Stalking Horse LLC Tea Talk

Add-on Code G2211

Users beware! It may be very tempting to use the new add-on code G2211 for many of your services because the description seems to fit your visits. However, the CMS Fact sheet for Calendar Year 2024 Medicare Physician Fee Schedule Final Rule states "CMS is finalizing that **the add-on code cannot be billed with an office or outpatient evaluation and management visit that is itself focused on a procedure or other service** instead of being focused on longitudinal care for all needed healthcare services, or a single, serious or complex condition". (https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule)

Essentially, if the provider performed this level of work, the key is making sure that the documentation accurately reflects the "cognitive load" of the continued responsibility of being the focal point for all needed services or the providers part in the care for a single, serious/complex condition. If this is not the case do not report G2211. Not all visits are appropriate!

On January 18, 2024, CMS released mln Matters Number: MM13473 "How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211" (https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf) to try and clear up some of the lingering questions. They provided two examples of documentation that they state supports the use of G2211 but, the examples they give lack actual documentation and is more of a theoretical discussion that I personally found unhelpful and a bit confusing.

Take caution when assigning/using G2211. Remember that when an auditor reviews the documentation, they must be able to see the support for G2211 and without more guidance from CMS on documentation requirements, many providers are sure to fall short on support. Take the information regarding the code seriously and ensure documentation demonstrates the "cognitive load" that CMS references. Do not take complexity/cognitive load for granted and assume that based on the diagnosis or plan that it can be assumed as complex. In the first example given from the mln matters article they state **"How the recommendations are communicated is important in that it not only affects the patient's health outcomes for this visit, but it also can help build an effective and trusting longitudinal relationship between you and the patient. This is key so you can continue to help them meet their primary health care needs."** The only way to know how and what recommendations are communicated is through documentation.

Although CMS states that there is no additional documentation required because a reviewer/auditor may use claims history, information in the medical record, assessment and plan, and other service codes billed to make the determination, the only sure way to show support is to document the support. Ideally this would already be captured within the assessment and plan of care however, with my experience in auditing across the country for over eight (8) years, I would say that many providers do not document enough detail to support G2211 currently when they are actually providing the service.

https://www.youtube.com/@StalkingHorseLLC

You heard it straight from the horse's mouth!

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