RESEARCH LETTER

Billing of Medicare's G2211 Longitudinal Care Code Among Traditional Medicare Beneficiaries

In January 2024, Medicare introduced the G2211 billing code to the Physician Fee Schedule, which specifies payment rates for traditional (or *original*) Medicare and is also used by most other payers.[1] Although Medicare cannot restrict codes to certain specialties, this add-on code pays clinicians an extra $16 per evaluation and management visit for the longitudinal care typically provided by primary care physicians and in many cases by specialists, ie, "serving as the continuing focal point for all of the patient's health care services needs" or providing "ongoing medical care related to a patient's single, serious…or complex condition (eg, sickle cell disease)".[1] Using Medicare claims, this study examined G2211 billing patterns in its first year to understand its uptake, the extent to which G2211 use was consistent with these objectives, and, given efforts to better support primary care,[2] how often G2211 payments went to primary care specifically.

Supplemental content

Methods | Using 2022-2024 100% claims/administrative data for all traditional Medicare beneficiaries, we described G2211 use in 2024, including by beneficiary, clinician, and visit characteristics (eTable in Supplement 1). We identified G2211-eligible evaluation and management visits per Medicare specifications (Current Procedural Terminology codes 99202-5 and 99211-5 without level-25 modifier; eBackground in Supplement 1).[1] To investigate how coding practices aligned with Medicare's intentions for specialists to use the code for serious or complex conditions, we identified the most common primary diagnoses for G2211-billed visits by specialty. To investigate intended use by clinicians providing longitudinal care, we calculated the percentage of initial G2211 codes billed (ie, the first time a clinician billed G2211 for a given patient on an established patient visit among patients continuously enrolled for the prior 2 years) for which that same patient-clinician dyad had any visit in the preceding 2 years or in the remaining months of 2024. *P* values were 2-sided and considered significant at less than .05. Mass General Brigham's institutional review board waived study review. We used SAS Enterprise Guide 8.5 (SAS Institute) and followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

Results | In 2024, a total of 26 million G2211 codes were billed by 206 813 clinicians for 10.6 million patients, totaling $394 million in payment (1.1% of these clinicians' total Medicare billing). Among the 855 265 clinicians who billed any G2211-eligible visit in 2024, 24.0% billed G2211. G2211-billing clinicians billed G2211 for a median (IQR) of 30.1% (6.9%-61.8%) of their G2211-eligible visits.

Table. G2211 Billing by Patient, Clinician, and Visit Characteristics Among G2211-Eligible Visits

Characteristics[a]	G2211-billed visits, No. (%)[b]
Total	24 610 168 (14.5)
Patient characteristics	
Age, y	
<65	1 664 703 (11.0)
65-74	10 156 155 (14.0)
75-84	9 434 492 (15.4)
≥85	3 354 818 (16.1)
Sex	
Female	13 541 851 (13.9)
Male	11 068 317 (15.4)
Medicaid eligibility	
Yes	2 683 064 (11.4)
No	21 927 104 (15.0)
Race and ethnicity	
American Indian or Alaska Native	70 976 (10.7)
Asian	633 259 (13.5)
Hispanic	982 949 (11.6)
Non-Hispanic Black	1 648 774 (14.7)
Non-Hispanic White	20 469 667 (14.7)
Unknown/other	804 543 (14.2)
Rural-urban	
Metropolitan	19 474 026 (14.8)
Non-metropolitan	4 851 714 (13.7)
Census region	
Northeast	4 755 213 (13.9)
Midwest	4 854 809 (15.0)
South	10 419 581 (15.2)
West	4 568 882 (13.4)
No. of chronic conditions	
0	2 865 522 (12.5)
1-2	2 199 117 (12.6)
≥3	19 090 126 (15.2)
Clinician characteristics	
Time since medical school graduation, y	
<10	4 596 346 (13.8)
10-29	13 072 799 (16.1)
≥30	6 540 044 (12.9)
Sex	
Male	14 687 015 (14.5)
Female	9 544 804 (15.0)
Specialty	
Primary care physician	9 616 505 (24.1)
Specialist physician	10 789 868 (13.1)
Other clinician	4 206 416 (8.9)

(continued)

The largest share of all G2211 codes billed in 2024 were billed by specialist physicians (43.0%) followed by primary care physicians (PCPs; 39.7%) and other clinicians (eg, nurse practitioners, physician assistants; 17.4%). Per G2211-eligible visit, PCPs had the highest billing rate (24.1% vs 13.1% for specialist

Table. G2211 Billing by Patient, Clinician, and Visit Characteristics Among G2211-Eligible Visits (continued)

Characteristics[a]	G2211-billed visits, No. (%)[b]
Visit characteristics	
Modality	
Virtual	1 571 704 (14.7)
In-person	23 041 085 (14.5)
Visit type	
99202	4341 (0.70)
99203	119 307 (1.9)
99204	757 996 (7.4)
99205	338 168 (12.6)
99211	24 638 (2.3)
99212	125 222 (2.7)
99213	3 856 644 (7.6)
99214	16 568 017 (20.2)
99215	2 818 456 (26.0)

[a] Variable specifications are detailed in the eTable in Supplement 1. Age, sex, race, and dual eligibility status were missing for 0.01% of eligible visits. Rural/urban designation was missing for 1.3% of eligible visits, census region was missing for 0.19% of eligible visits, chronic conditions were missing for 1.9% of eligible visits, clinician time since graduation was missing for 2.7% of eligible visits, and clinician sex was missing for 2.6% of eligible visits.

[b] Row percentages reflect the proportion of all G2211-eligible visits with the given patient, visit, or clinician characteristic for which the G2211 code was billed.

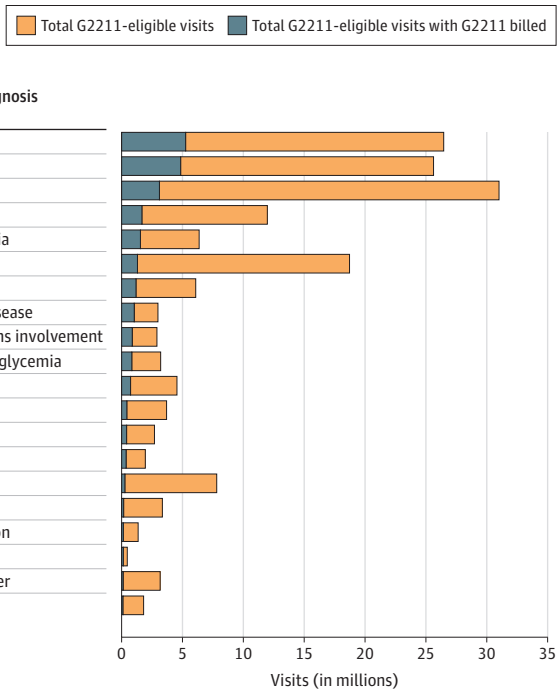
physicians and 8.9% for other clinicians; **Table**). By specialty, the most frequent G2211 billers per visit were nephrology, rheumatology, geriatrics, endocrinology, and urology. The highest aggregate billers were family medicine, internal medicine, nurse practitioners, cardiology, and urology (**Figure**). The most common primary diagnoses among specialist-billed codes included asymptomatic coronary artery disease, gastroesophageal reflux disease, and mild glaucoma.

The billing clinician had no observed prior or subsequent visit with the patient for 15.2% of all initial G2211-billed visits: 8.2% for PCPs, 9.0% for specialist physicians, and 30.1% for other clinicians. G2211 use varied minimally by patient characteristics (eg, chronic condition count); use varied more by visit complexity (Table).

Discussion | Results of this study show robust early uptake of G2211 codes, higher than for Medicare's prior care management codes.[3,4] The plurality were billed by specialists, with substantial heterogeneity across specialties,[5] potentially assuaging the concerns of the specialist societies initially lobbying against the introduction of G2211 that it would detract from specialist earnings.[6] In many cases, specialist G2211-billed visit diagnoses were for conditions that may not qualify as serious or complex. In most cases, physicians billing G2211 for patients saw them more than once (other clinicians' G2211 billing may reflect their roles on longitudinal care teams). Study

Figure. Bar Chart and Data Table Depicting G2211 Billing by Clinician Specialty in 2024

Specialty	Clinicians with at least 1 billed G2211, No. (%)	Eligible visits with billed G2211 among G2211-billing clinicians, median (IQR), %	Most common primary diagnosis for G2211-billed visits
Family medicine	37 975 (47.3)	37 (11-65)	Hypertension
Internal medicine	28 427 (39.5)	41 (12-68)	Hypertension
Nurse practitioner	38 377 (21.7)	27 (6-60)	Hypertension
Cardiology	7835 (36.8)	35 (9-64)	CAD without angina
Urology	4861 (50.1)	38 (8-71)	Benign prostatic hyperplasia
Physician assistant	17 244 (18.6)	25 (6-58)	Hypertension
Hematology-oncology	5333 (53.1)	34 (8-63)	Prostate cancer
Nephrology	5288 (56.5)	60 (26-80)	Stage 3b chronic kidney disease
Rheumatology	3595 (67.1)	53 (21-75)	RA without organ or systems involvement
Endocrinology	4063 (59.9)	45 (15-71)	Type 2 diabetes with hyperglycemia
Neurology	6733 (41.8)	34 (9-64)	Parkinson disease
Pulmonary disease	3932 (38.7)	27 (6-57)	Obstructive sleep apnea
Interventional cardiology	1835 (38.4)	33 (8-64)	CAD without angina
Medical oncology	2127 (51.6)	34 (9-63)	Prostate cancer
Ophthalmology	2483 (15.0)	8 (1-30)	Mild glaucoma
Gastroenterology	3626 (24.6)	12 (3-37)	GERD without esophagitis
Cardiac electrophysiology	985 (37.2)	26 (5-55)	Paroxysmal atrial fibrillation
Geriatric medicine	845 (54.1)	50 (19-75)	Hypertension
Psychiatry	2079 (10.0)	35 (9-67)	Generalized anxiety disorder
Pain management	692 (22.7)	25 (4-57)	Lumbar radiculopathy



Each row includes all clinicians within that specialty who billed Medicare for at least 1 G2211-eligible visit in 2024. Clinicians were identified based on their National Provider Identifiers. The top 20 specialties by G2211 billing volume are included. Benign prostatic hyperplasia indicates benign prostatic hyperplasia with lower urinary tract symptoms; CAD without angina, atherosclerotic heart disease of native coronary artery without angina pectoris; GERD, gastroesophageal reflux disease; hypertension, essential (primary) hypertension; mild glaucoma, primary open-angle glaucoma, bilateral, mild stage; Parkinson disease, Parkinson disease without dyskinesia, without mention of fluctuations; prostate cancer, malignant neoplasm of prostate; RA, rheumatoid arthritis with rheumatoid factor of multiple sites.

limitations include the lack of specialty information for nonphysician clinicians.

To the extent that G2211 was anticipated to support primary care, these results demonstrate challenges in steering payment via specialty-agnostic fee schedule changes and suggest other mechanisms may be necessary (eg, population-based payments that allow targeting to clinicians or practices primarily responsible for their patients' primary care).[2]

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