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In this issue

Billing

CMS unveils fresh guidance, answers key questions about G2211

Make sure documentation supports encounters reported with visit complexity add-on code **G2211**, remember that you can only report it in conjunction with office/other outpatient E/M visits (**99202-99215**) and watch for more education materials soon.

Those are three tips that attendees received during CMS' Physicians, Nurses & Allied Health Professionals Open Door Forum on Jan. 24.

In prepared remarks about the code, Erick Carrera, with CMS' Center for Medicare, announced the publication of MLN Matters 13473, an article that describes how to report the code (*see resources, below*).

Carrera reminded attendees to pay close attention to the provider/patient relationship. "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," he said. The code's descriptor lists the two types of eligible relationships. A provider might be the continuing focal point for "all needed health care services" and/or "part of ongoing care related to a patient's single, serious condition or a complex condition."

Carrera also emphasized that practices can only append the code to office/outpatient E/M codes and outlined the types of documentation that could support G2211, according to the new MLN article:

- Relevant information in the medical record such as diagnoses.

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- The visit's assessment and treatment plan.
- Other services the provider has billed related to the patient's care.

People had questions, CMS gave answers

CMS opened the gates to attendees, and questions about G2211 flooded in. Gift Tee, also with CMS's Center for Medicare, fielded more than a dozen questions about the code.

Here are six questions from the session that you can use to explain the service to your staff. The questions and answers have been edited for clarity.

Question: *How can a provider show that a new patient visit (99202-99205) is part of continuing care?*

Answer: The treating practitioner should make sure their documentation supports their intent to provide ongoing care to the patient, Tee explained. However, based on his remarks, establishing such intent goes beyond a statement that the provider plans to provide ongoing care or schedules a follow-up visit. The circumstances of the visit should support the extra work involved in becoming the focal point of the patient's care or providing ongoing care for a serious or complex condition.

Question: *Dr. Red works at a primary care practice, is the focal point for a patient's care and has reported G2211. If Dr. Yellow, who is the same specialty, or Mr. Green, a nurse practitioner, is covering for Dr. Red, and the patient comes in for a visit, can they report G2211 for that visit?*

Answer: Yes. The same specialty/same provider rules would apply in this situation, Tee explained. But remember that Dr. Yellow's or Mr. Green's documentation for that encounter must support the code.

Question: *Can a resident report G2211 under the primary care exemption?*

Answer: Yes, so long as the service and the documentation meet all the requirements for the exemption and the visit complexity code, Tee emphasized. For example, the resident can only report low-level E/M codes, and the resident must be "the focal point for that person's care," he said.

Question: *Are there frequency limits for how often we can report G2211, either for a single patient in a given time period or by a provider or a practice?*

Answer: Not at this time, but make sure your providers are following the rules for reporting the code. "There's got to be documentation that suggests why the practitioner believes they are treating the patient on this long-standing, longitudinal trajectory, and we'll be able to see how that interaction is happening," Tee said. He also issued a subtle warning to attendees by reminding them that CMS has a very strong program integrity program. Your practice can avoid problems with thorough training, frequent chart review and encouraging the team to ask questions until you feel that everyone is comfortable with the code.

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Question: *Are there any limits on the specialties that can report the code? Is it just for primary care providers?*

Answer: No. Remember that a provider who is managing a single serious or complex condition can also report the code. But CMS expects the documentation to support the ongoing nature of the treatment. If a patient sees a provider as a one-off encounter, perhaps to manage an acute problem, that visit wouldn't qualify. But if the provider clearly documents that they are actively managing the patient's condition, the encounters could qualify.

Question: *Will CMS issue a list of conditions that meet the code's serious or complex condition requirement?*

Answer: CMS has included the examples of HIV and sickle cell anemia in existing guidance, and it plans to issue a few more examples "that help folks understand what is expected," Tee said. However, it won't be a complete list of every condition that might qualify.

3 more tips for early adoption of G2211

Watch for more information from CMS and your MAC on how to report this code. In addition, consider these three tips.

1. **Practices that use the optional patient relationship modifiers might find it easier to check patient relationships against the code's requirements.** Modifiers **X1** (Continuous/broad services — For reporting services by clinicians who provide the principal care for a patient, with no planned endpoint of the relationship) and **X2** (Continuous/focused services — For reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time) track closely to CMS information on the code.
2. **Prepare for a delay in claims processing or unexpected denials if you submit claims before the middle of February.** The MLN article and its companion change request list a Feb. 19 implementation date for the code. The implementation date is the date Medicare administrative contractors (MAC) must be able to follow a new or revised policy.
3. **Ignore guidance that forbids reporting G2211 with modifier 24 (Unrelated E/M service by the same physician during a postoperative period) or 53 (Discontinued procedure).** According to Internet-only manual 100-04, chap. 12, §30.6.7(F), CMS does not "expect reporting of HCPCS code G2211 when the office/outpatient E/M visit is reported with payment modifiers such as a modifier -24, **-25**, or -53." An updated version of the guidance clarifies that only modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) will trigger an edit and a denial. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCES

- MLN 13473: How to use office & outpatient E/M visit complexity add-on code G2211: www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf
- MLN 13272: Edits to prevent payment of G2211 with office/outpatient E/M visit and modifier 25: www.cms.gov/files/document/mm13272-edits-prevent-payment-g2211-office/outpatient-evaluation-and-management-visit-and-modifier.pdf
- MLN 11259: Reporting the HCPCS level II modifiers of the patient relationship categories and codes: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11259.pdf
- Internet-only manual 100-04, chap. 12: www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

Billing

Include G2211's full descriptor in your training

Your practice may call it the visit complexity code, but make sure your coders refer to the full descriptor for **G2211** when they perform or report the service. The details will help them understand when and how to report it. For example, it can only be performed in conjunction with office/other outpatient visits (**99202-99215**).

- Code and full descriptor: 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]).

PBN Perspectives

AI proliferates: Coding and chat remain fertile ground, but watch decision-making

If you've looked around lately, you were sure to notice a predominant story: The boom in artificial intelligence (AI), which has become big news and has penetrated the health care industry via coding, patient communications, information indexing and even patient care. However, the "intelligence" part of the technology seems not to have developed sufficiently to supplant human decision-making in clinical matters.

Spurred by the rise of OpenAI's ChatGPT, AI broke out as the hot tech of the moment across social media and several industries in 2023, including health care. This boom came with advances in "generative" AI — or AI that, like ChatGPT, doesn't just sort information but combines information inputs to perform something like the analysis that distinguishes human creativity.

While processing errors and fears of AI's reach have developed, AI has found its way into the sensitive field of health care without apparent untoward effects.

"Open AI and others that published their work gave a significant leg up to companies that are now able to build off it — folks who already did the hard work of going out and securing the available information, finding hundreds of millions of parameters, and pre-training the model," says Sri Velamoor, president and COO of health IT company NextGen Healthcare, which offers its own AI-assisted encounter note tool Ambient Assist that works with its electronic health record (EHR).

As reported in February 2023, AI was already making its mark in health care via applications that index functions for advanced imaging, turn provider-patient discussions into structured data for EHRs, and enable chatbots to be more responsive to patients than in the past (*PBN 2/20/23*).

Since then, health care AI has taken off. Morgan Stanley research analysts reported in August that "94% of health care companies said they employ AI/ML [machine learning] in some capacity," and the health care industry's "average estimated budget allocation to these technologies is projected to grow from 5.7% in 2022 to 10.5% in 2024."

The 2024 J.P. Morgan Healthcare Conference, held in San Francisco on Jan. 8-11 and featuring speakers such as Tony Blair and Jamie Dimon, had several AI-related panels and presentations, including the unveiling of a Mayo Clinic-Cerebras "multi-year strategic collaboration" on solutions to be powered by the kind of large language models (LLM) used in generative AI, starting with one that the Clinic's news service says "will combine genomic data with deidentified data from patient records and medical evidence to explore the ability to predict a patient's response to treatments to manage disease initially applied to rheumatoid arthritis."

Some available clinical tools sound like the stuff of science fiction. Oncoustics, for example, has an "OnX Liver Assessment Solution" that, the company says, can "apply AI to raw ultrasound signals from readily available handheld ultrasound devices to rapidly differentiate healthy versus diseased tissues." In other words, says James Wang, general partner with VC firm Creative Ventures in Oakland, the AI can "assess physical properties that do not show up on a 2D or 3D image" from the ultrasound data itself.

AI in the trenches?

Some of the models are forward looking, even futuristic. What does AI mean for providers and practices today?

You may already be using simple AI in your EHR. Some vendors plug AI into their software (Cerner's, for example, comes from Oracle), and pair it with a voice transcription module to more quickly populate EHR fields.

"Patient demographic info, vital signs, lab values, medication lists, and even patient history are the most structured and the easiest for AI to process without ambiguity," explains Dev Nag of chatbot company QueryPal. Because it can recognize associative patterns, the AI might even make recommendations — for example, to change a patient's medication dosages if the current dose is underperforming.

But, Nag says, human review is still important: "A physician will be able to appreciate the larger social/physical context" of the patient history, he says. That could mean directing the patient to physical therapy and exercise rather than a higher dose of blood pressure meds.

"Physicians are used to gathering the broadest context they can, and implicitly build causal models of the patient that integrate all aspects," Nag says. "AI — specifically,

(continued on p. 6)

Benchmark of the week

Practices reported fewer E/M modifiers with office visits after new guidelines

Providers were less likely to report an E/M modifier with an office/other outpatient visit one year after the new rules for reporting the visits went into effect.

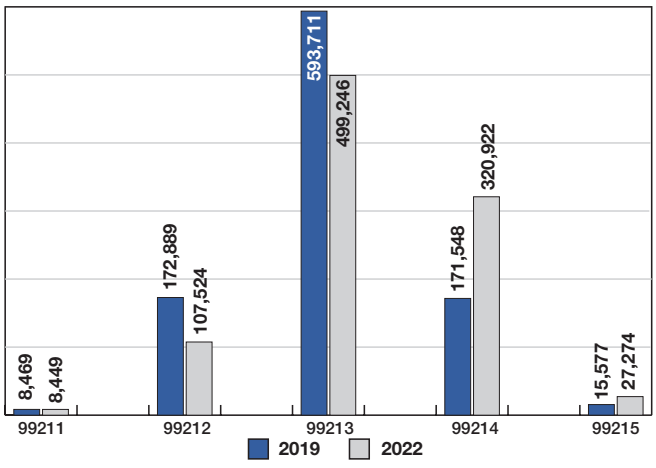
A comparison of Medicare Part B claims data for established patient visits (**99211-99215**) in 2019 and 2022 shows a decrease in claims for 99212 and 99213 with modifier **24** (Unrelated evaluation and management service by the same physician during a postoperative period), **25** (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) or **57** (Decision for surgery).

However, the use of modifier 24 with 99214 and 99215 saw a striking increase during the same period. Practices also increased their use of modifier 57 with level 4 codes.

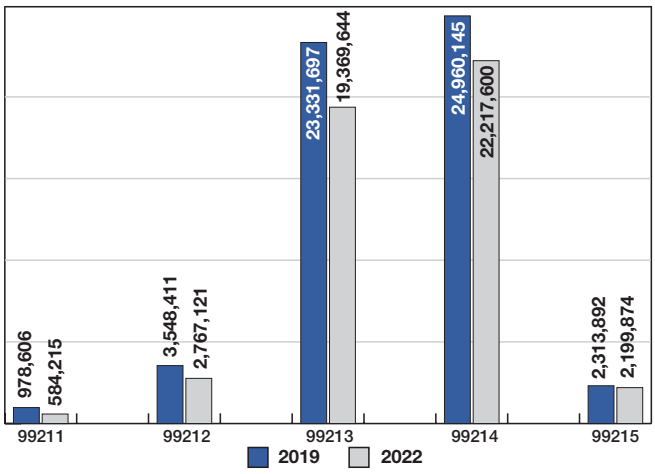
Modifier 25 was the only code that saw a decrease across all codes during the period covered by this benchmark.

The following charts provide a detailed look at coding patterns before and after CMS adopted the new CPT guidelines. The review used data from 2019 rather than 2020 because the overall utilization fell during the COVID-19 public health emergency. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com)

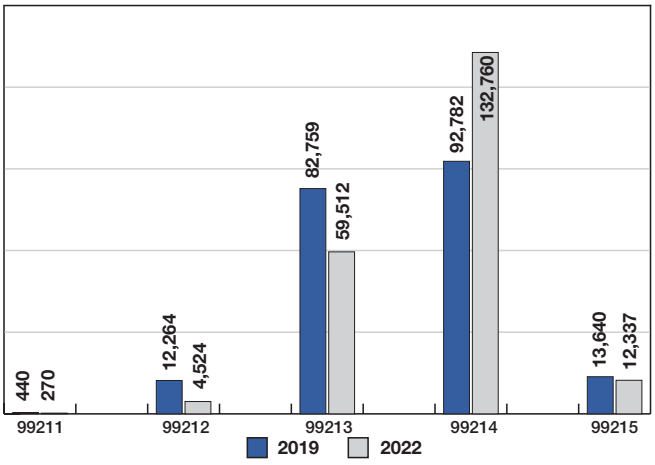
Utilization of E/M office visits with modifier 24 — 2019 vs. 2022



Utilization of E/M office visits with modifier 25 — 2019 vs. 2022



Utilization of E/M office visits with modifier 57 — 2019 vs. 2022



Source: Part B News *analysis of 2019 and 2022 Medicare claims data*

(continued from p. 4)
current large language models — are limited to the context provided in the specific training and inference data, and don't (yet) build internally consistent models" that can be relied on to make human-level decisions.

Still, generative AI can safely deliver substantial improvements on basic health IT in the proper context.

Jessica Jarvis, principal and digital transformation lead at ZS, a management consulting and technology firm in Los Angeles, gives the example of Azure OpenAI, an email-writing solution developed by Epic and Microsoft that responds to patient inquiries — the kind physicians "spend as much as two hours a day responding to," Jarvis says, so it represents a significant time savings. But not only that: an analysis showed these AI-written emails were perceived as "more empathetic than those were coming [directly] from the physicians, who are kind of rushing and doing it all from scratch," Jarvis says.

Can AI code?

Another ground-level aspect of health care in which AI has made real inroads is medical coding. Multiple coding consultancies and products have sprung up advertising AI capabilities that help narrow down choices for human coders. Some have quickly prospered: CodaMetrix, for example, whose CMX Automate coding technology took first place in the 2023 KLAS Research "Reduce Cost of Care" category, has recently scored big-money deals with the Henry Ford Health System and GE, among others.

CodaMetrix promotes Automate as an "autonomous medical coding platform" that "leverages AI in the forms of machine learning (ML) and deep learning in conjunction with NLP (natural language processing) to continuously learn from and act upon the clinical evidence it identifies in EHRs." Other companies such as AGI Health, Fathom and Medicodio have similar offerings.

Susan Boisvert, senior patient safety risk manager with The Doctors Company in Jacksonville, Fla., sees the usefulness in these tools. "Coding is onerous, especially now that we have so many options, e.g. 14,000 codes in the base [ICD] set," she says. But, she also cautions, "once the coding tool has evaluated the record, someone with expertise will have to look at the codes and make sure they're accurate."

While some AI-assisted processes can be monitored intermittently to check how they're working, Boisvert notes the recommendation of the National Institute of Standards and Technology (NIST) is that "high-risk uses of AI such as health care should be monitored continuously — because the difference really between AI and a human, when you get right down to it, is that AI doesn't have judgment."

Feds urge a slow down

NIST isn't the only government player on the case, and their colleagues in Washington, while encouraging of innovation, generally show the industry a yellow light.

On Dec. 14, 2023, the White House announced it had obtained "voluntary commitments from a group of 28 health care provider and payer organizations to help move toward safe, secure, and trustworthy purchasing and use of AI technology." One of these mandates included "adhering to a risk management framework that includes comprehensive tracking of applications powered by frontier models and an accounting for potential harms and steps to mitigate them."

The U.S. Department of Justice has its antennae up as well. A Jan. 29 Bloomberg Law story cites sources claiming federal prosecutors "have started subpoenaing pharmaceuticals and digital health companies to learn more about generative technology's role in facilitating anti-kickback and false claims violations."

The U.S. House Energy and Commerce Subcommittee on Health held a hearing labeled "Understanding How AI is Changing Healthcare" on Nov. 29, 2023, at which committee chair Senator Cathy McMorris Rodgers (R-Wash.) warned of "the potential for human biases to be implicitly baked into AI technologies."

Some investigations, such as one with results published in the journal Science on "Racial bias in health algorithms," have shown AI recommendations in population health contexts may lead to inequitable conclusions that suggest bias, sometimes based on "race and ethnicity as collected in health care demographics," Boisvert says.

Problems with the data?

But other kinds of bias can find their way into AI operation in their current state of development. That may include statistical bias, Boisvert says, whereby flawed data can warp models and to lead to error and misapprehension.

On Dec. 19, 2023, the Journal of the American Medical Association (JAMA) published results of a

study in which clinicians were shown clinical vignettes of imaginary patients hospitalized with acute respiratory failure and were asked to guess the condition. Some vignettes came with "clean" AI predictions, and some came with AI predictions systematically biased to nudge the clinicians toward a conclusion.

Not only were the clinicians who got biased data more likely to come to an inaccurate conclusion — suggesting overreliance on the AI data — but "66.7% of participants were unaware that AI models could be systematically biased," the study authors report. "This study demonstrates that the ability to check an AI model's reasoning using current image-based explanation approaches could fail to provide meaningful safeguards against systematically biased models."

"Unexpected effects on physician decision-making is one of the big concerns associated with the introduction of AI-enhanced tools in the practice setting," Boisvert says.

"Some research does consider whether, as you start to use and get recommendations from AI Solutions, do you as a person risk 'falling asleep at the wheel,'" Jarvis says. "To combat this risk, the upskilling programs that we work on focus on training on how to use the information correctly, and making sure that you're watching out for errors and still incorporating human intelligence."

Perhaps for these reasons, physician respondents to a recent AMA survey on health care and AI were somewhat dubious. While 65% of respondents "see an advantage to AI," only 38% said they were currently using it in practice, and 41% said they were "equally excited and concerned" about it.

As generative AI matures and offers greater security in its use, its health care applications are likely to expand well beyond the chatbots and coding tools that are currently the biggest part of their presence. But that remains in the offing. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

Editor's note: *Read more expert analysis of the state of AI in health care at the Part B News blog:* https://pbn.decisionhealth.com/Blogs/.

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Coding

CPT 2024: Now you can bill multiple unlisted codes with modifiers

In a sign of the expanding role of unlisted CPT codes, practices will be able to append certain modifiers to the codes and even report unlisted codes more than once on a claim in certain circumstances, according to new coding guidelines added to the introduction of the 2024 CPT manual.

Previously, the guidance for reporting unlisted services and procedures was always to gather all the unlisted services provided and report them under a single unlisted code, which was billed just once for the entire encounter.

Starting this year, however, the AMA will permit use of multiple unlisted codes in addition to Category I and III codes. If two separately reportable unlisted procedures are performed in the same anatomic region, "then multiple units of the same unlisted code may be reported with modifier **59** [Distinct procedural service] appended to the additional unit(s)," the manual states.

If unlisted services are done in different anatomic regions providers may report two different unlisted procedure codes, AMA says.

The AMA expanded its reporting guidelines for unlisted codes to allow "reporting unlisted services when separate work effort is performed for two or more procedures that do not have a specific CPT code," the association explained in the book, CPT Changes 2024. The expansion "also involves allowance of reporting undescribed work in conjunction with services(s) that may have specific CPT codes, whether it is Category I or Category III. Lastly, on many occasions, it may be appropriate to report multiple unlisted codes together and existing modifier to explain the circumstances for reporting," the AMA states.

Only certain modifiers apply

According to the new guidelines, practices may append anatomic modifiers such as **50** (Bilateral procedure) or modifiers to indicate a distinct service, such as 59 or **80** (Assistant at surgery). Other modifiers that describe place of service also may be used.

However, it would not be appropriate to use modifiers that describe "alteration of a service or procedure," including modifiers **52** (Reduced services) and **22** (Increased procedural service) with an unlisted code, the manual instructs.

The CPT manual gives the example of a case where two reportable unlisted arthroscopic procedures are done on two separate joints on the same date of service and same patient by the same clinician. Such cases now could be coded with **29999** (Unlisted procedure, arthroscopy) listed on two separate claim lines, with modifier 59 appended to the second unit, the manual says.

Real world use may vary

The changes may open up new opportunities for orthopedic practices. For instance, "our most common multiple unlisted codes are for scopes done on the same joint," says Minnesota-based coding educator Ruby Woodward, CPC, CPMA, CDEO, CEMC, CPCO, CPB, COSC, CSFAC, CPC-I.

Until now, CPT coding guidelines had limited you to reporting only one unlisted code on a single joint. Now, however the manual states that multiple units of an unlisted code may be reported for the same anatomic region, which appears to mean the same joint, points out coding consultant Margie Scalley Vaught, CPC, CCS-P, COC, MCS-P, ACS-EM, ACS-OR.

Woodward, however, isn't entirely sure. "That was what I thought at first as well," she says. But because the CPT manual example only states that two unlisted scope procedures done in two separate joints would be reportable, she worries that payers will limit reimbursement only to those cases.

Even before the new guidelines, Woodward says her practice had been appending modifiers to unlisted codes when appropriate, which was "generally only laterality and assists." And when the assistant at surgery modifier was used, she reports, they would "rarely get them paid."

Practices should not be surprised if they run into payer limits on unlisted code billing. For example, while the CPT manual says a 50 modifier may be appended for bilateral unlisted procedures, "none of the unlisted CPT codes have a 'bilateral allowed' indicator on the [Medicare] fee schedule, so I don't see how that would fly," Woodward observes. "In Minnesota, all of the payers follow Medicare for use of the 50 modifier," she adds.

Some existing rules for billing unlisted codes have not changed. For example, as the CPT manual notes: "unlisted codes are not used to separately report component(s) of an existing Category I or Category III service." Similarly, if a Category I or Category III code exists that is specific to a procedure or service, it would not be appropriate to use an unlisted code to report it. — *Laura Evans, CPC* (*laura.evans@decisionhealth.com*) ■

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