

Background

- CMS realized that E/M payments don't fully reflect/recognize the complexity of care and comprehensive nature of care that primary care provides.
- In 2024, CMS introduced an add-on complexity code for office-based practices (but excluded HBPC)
- With the American Academy of Home Care Medicine (AAHCM)'s advocacy this was expanded to HBPC as of 1/1/2026.

G2211 CPT Description

"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."

Can be billed WHEN:

1. You currently serve as the patient's PCP/single-point-of-contact managing chronic medical conditions OR
2. You are assuming responsibility for ongoing care during a new patient visit

Use only when visits are medically necessary and when documentation clearly supports continuity, complexity, and longitudinal care.

CAN Bill:

- Primary care visits (acute, follow up and new visits by PCP)
- Along with an E/M done in conjunction with a preventative service (vax, AWW)
- Telemedicine visits
- MA and Medicare FFS patients qualify (confirm with payors)
- When patients are receiving hospice (if PCP still following them), APCM, CCM or PCM

CANNOT Bill:

- Same day as a minor procedure (PEG, joint injections, OR even Advance Care Planning (ACP))
- Preventative services (e.g. AWW) without a separately billable E/M
- If chronic conditions are documented but not considered/addressed at the visit
- If your relationship with the patient is time-limited (not a continuing relationship). However, CAN be billed by a covering provider for an acute exacerbation of a chronic medical condition (if there is continuity, e.g. coverage for PCP leave), but not for a one-time consult.
- With a TCM visit or AWW (because the services are felt by CMS that complexity is inherently covered by those services).

Tips for implementation:

- Provide education to both providers and billing staff
- Consider using macro stating that you are the single-point of focus/primary medical provider for ongoing medical management for this patient. (not a requirement but helps with clarification during audits – make it short and simple: recommendation).
- Avoid templated or repetitive language; documentation should reflect ONGOING management and individualized care planning.
 - IMPORTANT: CMS put in a line that providers notes must be SIGNIFICANTLY different from visit to visit.
- Add G2211 to billing selections to prompt selection alongside E/M codes
- Monitor reporting to ensure consistent and accurate use.
- Be aware that the reimbursement is ~\$16; BUT estimated copay: \$3.20; per G2211 billable visit
- Cannot be used for SNF patients. Can be used for assisted living patients.
- Specialists can bill for this if managing a complex medical condition longitudinally (see office-based procedure above).

References:

American Academy of Home Care Medicine Webinar – Binder A and Ramey S "Policy Update on HCPCS Code G2211."

<https://aahcm.mclms.net/en/profile/my-courses/34545/lesson/154549/view>

American Academy of Family Physicians "G2211 Add-on Code: What It Is and When To Use It."

<https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/evaluation-management/G2211-what-it-is-and-how-to-use-it.html>