



CMS Releases Instructions on G2211; RPA Issues Revised Guidance on Use in Nephrology

On January 18, 2024, the Centers for Medicare and Medicaid Services (CMS) issued the instruction, “How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211.” In this document CMS discusses when to bill G2211; how billing for G2211 is not allowable when billing for services using modifier -25 indicating separately identifiable services; and the absence of additional documentation requirements for G2211 beyond what would be necessary to bill for the underlying evaluation and management (E&M) service (CPT codes 99202-99205, 99211-99215).

In the January 2024 *RPA News* Coding Corner column, RPA provided guidance on the application of G2211 in nephrology, and at that juncture took a conservative approach to use of the complexity add-on code in order to minimize potential audit risk for nephrology practices. This is aligned with RPA’s customary ‘do no harm’ stance on providing coding and billing advice to RPA members.

However, reconsideration of CMS’ language in the final rule for the 2024 Medicare Fee Schedule (MFS) combined with what is outlined in the recently released instruction has led RPA’s coding and billing experts to believe that the G2211 modifier will be more broadly applicable in nephrology patient care than previously thought. RPA’s updated interpretation of CMS’ rulemaking and intent is that the add-on code could be compliantly attached to any claim for a complex patient where the nephrologist has primary responsibility for managing at least one diagnosis until their next office visit with the nephrologist.

This interpretation is based on the thought that complexity in the G2211 code descriptor does not refer to complexity of medical decision making, but rather “complexity that is associated with medical care services when the provider is serving as the continuing focal point for all needed services and/or with medical care services that are part of ongoing care related to a patient’s single, serious condition or complex condition”. As such, the issue is not whether the physician’s medical decision making at the time of the office is complex (which entails how many chronic conditions the nephrologist is addressing, usually more than two) but rather whether they are the continuing focal point of care for at least one serious or complex condition. Given that almost all conditions a nephrologist treats are serious and complex, such as fluid or electrolyte abnormalities, hypertension, or CKD of all stages, the nephrologist just has

to determine whether they are the continuing focal point of care for the diagnosis(es) they are addressing. If yes, then G2211 applies.

Regarding documentation, as noted the CMS instruction focuses primarily on the reason for and medical necessity of the E&M visit. RPA would note that from an auditing perspective, it will likely be beneficial to document return follow up visit statements such as ‘return in X weeks/months’ along with the physicians painting a clear picture of how the condition is complex. Often there is a disconnect between the clinical activities and the billing aspect of documentation, and thus it is important to remember that most claims adjusters and coding auditors are not clinical staff and need key words to identify complexity.

Additionally, RPA made an inquiry to the Center for Medicare and Medicaid Innovation (CMMI) as to the disposition of G2211 in claims processing in the Kidney Care Choices (KCC) voluntary kidney payment models, and was advised that G2211 is not included in the list of codes that receive 100% fee reduction. This confirms that practices can apply G2211 to appropriate aligned KCC CKD patients just like they do for non-aligned CKD patients, and suggests that G2211 will be paid when appropriately coded by the provider.

To level set, RPA’s understanding and interpretation of CMS’ guidance and intent regarding the G2211 E&M visit complexity add-on code is that:

- **It should be compliantly billable on most complex patients seen by nephrologists.**
 - **However, it is only billable when there is a continuing, longitudinal relationship with the patient.**
- **The code is not billable on ESRD MCP patients.**
- **As set forth by CMS, it is not billable on claims where modifier -25 indicating a separately identifiable service is attached, including E&M services typically provided to CKD patients where an ESA injection for anemia management purposes is provided.**
- **The G2211 add-on code should be appended to claims being submitted within the KCC voluntary kidney payment models, and CMMI has indicated it will be paid when appropriately coded.**

Any questions or comments regarding this correspondence should be directed to RPA’s Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.