CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13316	**Date: July 24, 2025**
	Change Request 14047

SUBJECT: Update to Publication 100-04, Chapter 12, Section 30.6.7 to Establish Payment Criteria for Healthcare Common Procedure Coding System (HCPCS) Add-on Code G2211 Billed on the Same Day as Identified Preventive Services

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Publication 100-04, Chapter 12, Section 30.6.7 of the internet only manual and establish a link to the preventive services web page containing a list of preventive services that allows for separate payment of HCPCS code G2211 when provided on the same day.

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 25, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/30/30.6.7/Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99202 - 99215)

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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II. GENERAL INFORMATION

A. Background: In the Calendar Year (CY) 2024 Physician Fee Schedule (PFS) final rule (88 FR 78970 – 78982), the CMS finalized separate payment for the Office/Outpatient Evaluation and Management (O/O E/M) visit complexity add-on code. The full descriptor for the O/O E/M complexity add-on code, HCPCS code 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)).

The O/O E/M visit complexity add-on code "reflects the time, intensity, and practice expense resources involved when practitioners furnish the kinds of O/O E/M visit services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single high-risk disease) and to address the majority of a patient's health care needs with consistency and continuity over longer periods of time." (88 FR 78970 - 78971).

CMS responded to concerns raised by commenters about potential duplicative payment and potential misreporting of the code, noting that when procedures or other services are reported on the same day by the same billing practitioner with a significant, separately identifiable O/O E/M visit (the base codes that the visit complexity add-on code can be billed with), we believed that the services have resources that are sufficiently distinct from the costs associated with furnishing stand-alone O/O E/M visits to warrant a different payment policy (88 FR 78971). CMS finalized our proposal that the O/O E/M visit complexity add-on code is not payable when the O/O E/M visit is reported with Current Procedural Terminology (CPT) Modifier -25, which denotes a significant, separately identifiable O/O E/M visit by the same physician or other qualified health care professional on the same day as a procedure or other service (88 FR 78974).

B. Policy: CMS has finalized updates to refine our current policy for services furnished beginning in CY 2025 to allow payment of the O/O E/M visit complexity add-on code when the O/O E/M base code is reported by the same practitioner on the same day as an Annual Wellness Visit (AWV), vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting. This will ensure that our policy, which aims to make payment for previously unaccounted resources inherent in the complexity of all longitudinal primary care office visits, is achieved. In part, the visit complexity add-on

code recognizes the inherent costs of building trust in the practitioner-patient relationship. We believe that trust-building in the longitudinal relationship is more significant than ever in making decisions about the administration of immunizations and other Medicare Part B preventive services.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14047.1	Contractors shall update operational procedures, as necessary, to accommodate the revisions to Chapter 12 of the Medicare Claims Processing Manual: - Modify existing preventive vaccine services language to make payable claims with the add-on HCPCS code G2211 on the same date of service as an evaluation and management visit (codes 99202-99205, 99211-99215) reported with modifier 25 when a service identified on the preventive services list is also present for the same date of service. - Be aware of hyperlinks leading to the list of preventive services payable with the G2211 add-on, located on the preventive services web page.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99202 - 99215)

(Rev. 13316; Issued: 07-24-25; Effective:01-01-25; Implementation: 08-25-25)

A. Definition of New Patient for Selection of E/M Visit *Add-On* Code

Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3-year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or *electrocardiogram (*EKG*)* etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

B. Office/Outpatient E/M Visits Provided on Same Day for Unrelated Problems

As for all other E/M services except where specifically noted, the Medicare Administrative Contractors (MACs) may not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office, off campus-outpatient hospital, or on campus-outpatient hospital setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

C. Office/Outpatient or Emergency Department E/M Visit on Day of Admission to Nursing Facility

MACs may not pay a physician for an emergency department visit or an office visit and a comprehensive nursing facility assessment on the same day. Bundle E/M visits on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician (see section on Nursing Facility Services below).

D. Drug Administration Services and E/M Visits Billed on Same Day of Service

MACs must advise physicians that *Current Procedural Terminology (*CPT*)* code 99211 cannot be paid if it is billed with a drug administration service such as a chemotherapy or nonchemotherapy drug infusion code (effective January 1, 2004). This drug administration policy was expanded in the Physician Fee Schedule Final Rule, November 15, 2004, to also include a therapeutic or diagnostic injection code (effective January 1, 2005). Therefore, when a medically necessary, significant and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of these drug administration services, the appropriate E/M CPT code should be reported with modifier -25. Documentation should support the level of E/M service billed. For an E/M service provided on the same day, a different diagnosis is not required.

E. Prolonged Office/Outpatient E/M Visits

When the practitioner selects office/outpatient E/M visit level using time, the practitioner reports prolonged office/outpatient E/M visit time using *Healthcare Common Procedure Coding System* (HCPCS) add-on code G2212 (Prolonged office/outpatient E/M services). See Prolonged Services section for additional information.

F. Add-On Code for Office/Outpatient E/M Visit Complexity

Beginning January 1, 2021, Medicare established HCPCS add-on code G2211 describing visit *intensity and* complexity inherent to office/outpatient E/M visits 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.

The Consolidated Appropriations Act, 2021 delayed PFS payment for this code until January 1, 2024, or later. Effective January 1, 2024, Medicare changed the status of HCPCS add-on code G2211 to make it separately payable by assigning it an "active" status indicator. The add-on code, list is separately billed in addition to office/outpatient evaluation and management visit, new or established. (See the CY 2021 Medicare Physician Fee Schedule final rule in the Federal Register (85 FR 84571.)
HCPCS add-on code G2211: Long Descriptor - 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

• HCPCS *add-on* code G2211 includes services that enable practitioners to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single, high-risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. This includes furnishing services to patients on an ongoing basis that result in care that is personalized to the patient. The services result in a comprehensive, longitudinal, and continuous relationship with the patient and involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape. The "continuing focal point for all needed health care services" and "part of ongoing care related to a patient's single, serious condition or a complex condition" describe relationships between the patient and the practitioner.

• Reporting is not restricted based on specialty. HCPCS *add-on* code G2211 may be reported with any visit level (99202-99205, 99211-99215). *Prior to January 1,2025, the A/B MACs (A & B) shall not pay code G2211 on the same date of service as an office/outpatient evaluation and management visit (codes 99202-99205, 99211-99215) reported with Modifier 25, to the same beneficiary by the same practitioner or nonphysician practitioner. Effective January 1, 2025, claims with the HCPCS add-on code G2211 reported on the same date of service as an office/outpatient evaluation and management visit (codes 99202-99205, 99211-99215) reported with modifier 25 could be billed when a service identified in the preventive services list is also present for the same date of service. The list of eligible preventive service HCPCS codes can be found at the following link: https://www.cms.gov/medicare/payment/fee-schedules/physician/evaluation-management-visits*

• Example 1: A patient has a primary care practitioner that is the continuing focal point for all health care services, and the patient sees this practitioner to be evaluated for sinus congestion. The inherent complexity that this *add-on* code G2211 captures is not in the clinical condition itself— sinus congestion —but rather the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. There is previously unrecognized but important cognitive effort of utilizing the longitudinal relationship itself in the diagnosis and treatment plan and weighing the factors that affect a longitudinal doctor patient relationship. In this example, the primary care practitioner could recommend conservative treatment or prescription of antibiotics. If the practitioner recommends conservative treatment and no new prescriptions, some patients may think that the doctor is not taking the patient's concerns seriously and it could erode the trust placed in that practitioner. In turn, an eroded primary care practitioner/ patient relationship may make it less likely that the patient would follow that practitioner's advice on a needed vaccination at the next visit. The primary care practitioner must decide—what course of action and choice of words in the visit itself, would lead to the best health outcome in this single visit, while simultaneously building up an effective, trusting longitudinal relationship with this patient for all of their primary health care needs. Weighing these various factors, even for a seemingly simple condition like sinus congestion, makes the entire interaction inherently complex, and it is this complexity in the relationship between the doctor and patient that this code captures.

• Example 2: *A* patient with *Human Immunodeficiency Virus (*HIV*)* has an office visit with their infectious disease physician, who is part of ongoing care. The patient with HIV admits to the infectious disease physician that there have been several missed doses of HIV medication in the last month. The infectious disease physician has to weigh their response during the visit —the intonation in their voice, the choice of words—to not only communicate clearly that it is important to not miss doses of HIV medication, but also to

create a sense of safety for the patient in sharing information like this in the future. If the interaction goes poorly, it could erode the sense of trust built up over time, and the patient may be less likely to share their medication adherence shortcomings in the future. If the patient isn't forthright about their medication adherence, it may lead to the infectious disease physician switching HIV medicines to another with greater side effects, even when there was no issue with the original medication. It is because the infectious disease physician is part of ongoing care, and has to weigh these types of factors, that the E/M visit becomes inherently more complex and the practitioner bills this *add-on* code (G2211). Even though the infectious disease doctor may not be the focal point for all services, such as in the previous example, HIV is a single, serious condition, and/or a complex condition, and so as long as the relationship between the infectious disease physician and patient is ongoing, this E/M visit could be billed with the add-on.

The most important information used to determine whether or not the add-on code could be billed is the relationship between the practitioner and the patient. If the practitioner is the focal point for all needed services, such as a primary care practitioner, the HCPCS *add-on code* G2211 could be billed. Or, if the practitioner is part of ongoing care for a single, serious condition or a complex condition, e.g., sickle cell disease, then the add-on code could be billed. The add-on code captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.

G. Medical Review When Practitioners Use Time to Select Visit Level

Our reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit.