CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13753	**Date: May 7, 2026**
	Change Request 14447

SUBJECT: Update of Edits That Deny Payment of Healthcare Common Procedure Coding System (HCPCS) Add-On Code G2211

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the edits that prevent payment of HCPCS add-on code G2211. There will also be updates to the Internet Only Manual (IOM) in chapter 12 sections 30.6.7 and 30.6.19 that will highlight the G2211 add-on.

EFFECTIVE DATE: January 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2026

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
R	12/30/30.6.19/Office/Outpatient Evaluation and Management (O/O E/M) Complexity Add-on Payment (Code G2211)

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

Pub. 100-04	Transmittal: 13753	Date: May 7, 2026	Change Request: 14447

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the edits that prevent payment of HCPCS add-on code G2211. There will also be updates to the Internet Only Manual (IOM) in chapter 12 sections 30.6.7 and 30.6.19 that will highlight the G2211 add-on.

II. GENERAL INFORMATION

A. Background: This CR applies the same criteria established in CR 13272 and CR 13705 to allow payment of the Evaluation and Management (E/M) visit complexity add-on code G2211 when billed with home or residence E/M Current Procedural Technology (CPT) code ranges 99341, 99342, 99344, 99345 and 99347–99350. As a result, G2211 is now permitted to be reported with these specified home/residence E/M services when all applicable billing requirements are met.

B. Policy: CMS has finalized updates to refine our current policy for services furnished beginning in Calendar Year (CY) 2025 to allow payment of the E/M visit complexity add-on code when in an Office/Outpatient (O/O), and beginning in CY 2026 home or residence, when an 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, outpatient, home or residence 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	
14447.1	The contractor shall add the existing editing and		X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	bypass criteria identified in CR 13272 and CR 13705 for CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, and 99350.									
14447.2	The Medicare Contractors shall be aware of the manual updates in Pub 100-04 chapter 12, sections 30.6.7 and 30.6.19.		X							
14447.3	Contractors shall update the User-controlled table to reflect changes in attachment 1 and they shall update the user table to add the following codes within 10 business days from the issuance of this CR: Codes to add- 91323	X	X							

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

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: 1

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

(Rev. 13753; Issued: 05-07-26; Effective: 01-01-26; Implementation:10-05-26)

A. Definition of New Patient for Selection of E/M Visit 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. ***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.

30.6.19 – Office/Outpatient Evaluation and Management (O/O E/M) Complexity Add-on Payment (Code G2211)

(Rev. 13753; Issued: 05-07-26; Effective: 01-01-26; Implementation:10-05-26)

Beginning January 1, 2021, Medicare established HCPCS add-on code G2211, describing intensity and complexity inherent to O/O E/M visits (CPT codes 99202-99205, 99211-99215) 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. (See the CY 2021 Medicare Physician Fee Schedule final rule in the Federal Register (85 FR 84571)). The Consolidated Appropriations Act, 2021, delayed PFS payment for HCPCS code G2211 until January 1, 2024, or later. To implement the delay Medicare changed the status indicator to "bundled" for HCPCS add-on code G2211. Effective January 1, 2024, Medicare changed HCPCS add-on code G2211's status indicator to "active" to make it separately payable.

Beginning on January 1, 2026, Medicare allowed payment for HCPCS add-on code G2211 billed as an add-on code with the home or residence E/M visit code family (CPT code 99341, 99342, 99344, 99345, 99347- 99350). Medicare refined HCPCS add-on code G2211's code descriptor to read as follows, "(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))". (See the CY 2026 Medicare Physician Fee Schedule final rule in the Federal Register (90 FR 49462-49644.)

HCPCS add-on code G2211 reporting is not restricted based on specialty. HCPCS add-on code G2211 may be reported with any O/O E/M visit level (CPT codes 99202-99205, 99211-99215) and home or residence E/M visit level (CPT codes 99341, 99342, 99344, 99345, 99347-99350). 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 results 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.

Prior to January 1,2025, the A/B MACs (A & B) shall not pay code HCPCS add-on code G2211 on the same date of service as an O/O E/M visit (CPT 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 with modifier 25 on the same date of service as an O/O E/M visit (CPT codes 99202-99205, 99211-99215), and effective January 1, 2026, as a home or residence E/M visit (CPT codes 99341, 99342, 99344, 99345, 99347-99350) may be payable when an AWV/IPPE, preventive and vaccine administration service is also present for the same date of service. The list of eligible preventive and vaccine administration services 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 HCPCS 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 HCPCS 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 HCPCS add-on code G2211 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, 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 HCPCS add-on code G2211 could be billed. HCPCS add-on code G2211 captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.

HCPCS/CPT Code	Short or Long Descriptor	Status Code
71271	Ct thorax lung cancer scr c-	A
74263	Ct colonography screening	A
76706	Us abdl aorta screen 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	Dxa bone density axl vrt fx	A
80061	Lipid panel	X
80081	Obstetric panel inc hiv tstg	X
81528	Oncology colorectal scr	X
82270	Occult blood feces	X
82947	Assay glucose blood quant	X
82950	Glucose test	X
82951	Glucose tolerance test (gtt)	X
83036	Hemoglobin glycosylated a1c	X
86592	Syphilis test non-trep qual	X
86593	Syphilis test non-trep quant	X
86631	Chlamydia antibody	X
86632	Chlamydia igm antibody	X
86704	Hep b core antibody total	X
86706	Hep b surface antibody	X
86780	Treponema pallidum	X
87110	Chlamydia culture	X
87270	Chlamydia trachomatis ag if	X
87320	Chlmyd trach ag ia	X
87340	Hepatitis b surface ag ia	X
87341	Hep b surface ag neutrlzj ia	X
87490	Chlmyd trach dna dir probe	X
87491	Chlmyd trach dna amp probe	X
87590	N.gonorrhoeae dna dir prob	X
87591	N.gonorrhoeae dna amp prob	X
87800	Detect agnt mult dna direc	X
87810	Chlmyd trach assay w/optic	X
87850	N. gonorrhoeae assay w/optic	X
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
90480	Admn sarscov2 vacc 1 dose	X
90653	Iiv adjuvant vaccine im	X
90656	Iiv3 vacc no prsv 0.5 ml im	X
90657	Iiv3 vaccine splt 0.25 ml im	X
90658	Iiv3 vaccine splt 0.5 ml im	X
90660	Laiv3 vaccine intranasal	X
90661	Cciiv3 vac abx fr 0.5 ml im	X
90662	Iiv no prsv increased ag im	X
90670	Pcv13 vaccine im	X
90671	Pcv15 vaccine im	X
90673	Riv3 vaccine no preserv im	X
90677	Pcv20 vaccine im	X
90684	Pcv21 vaccine im	X
90732	Ppsv23 vacc 2 yrs+ subq/im	X
90739	Hepb vacc 2/4 dose adult im	X
90740	Hepb vacc 3 dose immunsup im	X
90743	Hepb vacc 2 dose adolesc im	X
90744	Hepb vacc 3 dose ped/adol im	X
90746	Hepb vaccine 3 dose adult im	X
90747	Hepb vacc 4 dose immunsup im	X
90759	Hep b vac 3ag 10mcg 3 dos im	X
91304	Sarscov2 vac 5mcg/0.5ml im	X
91318	Sarscov2 vac 3mcg trs-suc im	X
91319	Sarscv2 vac 10mcg trs-suc im	X
91320	Sarscv2 vac 30mcg trs-suc im	X
91321	Sarscov2 vac 25 mcg/.25ml im	X
91322	Sarscov2 vac 50 mcg/0.5ml im	X
91323	Sarscov2 vac 10 mcg/0.2ml im	X
96380	Admn rsv monoc antb im cnsl	A
96381	Admn rsv monoc antb im njx	A
97802	Medical nutrition indiv in	A
97803	Med nutrition indiv subseq	A
97804	Medical nutrition group	A
99406	Behav chng smoking 3-10 min	A
99407	Behav chng smoking > 10 min	A
99497	Advncd care plan 30 min	A
99498	Advncd care plan addl 30 min	A
G0008	Admin influenza virus vac	X
G0009	Admin pneumococcal vaccine	X
G0010	Admin hepatitis b vaccine	X
G0011	Hiv prep counsel, md 15-30m	A
G0012	Injection of hiv prep drug	A
G0013	Hiv prep counsel, clin staff	A

G0101	Ca screen;pelvic/breast exam	A
G0102	Prostate ca screening; dre	A
G0103	Psa screening	X
G0104	Ca screen;flexi sigmoidscope	A
G0105	Colorectal scrn; hi risk ind	A
G0108	Diab manage trn per indiv	A
G0109	Diab manage trn ind/group	A
G0121	Colon ca scrn not hi rsk ind	A
G0123	Screen cerv/vag thin layer	X
G0124	Screen c/v thin layer by md	A
G0130	Single energy x-ray study	A
G0136	Adm of soc dtr assess 5-15 m	A
G0141	Scr c/v cyto,autosys and md	A
G0143	Scr c/v cyto,thinlayer,rescr	X
G0144	Scr c/v cyto,thinlayer,rescr	X
G0145	Scr c/v cyto,thinlayer,rescr	X
G0147	Scr c/v cyto, automated sys	X
G0148	Scr c/v cyto, autosys, rescr	X
G0270	Mnt subs tx for change dx	A
G0271	Group mnt 2 or more 30 mins	A
G0296	Visit to determ ldct elig	A
G0327	Colon ca scrn;bld-bsd biomrk	X
G0328	Fecal blood scrn immunoassay	X
G0402	Initial preventive exam	A
G0403	Ekg for initial prevent exam	A
G0404	Ekg tracing for initial prev	A
G0405	Ekg interpret & report preve	A
G0432	Eia hiv-1/hiv-2 screen	X
G0433	Elisa hiv-1/hiv-2 screen	X
G0435	Oral hiv-1/hiv-2 screen	X
G0438	Ppps, initial visit	A
G0439	Ppps, subseq visit	A
G0442	Annual alcohol screen 15 min	A
G0443	Brief alcohol misuse counsel	A
G0444	Depression screen annual	A
G0445	High inten beh couns std 30m	A
G0446	Intens behave ther cardio dx	A
G0447	Behavior counsel obesity 15m	A
G0472	Hep c screen high risk/other	X
G0473	Group behave couns 2-10	A
G0475	Hiv combination assay	X
G0476	Hpv combo assay ca screen	X
G0499	Hepb screen high risk indiv	X
G0513	Prolong prev svcs, first 30m	A

G0514	Prolong prev svcs, addl 30m	A
G9880	Em 5 percent wl	X
G9881	Em 9 percent wl	X
G9886	In-person attendance g code	X
G9887	Distance learning attendance	X
G9888	5% wl maintnd from bsline wt	X
J0739	Hiv prep, inj, cabotegravir	X
J0750	Hiv prep, ftc/tdf 200/300mg	X
J0751	Hiv prep, ftc/taf 200/25mg	X
J0799	Hiv prep, fda approved, noc	X
P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision	X
P3001	Screening pap smear by phys	A
Q0091	Obtaining screen pap smear	A
Q2039	Influenza virus vaccine, nos	X