CareSource

REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
G2211 Reimbursement-MP-PY-1779	IN, WV: 06/01/2026 OH: 07/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):			
☐ **Georgia**	☒ **Indiana**	☒ **Ohio**	☒ **West Virginia**

Table of Contents

A. Subject 2
B. Background 2
C. Definitions 2
D. Policy 2
E. Conditions of Coverage 2
F. Related Policies/Rules 2
G. Review/Revision History 2
H. References 3

A. Subject
G2211 Reimbursement

B. Background
Evaluation and Management (E/M) services are a category of healthcare services which involve assessing a member's health and managing their care, and can include office and outpatient visits, hospital visits, home services, and preventive medicine services. E/M coding utilizes current procedural terminology (CPT) codes in the 99202 to 99499 range. There are more than 2 dozen categories of E/M codes, which are further divided to distinguish new patients from established patients.

As an add-on code, HCPCS code G2211 seeks to capture the complexity of ongoing medical care and the longitudinal nature of the member-provider relationship as it pertains to a member's single, serious condition or complex condition during an associated office or outpatient E/M visit. G2211 is a Medicare-covered code, however, per this CareSource policy, visit complexity is already included in the associated office or outpatient E/M visit for Marketplace.

C. Definitions
- **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).

D. Policy
CareSource considers G2211 not eligible for reimbursement regardless of E/M code billed and/or modifier used.

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	03/11/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	IN, WV: 06/01/2026 OH: 07/01/2026	
Date Archived		

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.

H. References

1. *2026 HCPCS Level II Expert*. AAPC; 2025.
2. What are E/M Codes? AAPC. Accessed February 26, 2026. www.aapc.com