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Maximizing Impact: Decoding the CY2026 MPFS for Home-Based Primary Care

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Presenters



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Objectives

- **Understand the Role of G2211** – Complexity add-on code for longitudinal care and its reimbursement impact.
- **Leverage Advanced Primary Care Management** – CPT codes and payment structures for care coordination in home settings.
- **Identify Telehealth Policy Updates** – Expanded services, supervision flexibilities, and permanent changes for home-based care.
- **Explain Rate Setting & Conversion Factor Changes** – How CY2026 MPFS updates impact payment rates and budget neutrality.
- **Apply Policies for Chronic & Behavioral Health Care** – New codes and payment policies supporting integrated care.

Agenda



Add-On HCPC Code - G2211

What it is
How it maximizes reimbursement
Documentation examples



Advanced Primary Care Management (APCM)

New Add On Codes



Conversion Factor Updates

Alternative Payment Models (APM)



Telehealth Impacts

Key changes
Extensions



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Ask the Experts

A photograph of two women sitting at a table, engaged in a conversation. The woman on the left is smiling and looking towards the woman on the right. She is wearing a dark top and has a lanyard around her neck. The woman on the right is also smiling and looking back at the first woman. She is wearing a light-colored top and a scarf. The background is slightly blurred, showing what appears to be an office or meeting room setting. The entire image is overlaid with a semi-transparent blue filter.

G2211

G2211

Definition

- HCPCS add-on code that recognizes the complexity of longitudinal, relationship-based care for patients with chronic or serious conditions.
- Until the CY2026 MPFS Final Rule, G2211 was restricted to office/outpatient E/M codes (99202–99215). Home visits (CPT 99341–99350) were excluded - even in 2025 when modifier 25 flexibility was added.

Example Documentation

Heart Failure + COPD Management

Visit: Medication adjustment and care coordination at home

Billing: CPT 99350 + G2211

Tip: Document longitudinal care plan and complexity

Annual Wellness + Chronic Care

Visit: Preventive and chronic disease management combined

Billing: CPT 99348-25 + G0439+ G2211

Tip: Document preventive and longitudinal care

G2211: Common Questions

How do I use G2211? Do I need to add modifier 25?

- G2211 is an add on code which means that must be used in addition to "qualifying " codes.
 - The qualifying codes are:
 - Office/outpatient E/M codes 99202-99205 and 99211 to 99215
 - Home visit E/M codes 99341-99345 and 99347-99350
 - Modifier 25 is not needed for add on codes.

I hear that I cannot use G2211 when modifier 25 is used with the E/M code. Is that true?

- For 2025 and 2026, is it allowable to use modifier 25 with the E/M, only if the separately identifiable service is a CMS-covered preventive service like an Annual Wellness visit (AWV) or vaccine administration.
 - 99348-25, G0439, G2211
 - 99347-25, G0009, 90670, G2211



Advanced Primary Care Management (APCM)

APCM

APCM is a non-time based monthly bundled payment program which merges several care management services into one billing code

CMS aims to incentivize comprehensive, team-based, whole-person primary care by embedding value-based care elements into traditional fee-for-service

Billing requirements: **Primary** care provider, consent, initiating visit, 24/7 access & care continuity, comprehensive care management, electronic patient-centered care plan, care transitions coordination, medication reconciliation, electronic communication, population health analytics/risk stratification, performance measurement/quality reporting, ongoing coordination across providers/ settings.

APCM: Coding

APCM services for a patient with chronic condition(s) (expected to last at least 12 months, or until death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline), **provided by clinical staff and directed by a physician or other qualified health care professional** who is responsible for all primary care and serves as the continuing focal point for all needed health care services, **per calendar month**.

APCM Code	Description	2026 Add on code G0568	2026 Add on code G0569	2026 Add on code G0580
G0556	One chronic condition	Initial, first calendar month	Subsequent	Care management services for behavioral health conditions, directed by a physician or other qualified health care professional per calendar month
G0557	Two or more chronic conditions	Psychiatric collaborative care management, behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional		
G0558	Qualified Medicare Beneficiary (QMB) with two or more chronic conditions			

A photograph of two women sitting at a table, engaged in a conversation. The woman on the left is smiling and looking towards the woman on the right. The woman on the right is also smiling and looking back. They appear to be in a professional or collaborative setting. The image is overlaid with a semi-transparent blue filter.

Conversion Factor

Conversion Factor

Conversion factor is the dollar amount CMS multiplies by wRVUs to determine payment

- **2026**
 - Increase from 2025
 - \$33.40 – Non-Alternate Payment Models (APM)
 - \$33.57 - Alternate Payment Models (APM)
- **2025**
 - \$32.35

Why are there two conversion factors?

- Reward risk-bearing APM participants



Telehealth

Telehealth



The official end of Covid PHE was on May 11, 2023 and the waiver for restrictions was set to end in Dec 2024. This waiver was extended to March 2025, September 2025, January 2026 and now through December 31st, 2027.



Programs may continue delivering telehealth services as they do today, with Medicare beneficiaries able to receive care from any location—including their home—through December 31, 2027.



A permanent change was made by the Consolidated Appropriations Act. It allowed behavioral or mental telehealth to be conducted at the patient's home with no geographical restrictions.

Telehealth

CMS Telehealth coverage policy- COVID - 19 restrictions:

There were statutory limitations on the originating site (patient) location. Telehealth was only allowed when the originating (patient) site was geographically located in certain rural and underserved areas: A county outside a Metropolitan Statistical Area (MSA) or Health Professional Shortage Area (HPSA).

- COVID - 19 Public Health Emergency waived this restriction / limitation

Medicare & Payers who follow Medicare billing guidelines	All other payers (2025 AMA/CPT Telehealth codes) NOTE: Not recognized by Medicare
<ul style="list-style-type: none">• Office/Outpatient or Home visit codes• Append modifier 95 for audio-visual or modifier 93 for audio only• Use POS 10 for patient's home• Use POS 02 for other than patient's home• Modifier 93 can only be used for POS 10	<ul style="list-style-type: none">• CPT codes 98000 to 98007 for audio visual• CPT codes 98007-98015 for audio only• Use POS 10 for patient's home• Use POS 02 for other than patient's home

- Code 98016 is the only code under the 2025 AMA/CPT Telehealth codes recognized by Medicare.
- Brief communication technology-based service (virtual check-in) initiated by an established patient not related to an E/M (home visit) within the previous 7 days nor leading to a service within the next 24 hours, 5-10 minutes of medical discussion.



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Education

Maximizing Impact: Decoding the CY2026 MPFS for Home-Based Primary Care

 February 4, 2026

 2pm CT

 Live Webinar

A group of five healthcare professionals, including doctors and nurses, are gathered around a table in a meeting. They are looking at a laptop and a tablet. The image is overlaid with a blue tint.

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