CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13015	**Date: December 23, 2024**
	Change Request 13705

Transmittal 12804 issued August 20, 2024, is being rescinded and replaced by Transmittal 13015, dated December 23, 2024, to revise the policy section since the final rule has been finalized. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet.

SUBJECT: Allow Payment for Healthcare Common Procedure Coding System (HCPCS) Code G2211 when Certain Part B Preventive Services are Provided on the Same Day

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide instructions to the A/B Medicare Administrative Contractors (MACs) to allow payment of add-on code G2211 when certain Part B preventive services are provided on the same day.

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 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
N/A	N/A

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:
One Time Notification

Attachment - One-Time Notification

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II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to provide instructions to the A/B Medicare Administrative Contractors (A/B MACs) that will allow the payment processing with the Office/Outpatient Evaluation and Management (O/O E/M) (99202-99205, 99211-99215) add-on code G2211 when the modifier 25 is present for part B preventive services, immunization administrations, and annual wellness visits.

In the CY 2024 PFS final rule (88 FR 78970 – 78982), the Centers for Medicare & Medicaid Services (CMS) finalized separate payment for the 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 PE 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 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	
13705.1	Effective for dates of service on or after January 1, 2025, contractors shall allow 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 in attachment 1 is also present for the same date of service. NOTE: For institutional claims this applies to Method II Critical Access Hospital on the same encounter for TOB 85X (Revenue codes 096x, 097x or 098x) only.					X	X			
13705.2	Contractors shall allow HCPCS code G2211 on type of bill (TOB) 85x with revenue codes 096x, 097x or 098x.					X				
13705.3	Contractors shall create/use a User-controlled table to allow MAC changes for attachment 1.					X	X			
13705.3.1	Contractors shall update the User-controlled table to reflect	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	changes in attachment 1.									

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 B, A/B MAC Part A

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

Pre-Implementation Contact(s): Erick Carrera, erick.carrera@cms.hhs.gov , William Ruiz, william.ruiz@cms.hhs.gov , Charles Nixon, charles.nixon@cms.hhs.gov

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

VII. FUNDING

Section A: 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.

ATTACHMENTS: 1

HCPCS/CPT Code	Short or Long Descriptor	Status Code
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	A
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	A
76977	Us bone density measure	A
77063	Breast tomosynthesis bi	A
77067	Scr mammo bi incl cad	A
77078	Ct bone density axial	A
77080	Dxa bone density axial	A
77081	Dxa bone density/peripheral	A
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	A
90460	Im admin 1st/only component	A
90461	Im admin each addl component	A
90471	Immunization admin	A
90472	Immunization admin each add	A
90473	Immune admin oral/nasal	A
90474	Immune admin oral/nasal addl	A
96156	Hlth bhv assmt/reassessment	A
96158	Hlth bhv ivntj indiv 1st 30	A
96159	Hlth bhv ivntj indiv ea addl	A
96164	Hlth bhv ivntj grp 1st 30	A
96165	Hlth bhv ivntj grp ea addl	A
96167	Hlth bhv ivntj fam 1st 30	A
96168	Hlth bhv ivntj fam ea addl	A
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	A
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	A
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes	A
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	A
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	A

99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	A
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	A
G0101	Ca screen;pelvic/breast exam	A
G0102	Prostate cancer screening; digital rectal examination	A
G0104	Ca screen;flexi sigmoidscope	A
G0105	Colorectal scrn; hi risk ind	A
G0106	Colorectal cancer screening; alternative to g0104, screening sigmoidoscopy, barium enema	A
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	A
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes	A
G0120	Colorectal cancer screening; alternative to g0105, screening colonoscopy, barium enema	A
G0121	Colon ca scrn not hi rsk ind	A
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician	A
G0130	Single energy x-ray study	A
G0136	Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes	A
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	A
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	A

G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes	A
G0296	Visit to determ ldct elig	A
G0402	Initial preventive exam	A
G0403	Electrocardiogram, routine ecg with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report	A
G0404	Electrocardiogram, routine ecg with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination	A
G0405	Electrocardiogram, routine ecg with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination	A
G0438	Ppps, initial visit	A
G0439	Ppps, subseq visit	A
G0442	Annual alcohol misuse screening, 5 to 15 minutes	A
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	A
G0444	Annual depression screening, 5 to 15 minutes	A
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	A
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	A
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	A
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes	A
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)	A

G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code g0513 for additional 30 minutes of preventive service)	A
P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician	A
Q0091	Obtaining screen pap smear	A