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Jill Darling: Hi everyone, and welcome. We'll just give it a moment to get more folks in. Thank you for your patience. All right. Good morning and good afternoon, everyone. My name is Jill Darling…

(Recording in progress…)

Jill Darling: …in the CMS Office of Communications. Welcome to today's Physicians, Nurses, and Allied Health Professionals Open Door Forum. Before we begin, I have a—before I begin our agenda, I have a few announcements. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum Podcast and Transcript web page. That link is on the agenda, and I will add it to the chat as well for everyone. If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email press@cms.hhs.gov. All participants are muted upon entry. For those who need closed captioning, I will provide a link in the chat. For today's webinar, we have the—we'll have the agenda slide and one of our presenters, Scott Weinberg, will also present slides as well. And then at the end, I will have a resource slide during the Q&A.

We will be taking questions at the end of the agenda today. We note that we will be presenting and answering questions on the topics listed on the agenda during the Open Door Forum call. We ask that any live questions relate to the topics presented during today's webinar. If you have questions unrelated to the agenda items, we—we—may not have the appropriate person on the call today to answer your question. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the partnership@cms.hhs.gov mailbox and we will try to get your question to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen. And we will call on you when it time for Q&A. And when the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question. We will do our best to get to your questions, and now, I will turn the call over to our Co-chair, Dr. Gene Freund.

Dr. Eugene Freund: Thank you very much, Jill and welcome everybody. Thank you all for coming out for the first Physicians, Nurses, and Allied Health Professionals Open Door Forum of the year. And without further ado, we'll just turn it over to Camille Kirsch, who will be giving us an update on the Federal Independent Dispute Resolution (IDR) proposed rule. So go ahead, Ms. Kirsch.

Camille Kirsch: Thank you, Dr. Freund. I am here to give a brief update on the Federal Independent Dispute Resolution process. On January 22, the departments of Health and Human Services (HHS), Labor, and the Treasury as well as the Office of Personnel Management (OPM) published a notice in the Federal Register reopening the comment period for the Federal Independent Dispute Resolution Operations proposed rule. The comment period for the proposed rule is now reopened from January 22 to February 5, 2024. The departments and OPM are reopening the comment period on the Federal IDR Operations rule at this time in order to provide additional time for interested parties to consider and comment on any implications of the IDR fees final rule for the IDR Operations rule. That IDR fees final rule was published on December 21, 2023, and went into effect January 22, 2024. The IDR fees final rule set administrative and IDR entity fees to use the Federal IDR process, established a methodology for calculating those fees and established that such fees will be set in rulemaking rather than in guidance going forward. We encourage interested parties to submit new comments regarding the Federal Independent Dispute Resolution Operations proposed rule by February 5, 2024 at regulations.gov or via any of the other methodologies provided in the notice. And that notice is available at the link provided to participants, and I will also put it in the chat. Again, please do submit any comments by February 5. Thank you, and I will pass it on to Erick Carrera for PFS (Physicians Fee Schedule) updates.

Erick Carrera: Thank you. We are pleased to share that we have issued additional guidance about office or other outpatient evaluation and management visit complexity add-on, HCPCS (Healthcare Common Procedure Coding System) code G2211. This relates only to office or other outpatient evaluation and management code set, CPT 99202 through 99205, and 99211 through 99215, and other evaluation management code sets such as Emergency Department Services, Nursing Facility Care, or Home or Resident Services. We issued two pieces of additional guidance Thursday of last week. They are, one, MLN (Medicare Learning Network) Matters Article 13473, How to Use the Office and Outpatient Evaluation and Management Visit Complexity Add-on Code G2211, and two, Transmittal 12461, related to this MLN Article that will update the Medicare Claims Processing Manual 100-04, Chapter 12, Section 30.6.7, and from here on out, I'll refer as shorthand to O/O E/M (Office Outpatient Evaluation Management) visit complexity add-on code G2211.

As a refresher, with the end of the congressionally mandated suspension of payment for O/O E/M visit complexity add-on code G2211 last November for calendar year 2024, we finalized the rule to make the complexity add-on code G2211 separately payable by assigning the "active" status indicator to it. This policy became effective January 1, 2024. The long descriptor for this code reads "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 E/M visit, new or established."

In the preamble of the final rule, we discussed and illustrated how to determine when it would be appropriate to bill G2211. That discussion can be found beginning at Volume 88 Federal Register, page 78973. In that discussion, we noted that 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 Primary Care Practitioner, the O/O E/M visit complexity add-on code G2211 could be billed, or if the practitioner is part of ongoing care for single, serious condition or complex condition such as sickle cell disease, then the add-on code could be billed. The add-on captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.

We also finalized the rule that the visit complexity add-on code isn't payable when you report the O/O E/M visit with payment Modifier 25. Regarding documentation, practitioners must document the reason for billing the O/O E/M visit. The visits themselves would need to be medically reasonable and necessary for the practitioner to report G2211. In addition, the documentation would need to illustrate medical necessity. For the office or other outpatient evaluation management visit, we haven't required additional documentation. Our medical reviewers may use the medical record documentation to confirm the medical necessity of the visit. The following items could serve as supporting documentation for billing code G2211: Information included in the medical record or in the claim history for a patient-practitioner combination such as diagnoses, the practitioner's assessment and plan for the visit, other service codes billed. Each of, and together, the MLN articles, the transmittals and preamble go into further detail when it would be appropriate to bill the O/O E/M visit complexity add-on code G2211.

While we are still working through a back load of questions, we thank you for them and we welcome further questions. We will respond to each one. Furthermore, based on those questions that we have already received, we have developed and are planning to issue a Frequently Asked Questions (FAQ) document soon with specific responses to those questions. With that, thanks very much and I'll turn it over to Scott Weinberg for the next topic.

Scott Weinberg: Great. Thank you. I will get my screen up. Make sure everyone can see. Thank you very much, and thanks for everybody for coming today. My name is Scott Weinberg. I'm with the CMS Office of Burden Reduction and Health Informatics, and I'm here to talk to you about the CMS Interoperability and Prior Authorization final rule, which we released just last week. A quick overview is that, so last week as I said, we released this final rule which demonstrates our continued commitment to increasing efficiency by ensuring that health information is readily available to the right person at the right place at the right time. And we do that by leveraging the latest data exchange standards which are called HL7 (Health Level 7) Fast Healthcare Interoperability Resources, or FHIR as it's pronounced. You may have been—you may have heard about this. But these standards are used to build Application Programming Interfaces, or APIs, to enable the exchange of health care data. So this final rule finalizes policies that would require impacted payers to implement a certain—certain—provision by January the 1st, 2026, and then in response to many stakeholder comments—over 900 comments we received on the proposed rule—impacted payers will have at least until January the 1st, 2027, to meet the development—the API development and enhancement requirements of the final rule. So, the—a very brief overview: Over—there are the impacted payers of this rule. It means that most of the requirements of this final rule do fall on impacted payers and not providers. However, there are some—some—requirements on providers, namely a new measure for the MIPS (Merit-based Incentive Payment System) program and then an almost identical one in the

Promoting Interoperability Program for eligible hospitals and critical access hospitals (CAHs). But—so whereas most requirements fall on the impacted payers, the providers though will still be affected by the policies that we finalized last week. So, the impacted payers are Medicare Advantage (MA) organizations, state Medicaid and CHIP agencies, Medicaid managed care plans and CHIP managed care entities, and the Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs)—many of you may know those as the Marketplace plans.

So first, just for a little bit of background about our previous interoperability rule that was issued in May 2020—this was called the CMS Interoperability and Patient Access final rule. And the—and this rule focused on driving interoperability and patient access to help information. So, what this did is we finalized regulations to require payers to implement an API. So, an API—if you don't know what that is—is you very likely used one if you've ever booked a flight online through, say Kayak, it's the technology that allows two different systems to talk to one another. So, say you're booking a flight, it's the technology that allows Kayak to go to all the different airlines and pull all their data into one place so then the person going on the website can then just see all the data in one place in a standardized format. And that's—so that's—what we're doing with health care with our API policies. So, this rule required payers to implement an API that would allow patients to access their own data through a third party because the—through a third party app that would then use that API to get the data from the payer. So, as I said, this was finalized in May 2020, and it required—it also required impacted payers to make a provider directory information available through the API as well as a way to drive forward interoperability.

So, building on that foundation, the first policy that we finalized in this rule was expanding on this already established Patient Access API. So, payers would have to include information about prior authorization requests and decisions via this API. So additionally, payers would also have to report metrics about patient use of the API to CMS on an annual basis. So this new data that patients would have access to, they would be able to see for a—for a—prior authorization request, the status of a prior authorization, the date the prior authorization was approved or denied, the date or circumstance under which an authorization ends, the items and services approved, and then if the prior authorization was denied, a specific reason why the request was denied. I will note that the prior authorization data would be prior authorization-related only to prior authorizations of items and services and not those for drugs. It also—the data that would have to be exchanged would only be structured administrative and clinical documentation submitted by a provider who is doing the prior authorization request. And then just so we can assess use of this API, we're also requiring payers to annually report metrics in the form of aggregated de-identified data about how patients are using it. So, this would include total number of unique patients whose data is exchanged via the API as well as the total number of unique patients whose data are transferred more than once via the API.

So, the second policy that we finalized is the Provider Access API. So similar to the Patient Access API, this is—we're going to be requiring impacted payers by January 1, 2027, to implement and maintain an API that would share patient data with in-network providers with whom the patient has a treatment relationship. So the data that then providers would be able to have access to is individual claims and encounter data (not including provider remittances and

enrollee cost-sharing information), data classes and data elements included in what's called a "content standard" adopted by the Office of the National Coordinator (ONC)—so that's currently the U.S. Core Data for Interoperability (USCDI), and then the specified prior authorization information that I mentioned before like status—the status of the prior authorization. Again, this will not include prior authorizations for drugs. So, this would give a provider the ability to get data from the payer and then to just give them more insight into the patient's medical history say, for example, they do not—there might be information they need that might not be in the patient's medical record, the provider could then query this information directly from the payer. The payer would, in order to make sure that data would be transferred only to a provider that has a treatment relationship with the patient, the payer is required to develop an attribution process to associate patients with their providers. So, then that would ensure that the payer only sends data to those appropriate providers. And then, the patients would be given an opportunity to opt out of this data exchange. So, they would be able to opt out of having their information sent from the provider—sorry—from the payer to the provider under these new policies. I'll just note that this wouldn't necessarily preclude a provider requesting data on their—for HIPAA purposes but the opt out only apply to this policy that we finalized.

Now, the second API that we finalized is a Payer-to-Payer API. So, this would—this is the—this would enable one payer to exchange data with another payer when a patient changes coverage or has concurrent coverage or two or more payers at the same time. So, the—now different from the last API we just talked about, this would require payers to have patients opt into the data exchange. And then if a patient changes payers, then they would have to—the new payer would have to request patient data from a previous payer no later than one week after the start of coverage of the new payer. And then, if a patient has two or more payers, then the impacted payers would be required to exchange patient data within one week of started coverage and at least quarterly thereafter. The data that the payer would need to exchange with the new payer is the same data that I mentioned for the providers, which is claims and encounter data (not including cost-sharing information), the data classes and elements, and the U.S. Core Data for Interoperability, and then the information about prior authorizations.

Now, we did finalize also a requirement for the impacted payers to provide educational materials both to patients and providers about the Provider Access API. So, in plain language, patients will be provided with resources about the benefits of API data exchange and then also information about their ability to opt out of that exchange. And then similarly, providers would be provided with the resources as well. They would have to include information about requesting patient data from the payer as well as how the payer does their attribution process. And similarly, with the payer-to-payer data exchange, impacted payers will provide plain language materials about the benefits of payer-to-payer data exchange. This would be provided to the patient.

And so the—and then the—last API that we'll be requiring is a Prior Authorization API. So, this was proposed as a—we called it the PARDD API, which stood for Prior Authorization Requirements and Documentation API. But for simplicity's sake, we finalized it as the Prior Authorization API. And this—this API would have to be—this would be a—would benefit the providers in that it would have to be populated with a list of items and services excluding drugs, as with the others, that require prior authorization from the payer. And then, it would also have to identify the payer's documentation requirements for all items and services—again, excluding

drugs—that require a prior authorization request. And then finally, it would have—it would have—to support the prior authorization request from the provider itself. So, the payer would have to implement this API which then the provider could, from their PHR (Personal Health Record) practice management system, use an app to do the prior authorization request as well as view the requirements for the prior authorizations. Once again, I'll remind you, this only applies to items and services.

Now, that's really the technological—those were the technological policies that we finalized to improve data sharing and data exchange. However, we also did finalize several process improvements for the prior authorization process that would begin on January 1, 2026. So, the first is prior authorization decision time frames. So, the impacted payers that I mentioned at the beginning of the presentation will be required starting then to send standard prior authorization decisions within seven calendar days and expedited prior authorization decisions within 72 hours of the request. I'll just note that this policy change for the standard decisions does not include the Marketplace plans or the Qualified Health Plans on the Federally Facilitated Exchanges. Additionally, payers when—when—they respond to a prior authorization request, they have to provide specific information about why the prior authorization was denied. This applies regardless of how this—the prior authorization request was submitted. So if it was submitted via that electronic prior authorization, via the API that I just mentioned, they would—they have to do this, or if it was submitted through some kind of proprietary portal on the payer's website, the payers would have to provide a specific reason if it was denied. And then finally, prior authorization metrics. So, we are requiring impacted payers to report certain metrics about their prior authorization processes on their public website on an annual basis. So, some of this data they would have to report publicly is the percentage of prior authorization requests approved, denied, approved after appeal, and then the average time between provider submission and then the decision.

So I did mention at the very beginning that there are—well, most of rule places requirements on the impacted payers, we OER providers, we will be required, starting calendar year 2027, to report the new measures for both the MIPS Promoting Interoperability— performance category under the HIE (Health Information Exchange) objective as well as providers in the—at the Medicare Promoting Interoperability Program under the HIE objective. So, this is called the Electronic Prior Authorization measure. So, this is a measure to encourage providers to use electronic prior authorization, that API that I mentioned before. So broadly, providers, you would be reporting for at least one medical item or service ordered during the performance period whether the prior authorization is requested electronically from the payer’s Prior Authorization API using data from your certified health IT. So, we finalized this measure as a yes/no measure so participants would be required to report a “yes” response or claim a valid exclusion to satisfy the reporting requirements. I mentioned that the first year that this measure will go into effect is 2027 performance period and for the 2029 payment year. And then for hospitals, it's the 2027 EHR reporting period. So, the measure specifications are included in the rule itself. I won't go into them, but the rule that is currently posted on the Federal Register, they start appearing on page 506-507 so like I said, this won't apply until 2027. But just to—if you'd like to get ready, this is—you can find the measure specifications there.

And so, I won't spend a lot of time on standards. Standards are kind of what—are really what drive the data exchange that this rule seeks to improve. But we are—we specify certain technical standards we use in building and maintaining each of these APIs. There's a lot of behind-the-scenes, but we are—we will be allowing flexibility for payers wishing to use update versions. So, while we are requiring a floor, we are allowing payers to use updated versions of standards if they wish to if they—just to allow room for innovation. So, we're strongly encouraging but not requiring the use of certain implementation guides, which is an industry term, to support the API development. And then I just have a couple of slides on what our required standards are. As providers, you will almost never be dealing with the actual standards, but I want to leave these in here just so you see that there's a lot of behind-the-scenes work that has really gone into making—making—it possible for us to require that these APIs be built and maintained. And then additionally, we—some of our recommendations which will really apply to implementers of the APIs.

So, for—there's a lot of resources on our website. Our final rule is up, including our fact sheets. You can go to cms.gov and find that there. And our final rule intersects a lot with the—with final rules from the Office of the National Coordinator for health IT. So included links and a fact sheet to their recently finalized Health Data, Technology, and Interoperability (HTI-1) final rules as well. And then as well as links to our previous final rule that was finalized in May 2020, and the 21st Century Cures Act final rule also finalized then. Any more detailed questions, please reach out to our team. We're at CMSInteroperability@cms.hhs.gov. So, we—this is our main mailbox, and we will respond to every question. So, any questions, feel free to reach out. Thank you. And I will now turn things over to…

Jill Darling: You can turn it back to me.

Scott Weinberg: Great. To Jill. Great. Thank you.

Jill Darling: Thank you, Scott, Erick, and Camille. We'll be going to Q&A now. So, we'll wait to get more hands. I see three hands at the moment. So, if you would like to get into the queue, please click the raise hand feature and we will take a question from you and one follow-up.

Marvelyn Davis: Elisa, your line is unmuted.

Elisa Kogan: Hi, thank you. Elisa Kogan with the Medical College of Wisconsin. With respect to G2211 and the updated article that was published last week, which was very helpful, we're still struggling to understand how we can demonstrate continuing, ongoing, or longitudinal care when the service is reported with a new patient visit code 99205—202 to 99205 because that relationship has not yet been established.

Gift Tee: Thanks for that question, Elisa. It's the only question we've been hearing about from—from—from—lots of providers and practitioners out there. I would think of it this way, you know, certainly it's a new patient code, but the circumstance that practitioners treating—participants treating—you know, could envision the beginning of a relationship. I don't want to be too specific versus just painting a broad picture, right? Intention to establish a relationship given what's being treated. We're really looking for the idea of you know, a primary care

intervention that would require some time given a diagnosis, given the treatment guidelines and so on and so forth. Of course, all that have information would be represented in the documentation—in the patient's medical record. That would give us room to think about what has been billed and whether it appropriate, but that's how I would broadly think about using it in that context in the new patient versus the established patient.

Elisa Kogan: And so my follow-up: So, in the primary care scenario, patient presents to establish primary care they have blah, blah, blah, blah, whatever. That could be used to describe intent even if they haven't had a follow-up visit, it's the intention that they are seeking to establish a primary care relationship that would be sufficient?

Gift Tee: Well, there are a couple things there, right? It's not just, I intend to see the patient and never see the patient again. It's the circumstances, a collection of all of those pieces. I'm working towards treating the patient this way, this is what they're presenting with, I am the primary care, this is—I am the person that this patient's going to be seeing over some amount of time, therefore, I am doing these things. We're really thinking about the resource cost and the effort that would go into that relationship with the patient, and how to quantify that is what we thought about in the policy for G2211. So that's how we think about it, but I will emphasize, we certainly will want to see a record documentation, right? Why the practitioner thought about the patient that way and what they intend to do and what makes them clinically versus a one-off visit.

Elisa Kogan: Okay. Thank you.

Marvelyn Davis: Shelley your line is—Arlene, your line—Shelley, your line is unmuted. Shelley Nave? Nave?

Shelley Nave: Hello? I'm sorry.

Marvelyn Davis: No worries.

Shelley Nave: My name is Shelley Nave. I work at FinThrive, and I have a question. Could the G2211 be reported with nursing home E/M visits, 99307 through 99310?

Gift Tee: Hi, Shelley, no, no. At this point in time—maybe I should say that differently—the policy only considers the office/outpatient visit codes and no other E/M codes.

Shelley Nave: Okay. Thank you so much.

Marvelyn Davis: Arlene, your line is unmuted.

Arlene Wivell-Kozar: Can you hear me?

Marvelyn Davis: Yes, we can hear you.

Arlene Wivell-Kozar: Thank you. So, I'm calling from Heritage Valley Medical Group. And this is in relation to G2211 and covering partners in the same group practice. So, for example, we

have a primary care group made up of physicians and NPPs (nonphysician practitioners). So, when an NPP or another physician covers for their partner, can the covering partner report G2211? For example, Dr. A is the focal point for all patient care for a patient and then, the patient has an acute visit for elevated blood pressure and is seen by the NPP in the group instead of Dr. A. Can the NPP report G2211?

Gift Tee: Hey there, Arlene. Great question. So, we like to think about the relationship between the patient and the group considering the different practitioners, [inaudible] practitioners and their specialties. We have some long-standing policy that considers the relationship with—between the patient and the group as considering three years of time and whether the specialty for those practitioners are the same or different. So, there's different considerations here, but again, let me paint a broad picture just like I did for someone that asked the question recently—just now. I'll just use myself. I walk into that clinic, I see my usual doctor, doctor just happens to be on vacation the next time I need to go in but, you know, I'm being treated for some ongoing condition, but you are my primary practitioner. In that case, we would think that the group could bill, or another treating practitioner in the group could bill, the G2211 as an ongoing, right? Interaction or encounter with that patient. Assuming that those are the same—that those practitioners have the same specialty. Now, you called out an advanced practice practitioner, specifically an NP. We, at least from a Medicare perspective, don't currently differentiate the specialty for the NPP the way we do for physician practitioners. And so, at this point in time, I think it would be allowed if again, that relationship is there between that patient and the group. Does that help?

Arlene Wivell-Kozar: It does help. Thank you.

Marvelyn Davis: Debra, your line is unmuted. Deb Walsh, your line is unmuted.

Deb Walsh: Thank you, I'm calling from Essentia Health, and my question is in regards to the G2211 code. Under the teaching physician guidelines for services performed by residents under our primary care exception, will the G2211 code be another service that the resident can perform without the teaching physician present with a low-level E/M such as the 99202 through 992—or 99213?

Gift Tee: Debra, that's a great question. So, I really appreciate all these questions. We are working on FAQs that hopefully will address a broad swath of all of these. Again, primary care exemption, teaching resident is billing—is allowed to bill—those low-level E/M if they are the focal point for that person's care—that patient's care—right? And all this is evidence again, in the medical record. Again, assuming the interaction between the teaching physician and the resident, one could bill a G2211 if all those other things are true.

Deb Walsh: Okay. Thank you.

Gift Tee: For the low level. For those codes that fall within the primary care exception.

Deb Walsh: Correct. Great. Thank you.

Marvelyn Davis: Shannon McGrath, your line is unmuted.

Shannon McGrath: Thank you. My question is also regarding G2211. Can it be billed on the same day as the prolonged care code?

Gift Tee: Shannon, I think I'll have to take that one back. I don't know if you have our mailbox, but it would be helpful if you would send us an email and we'll consider that particular question.

Shannon McGrath: Okay. And may I ask a follow-up question as well?

Gift Tee: I think she's allowed. So yes, please.

Shannon McGrath: Okay, great. Thank you. Is there any limit to the number of times G2211 can be billed in a particular time period?

Gift Tee: Wow. For a different patient, I'm assuming, or same patient?

Shannon McGrath: Both actually. For a single patient during a particular time period and for total volume I guess, for multiple patients.

Gift Tee: So, you would bill G2211 in concert with an office/outpatient in that range. So, to the extent that those two visits are happening, the patient is being treated then, yes. But I'm going to underscore this and, you know, we've got a very strong program integrity framework here at CMS. There's got to be documentation [inaudible] that suggests why the practitioner believes they are, you know, treating the patient on this long-standing, long longitudinal trajectory and, you know, we'll be able to see how that interaction is happening. But those visits are being billed and the practitioner believes they are, you know, treating the patient appropriately then absolutely, there are no limits on the G2211 that way. At least not yet.

Shannon McGrath: Okay. Thank you.

Marvelyn Davis: Samantha Erks, your line is unmuted.

Samantha Erks: Hi, I actually—both of my questions were actually answered already. So, thank you.

Marvelyn Davis: Thank you. Karen, your line is unmuted.

Karen Pettit: Hi, I'm Karen Pettit from Texas Health Resources. My question overlaps with a prior question. The G2211s. I'd like clarification regarding whether [inaudible] in general, the resident participates in the service [inaudible] patient [inaudible]. In those situations, would we be—would it be appropriate to bill the G2211 in addition to that payment code?

Gift Tee: I'm sorry, Karen, your audio is garbled. I don't know if it's just me on my end but if you wouldn't mind sending your question to our mailbox. Jill was kind enough to put it in the

chat, partnership@cms.hhs.gov. I think we'll take the question that way and try to get a response back to you.

Karen Pettit: Okay. Thank you.

Marvelyn Davis: Paula Hannon, your line is unmuted.

Paula Hannon: Hi, thank you. I'm calling from Mercy Medical in Baltimore. Is G2211 specifically for primary care physicians? What about specialists like endocrinologists or gastroenterologists? Or is it more a primary care-focused because they're managing, you know, comorbid conditions.

Gift Tee: So, we don't have—thank you for the question. We don't have limits on what specialty is allowed to bill through the G2211, but what we are paying attention to is how they are serving as, you know, the primary clinical interaction for a longitudinal treatment plan or engagement encounter with that patient, right? In other words, you show up and meet your endocrinologist or some other specialist like that, what does that look and feel like over some amount of time? Unlike continuing to go to that person versus just a one-off encounter. So, we're really looking at it from a perspective of how is this person—practitioner—interfacing with that patient? What are they treating? And are they the primary clinical interaction versus I just need to see a specialist for this issue and then I'm gone? And then I go back to my primary care practitioner. But if I'm seeing that specialist on an ongoing basis because this is someone that is actively managing my care, right? Then I think we would consider that allowable for the specialist billing for that service.

Paula Hannon: Okay. Thank you.

Marvelyn Davis: Claudia Lewis, your line is unmuted.

Claudia Lewis: Hi, thank you. Claudia Lewis from UCSD (University of California San Diego), and I believe this is—it might have been answered but I have more of a question related to team-based approaches. So, we have, let's say a transplant team, that treats the patient in multiple—and they—the patient comes in and sees, you know, different providers but they're part of the same care team. If they are the same specialty, then that would be okay to report the G2211 by those providers?

Gift Tee: So, they're all part of the team-based care. They're seeing the patient at different times, right? Not all at the same time?

Claudia Lewis: Right.

Gift Tee: So, we should be able to see in the claims that are submitted different, let's say, office visits specifically with different MPIs (Master Patient Index) for each of the treating practitioners, right?

Claudia Lewis: Yes.

Gift Tee: Okay. Well, in that case again, no limits on that. I'll stop repeating myself about the medical record and, you know, fraud and program integrity, but for each office/outpatient being treated—being billed—by the treatment practitioner that just happened to be practicing team-based care, the G2211 would be allowed.

Claudia Lewis: By any of the providers. Perfect. Thank you so much.

Marvelyn Davis: Amy Rogers, your line is unmuted.

Amy Rogers: Hi, good afternoon. More G2211 questions. We're rheumatology specialists in Illinois and we're anticipating using the G211 due to the chronic illness. The thing that we struggle with the most is, quote, "the longitudinal description of documentation." You know, of leaving it up to someone if there would be an audit what—you know—what they think we're saying. So, we're trying to look for some—some—information from you with regards to if they—if we—say we're going to see you in three months, and we order labs and they have a diagnosis code like RA or something, is that suffice to support these G2211s?

Gift Tee: So, I think a lot of you need to have these conversations with your compliance officers about, you know, what the expectation might be, but again, painting in broad strokes, we really rely on the medical record documentation to suggest what that interaction between the patient and the practitioner look and feels like. Is it reasonable given what information is in there if there is some, you know, long-standing relationship between patient/practitioner, because there is something that the practitioner is actively treating and working on and you know, serving as the focal point for care? You know, we use the word "primary care." What we're meaning is really that interaction. What is the patient—what is the practitioner—having to put in to making sure that that patient is receiving the treatment that they need? In your specific case, right? The idea that you're thinking 30 days or 60 days beyond for the rheum treatment, you know, I would defer to how that interaction looks like from your organization's perspective and make your call there.

Amy Rogers: Well, being rheum treatment is a lifetime—it doesn't go away—so do we document in the chart every time that we've seen this patient for the last five years for this diagnosis?

Gift Tee: I purposely danced around your question a bit, Amy. That's why I'm pointing back to how you all would usually treat such patients. But again, from our perspective, are you serving as the focal point for that care? And in this case, it sounds like it, you know.

Amy Rogers: It's just a little bit scary when there's not—you know what I mean? I understand it's something new and it's very open-ended but yeah, we just want to make sure we're doing the right thing and documenting it correctly. Thank you.

Gift Tee: No, absolutely. And again, I'm going to double down on the documentation being your friend in this case, right? Really helping folks understand what you are—what that practitioner is doing with that patient.

Amy Rogers: Yeah.

Marvelyn Davis: Lance Marshal, your line is unmuted. Lance Marshal, your line is unmuted.

Gift Tee: Folks, we've got maybe one more minute. So, Lance, if you're out there, this may be the last question. Otherwise, we might go to the next and you know, we'll take all the questions that we're unable to answer today, which are great by the way, to our mailbox. This way, we can consider them and continue to build—build our FAQ database to share information broadly. So, one more time, Lance. If not, Marvelyn, let's go to the next person, please.

Marvelyn Davis: Will do. Kayla Mangler, your line is unmuted.

Kayla Meagher: Hi, can you hear me?

Marvelyn Davis: Yes.

Kayla Meagher: Okay. So, my question is in regard to again, G2211, but I'm specifically wondering if CMS is going to put out a definition of any kind for a serious—a single serious or a complex diagnosis or condition or whatever, you know, whatever that wording is. I've had a couple of providers already ask me what—well, does hypertension count or does it need to be something more complex than that, you know? So just some guidance on that.

Gift Tee: No, appreciate that, Kayla. A good question to close out the series of questions. I'll mention again that we are working on an FAQ document that will try to touch on all of these questions and may offer some examples of what such, you know, conditions might look like for your consideration. It won't be an expansive—what's the word I want to use—prescriptive list of conditions to consider versus just examples that help folks understand what is expected and what should be documented in record or at least considered when billing for the service. But again, thank you—thank you all for the great questions.

Kayla Meagher: And if I could have just one quick follow-up question. I know that we're running short on time. I'm just wondering if G2211 can be billed with 99211 if, for example, a patient is being followed longitudinally for hypertension and then they're coming in for their blood pressure checks and that's what the 99211 is billing—being billed for.

Gift Tee: Go ahead and send that question to us. It's a lot for us to think through how specific we want to be and how broad.

Kayla Meagher: Sure. Absolutely, thank you.

Gift Tee: Thank you.

Jill Darling: Well, thank you everyone for joining us today. I know we did have a few hands that we could not get to, but I did put the partnership email in the chat as well as the link when the transcripts and Q&A document will be posted to the Podcast and Transcript web page. Again, thank you for joining us. And then I'll pass it to Gene.

Dr. Eugene Freund: Okay. Thank you. It was about early in the century I was in another part of CMS, and they brought on my predecessor, Dr. Bill Rogers, and started the whole set of Open Door Forums. And I've been pleased and happy to be a part of some of these and some of the other interactions. And I'm letting you know that I retire from federal service effective this Sunday. And I just want to thank you for the good questions. I want to state my own personal opinion that I think that over all those years, CMS has made big strides at being open and getting feedback from the practitioner community. And that has nothing to do about my being here or not, so it's going to continue. I think it's part of the agency's DNA. Please keep giving us the questions and helping us get better, and thank you so much for what you do for patients all around the country. And that's it. Jill?

Jill Darling: Yes, great. Thanks, Gene. We will miss you, but enjoy your retirement. And thanks again, everyone, for joining. And that will conclude today's webinar. Thank you.