

Reimbursement Policy

Medicare Reimbursement for HCPCS G2211

REIMBURSEMENT POLICY NUMBER: 79

Effective Date: 10/1/2026

Last Review Date: 9/2026

Next Annual Review: 5/2027

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INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits, reimbursement methodologies, and acceptable billing practices, intended to help health care providers submit claims accurately in order to reduce delays and ensure more accurate claim adjudication. Reimbursement policies do not constitute a guarantee of coverage. They allow for the consistent application of our member contracts, provider contracts, clinical edits, and medical policies. In the event of a conflict between one of these documents and a reimbursement policy, these documents will take precedent over the reimbursement policy. If contracts and policies are silent, the Company may defer to guidance from the Centers for Medicare & Medicaid Services (CMS) when available and applicable. In addition to correct billing practices, in order to qualify for reimbursement, all services, items, and procedures must be covered member benefits and must also meet applicable authorization and medical necessity guidelines. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time.

SCOPE AND APPLICATION

Provider Type:

- ☒ Providence Health Plan Participating Providers
- ☒ Non-Participating Providers

Plan Product:

- ☐ Commercial
- ☒ Medicare
- ☐ Medicaid/Oregon Health Plan (OHP)

POLICY STATEMENT

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

NOTES:

- Provider contract language applies and may vary.
 - This policy applies to **Medicare Advantage** Plan members **only**. For *Commercial* plan members, HCPCS code G2211 is **denied** as a bundled service (see Cross References below).
- I. A flat rate of \$16.04 will be allowed for HCPCS code G2211 to report for office/outpatient evaluation and management visit complexity (O/O E&M visit complexity) for **Medicare Advantage** Plan members, for both out-of-network and in-network providers, unless a different rate is specified in the provider's contract. This includes claims billed by providers who are paid for laboratory services based on Medicare's fee schedule for laboratory services, even if all other services for that provider are paid at a percent of billed charges.

POLICY GUIDELINES

BACKGROUND

HCPCS code 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 condition or a complex condition. (add-on code, list separately in addition to home or residence or office/outpatient evaluation and management service, new or established)

This code is intended to describe intensity and complexity inherent to O/O EYM 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, or complex condition.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 4/6/2026, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses appropriate use of HCPCS code G2211:

- How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211
- Frequently Asked Questions (FAQs) About Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-On HCPCS Code G2211
- CY 2024 physician fee schedule (PFS) final rule, 88 FR 78818
- Medicare MLN Matters MM14315

The above criteria are consistent with the CMS guidance regarding G2211.

BILLING AND CODING GUIDELINES

HCPCS code G2211 should be billed in conjunction with select office/outpatient evaluation and management (E&M) codes when:

- The provider is the continuing focal point for all the patient's healthcare needs.
- The provider manages a single, serious, or complex condition over time.

The Company follows CMS guidance regarding HCPCS code G2211 for Medicare Advantage lines of business. All CMS billing requirements must be followed, including the E&M codes billed in conjunction with G2211. Please refer to the CMS billing instructions in effect at the time services are rendered. In addition, it is not appropriate to use HCPCS G2211 for one-time consultations, acute issues, or when the provider does not intend to establish an ongoing care relationship with the patient.

CROSS REFERENCES

Coding Policies

- [Procedure-Specific Policies](#), CP4

The full Company portfolio of current Reimbursement Policies is available online and can be [accessed here](#).

REFERENCES

1. Centers for Medicare & Medicaid Services (CMS). How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211. 18 Jan 2024. <https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf>. Updated 4/29/2025. Accessed 4/6/2026.
2. CMS. Frequently Asked Questions (FAQs) About Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-On HCPCS Code G2211. <https://www.cms.gov/files/document/hcpcs-g2211-faq.pdf>. Accessed 4/6/2026.
3. CY 2024 physician fee schedule (PFS) final rule, 88 FR 78818. 16 Nov 2023. <https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other>. Accessed 4/6/2026.
4. Medicare Learning Network (MLN) Matters. MM14315. Release date December 5, 2025. Effective January 1, 2026. <https://www.cms.gov/files/document/mm14315-medicare-physician-fee-schedule-final-rule-summary-cy-2026.pdf>. Accessed 4/6/2026.

POLICY REVISION HISTORY

Date	Revision Summary
8/4/2025	New Reimbursement Policy

1/2026	Interim update due to changes to CMS billing instructions
4/2026	Q2 2026 code update to revise description of G2211
6/2026	Annual review. No changes.
10/2026	Interim update to clarify intent to use flat rate