PAYMENT POLICY – Care Integration Services

Owner	Current Effective Date	Next Review Date
Operations	11/04/2026	11/04/2027

OVERVIEW

The purpose of this policy and procedure is to explain Community Health Choice reimbursement guidelines for Care Integration Services reported with HCPCS code G2211. G2211 describes visit complexity inherent to evaluation and management services and is considered as part of the associated office or outpatient evaluation and management service.

This policy applies to Health Insurance Marketplace claims submitted by participating and non-participating providers, unless otherwise required by applicable law, regulation, member benefit plan, or provider contract.

This policy is intended to provide general reimbursement guidance. It does not determine member eligibility, authorize services, guarantee coverage or payment, replace medical necessity review, or supersede applicable federal or Texas requirements, the member's benefit plan document, Community Health Choice coverage criteria, or the terms of an applicable provider agreement.

Payment Policy

Community Health Choice does not separately reimburse HCPCS code G2211 when it is billed with an associated office or outpatient evaluation and management service. G2211 is considered incidental to, and included in, reimbursement for the related evaluation and management service.

Separate payment will not be made for G2211 when billed on the same date of service as the associated evaluation and management visit. Additional reimbursement for G2211 is not allowed beyond the reimbursement applied to the related office or outpatient evaluation and management service.

Community Health Choice may review, deny, adjust, recoup, or recover payment for services when billing, coding, documentation, benefit, contract, medical necessity, or regulatory requirements are not met. Medical records or other supporting documentation may be requested to validate services rendered and support claim review activities.

Impacted Code

• Code Type	• Code	• Description
• HCPCS	• G2211	• Visit complexity inherent to evaluation and management services

Claim Review and Provider Responsibility

Providers are responsible for submitting complete and accurate claims in accordance with current coding, billing, documentation, claim submission, benefit, and contractual requirements. Claims must be submitted using valid codes effective for the date of service and must accurately reflect the services rendered.

Sources Considered

Community Health Choice may consider applicable coding guidance, current CPT® and HCPCS publications, Centers for Medicare & Medicaid Services guidance, state and federal regulatory requirements, plan-specific

coverage criteria, Community Health Choice reimbursement policies and system configuration, and provider contract requirements when applying this payment policy.

Provider Disclaimer

Codes listed in this policy are for reference only and may not be all-inclusive. Deleted codes, or codes not effective on the date of service, may not be eligible for reimbursement. Listing of a code or service in this policy does not guarantee coverage or payment. Coverage is determined by the applicable benefit document. Providers and facilities are expected to follow industry-standard coding and billing practices. Failure to do so may result in claim denial, adjustment, recoupment, or recovery of payments.

Community Health Choice follows the Current Procedural Terminology (CPT®) code set. CPT codes and descriptions are copyrighted by the American Medical Association (AMA) and are included for informational purposes only. CPT® is a registered trademark of the AMA. Community Health Choice reserves the right to revise this policy at any time.

RELATED POLICIES

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