



I Ain't Afraid of No G-Codes!

April 2026





Objective & Agenda

Objective: To provide an understanding and answer questions regarding the prolonged care codes and add-on complexity code G2211.

Agenda

- Billing prolonged care
- How to use G2211
- Denials and rejections
- Interactive Q&A





Prolonged Care Overview



Medical Necessity

- Social Security Act [1862\(a\)\(1\)\(A\)](#)
- Services must be:
 - Reasonable
 - Medically necessary
 - Not statutorily excluded



Prolonged Care Basics

- Billed with primary E/M code
- Not used if using MDM
- Time based codes
- Additional time spent on patient care
- Includes
 - Face-to-face time
 - Non-face-to-face time



Non-Face-to-Face Time

- Preparing to see patient
- Obtaining or reviewing separate history
- Performing exam
- Counseling or educating patient/family/caregiver
- Ordering
 - Medications
 - Tests
 - Procedures
- Referrals and communications
 - Not separately reported
- Documenting encounter
- Independently interpreting results
 - Not separately reported
- Care coordination
 - Not separately reported



Do Not Count

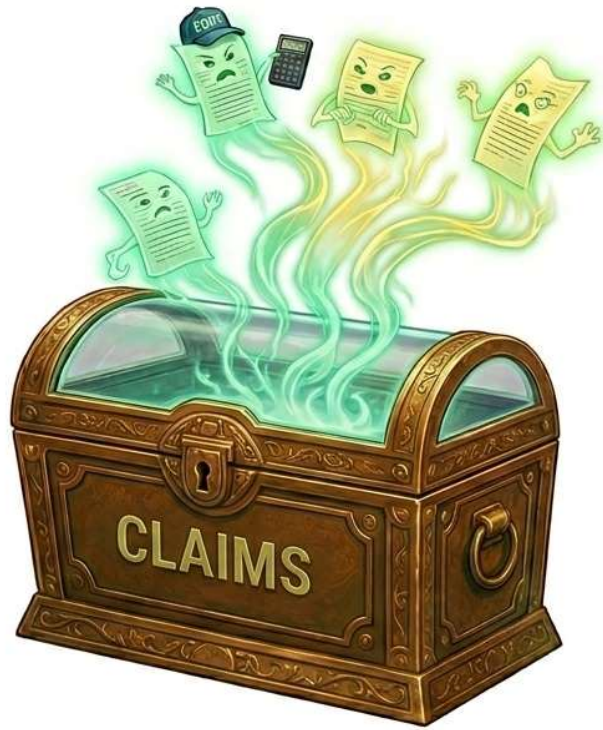
- Performance of services separately reported
- Travel time
- Teaching that is general and not specific for management of individual patient



Time Thresholds

- Must exceed highest level of service
- Examples
 - 99205
 - 99215
- Must meet or exceed threshold
- 15-minute increments





Billing Requirements



Office/Outpatient Services

HCPCS Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes.	99 or more

- Procedure code G2212
- Level of service chosen by time
- Same DOS
- Must exceed highest level
 - 99205
 - 99215
- Must meet full 15 minutes



Additional G2212

- Cognitive assessment and care planning
- Include time from:
 - 3 days before
 - DOS
 - 7 days after

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Cognitive Assessment and Care Planning (99483)	G2212	100 minutes	3 days before visit + date of visit + 7 days after



Nursing Facility

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial NF Visit (99306)	G0317	95 minutes	1 day before visit + date of visit + 3 days after
Subsequent NF Visit (99310)	G0317	85 minutes	1 day before visit + date of visit + 3 days after
NF Discharge Day Management	n/a	n/a	n/a

- Procedure Code G0317
- Must exceed highest level
 - 99306
 - 99310
- Include time from:
 - 1 day before
 - DOS
 - 3 days after



Home Visits

- Procedure Code G0318
- Must exceed highest level
 - 99345
 - 99350
- Include time from:
 - 3 days before
 - DOSs
 - 7 days after

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Home/Residence Visit New Pt (99345)	G0318	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	110 minutes	3 days before visit + date of visit + 7 days after



Documentation

- Clearly document total time
- Total time includes:
 - Face-to-face time
 - Non-face to face qualifying activities
- Reason for prolonged care
- Medical necessity



Resources

- [Evaluation and Management Services MLN Booklet](#)
- *Medicare Claims Processing Manual, [Chapter 12](#), section 30.6.15*
- [Prolonged Care Procedure Codes](#)



Top Denials

- Must bill with primary service
- Units of service exceeded
- Period of managed care
- Duplicate charge
- Not payable in a facility



Top Rejections

- Invalid or missing modifier
- Claim lacks information needed for adjudication
- No submitted charges billed
- Clinic number missing or not entered accurately
- Claim must be submitted to RRB





Prolonged Care Q&A Activity



Prolonged care may be used when the level of service is chosen by MDM. True or false?

A

True

B

False

C

I'm afraid I don't know

D

What is MDM?



Complex CCM may be reported the same month as prolonged E/M services. True or false?

A

True

B

False

C

Sometimes

D

What are prolonged services?



Prolonged care may **not** be reported with which of the following E/M services?

A

Inpatient visits

B

Critical care services

C

Office services

D

Home visits



Prolonged care may be reported for emergency department services. True or false?

A

True

B

False

C

Sometimes

D

Call
Ghostbusters
for my answer



All prolonged care codes allow you to provide the additional time on days other than the encounter date. True or false?

A

True

B

False

C

Prolonged care is not covered by Medicare

D

Only in Hollywood



Charts identifying the prolonged time required for each category of service may be found in which resource?

A

Program Integrity Manual, Chapter 3

B

Claims Processing Manual, Chapter 12

C

WPS website

D

Medicare.gov



Prolonged care time may be counted for nursing facility care on:

A

Day of visit
only

B

Day of visit
+
3 days after

C

Day before visit
+
day of visit
+
3 days after

D

Day of visit
+
day after



If a provider is billing an office visit with 77 minutes total, which is the appropriate combination for time spent on this visit?

A

99204 x 1
and
G2212 x 1

B

99205 x 1
and
G2212 x 1

C

99205 x 1

D

G2212 x 2



If a provider is billing an initial nursing facility visit with 97 minutes total, which is the appropriate combination for time spent on this visit?

A

99306 x 1
and
G0317 x 1

B

99306 x 1
and
G0318 x 1

C

99306 x 1

D

99310 x 1
and
G0317 x 2





Questions and Answers



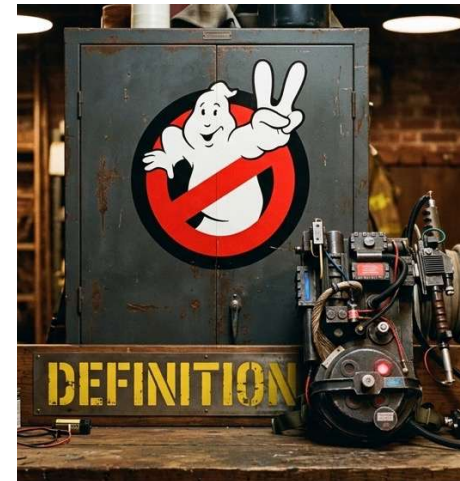


G2211 Made Easy: What You Need to Know



Definition

- Longitudinal relationship
 - Long-term relationship with this patient
- Focal point of health care
- Single, serious condition
- Complex condition



Add-on Code



- Primary code
- New patient
 - 99202-99205
- Established patient
 - 99211-99215
- Home visits
 - 99341-33950



Relationship

- Appropriate use depends on relationship between practitioner and patient
- Focal point for all patient health care needs
- Ongoing medical care
 - Single, serious condition
 - Complex condition



Relationship Changes



- No longer use G2211 if
 - You are no longer focal point for all their health care needs
 - Patient no longer has single, serious condition or complex condition



Provider Specialty



- Not restricted to any specialty
- Documentation will show
 - Relationship between patient and practitioner
 - Focal point of health care needs
 - Single, serious condition
 - Complex condition

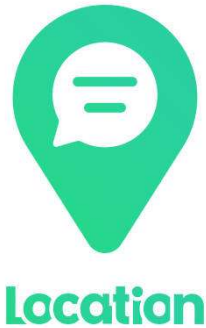


Eligible Practitioners

- MD/DO
- NPP
- CAH – Method II, Bill type 85
- RHC
- FQHC
 - For RHC/FQHC, no additional reimbursement
 - Can include on your claim



Place of Service



- 02 – Telehealth
- 10 – Telehealth in patient’s home
- 11 – Office
- 19 – Outpatient off-campus
- 22 – Outpatient on-campus
- Home
 - 12, 13, 14, 33, 55

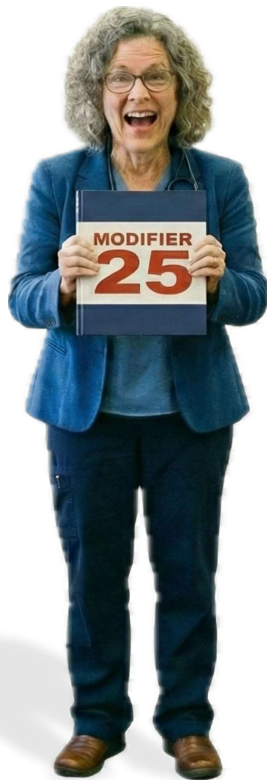


Additional Details

- Patient has cost-sharing
 - Deductible
 - Coinsurance
- Frequency
 - If appropriate to submit, there are no frequency limitations



Modifier 25



- Indicates significant, separately identifiable E/M service
- Applies to:
 - Services with a global surgery period
 - Could apply to additional services
- Verify using modifier correctly



Modifier 25 Exceptions

- Do not submit G2211 when modifier 25 appended to E/M service
- Exceptions effective January 1, 2025:
 - Part B preventive services
 - Immunization administrations
 - Annual wellness visits
- How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211



G2211 Documentation

- Documentation must support:
 - Medical necessity of encounter
 - Level of service
 - Patient and practitioner longitudinal relationship
 - Focal point for health care needs
 - Single, serious condition
 - Complex condition



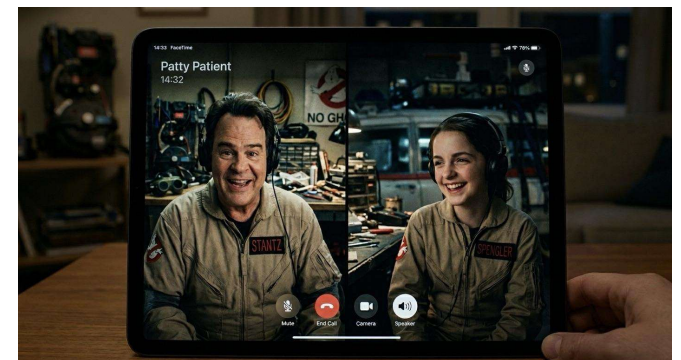
Teaching Physician

- Teaching physician submitting under teaching physician guidelines may submit when appropriate
 - Present during encounter
- Applies under primary care exception
 - Low-level E/M codes
- [Guidelines for Teaching Physicians, Interns & Residents](#)



Telehealth

- Appropriate when providing the primary service through telehealth
- If service appropriate for telehealth
- [List of Telehealth Services](#)



Resources



- [How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211](#)
- [CMS FAQs for G2211](#)
- [Change Request 13705](#)
- *Medicare Claims Processing Manual, [Chapter 12](#), Section 30.6.19*



Denials

- Not payable with other service rendered on same DOS
- Must be billed with primary service
- Duplicate charge
- Periods of managed care
- Common Claim Denials

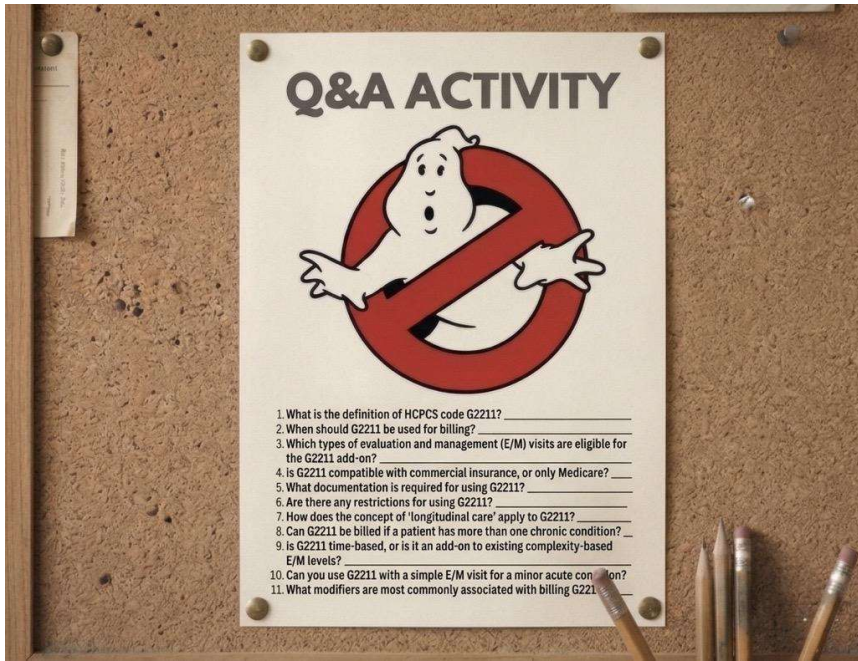


Rejections



- Claim lacks information needed for adjudication
- Missing, incomplete, or invalid place of service
- Unable to obtain primary insurer information
- Rendering physician number invalid or missing
- [How to Correct a Rejected Claim](#)





G2211 Q&A Activity



G2211 is an add-on complexity code used only for office or outpatient visits. True or false?

A
True

B
False

C
Unless the
patient is a
ghostbuster

D
I'm afraid to
answer



You must be the focal point of care, treating a single serious condition, **and** treating a complex condition to bill G2211. True or false?

A

True

B

False

C

True, and you
must be a
ghostbuster

D

I want some
popcorn



G2211 requires a longitudinal relationship with the patient. How long must they be a patient to meet this requirement?

A

2 years

B

There is not a defined length of time

C

5 years

D

30 days



G2211 may not be billed when the E/M service includes modifier 25. Which of the following services done the same day as the E/M are an exception to this rule?

A

Annual
wellness visits

B

Mole removal

C

Destruction of
skin lesions

D

Immunization
administrations



G2211 is billable when the E/M service was done via telehealth. True or false?

A
True

B
False

C
What is
telehealth?

D
Not sure





G2211 Questions and Answers





WPSTM

A HEALTH SOLUTIONS COMPANY

Up next...



Disclaimers

This material is a tool to assist the provider community. Medicare rules change often. Access [CMS' website](#) for current coverage, regulations and rulings.

The basis for answers given today rely on facts given in the question. Medicare rules determine final coverage.

Do not record the event as CMS does not allow this for profit making purposes.



CPT Copyright Notice

CPT codes, descriptions, and other data only are copyright 2025 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

