payments subject to review or audit. As a reminder, you also must include your billable charge.]

PROFESSIONAL AND INSTITUTIONAL ELECTRONIC CLAIM GUIDELINES (ANSI 837P and ANSI 837I)

Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter **N4** in this field.	2410	LIN02
National Drug Code	Enter the 11-digit NDC billing format assigned to the drug administered.	2410	LIN03
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Unit or Basis for Measurement	Enter the NDC unit of measure for the prescription drug given (**UN**, **ML**, **GR**, or **F2**)	2410	CTP05

Note: The total charge amount for each line of service also must be included for the Monetary Amount SV102 Segment, 2400 loop.

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