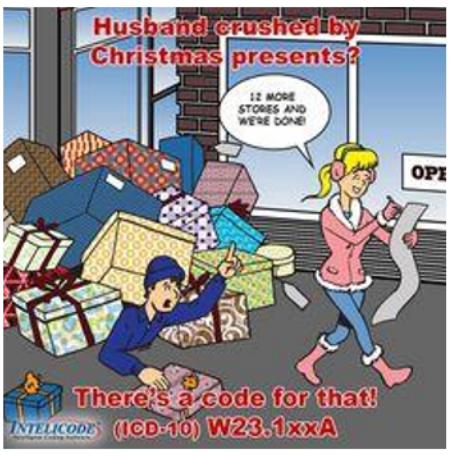
ANO REVENUE CYCLE MANAGEMENT MONTHLY NEWSLETTER

January 2026

CODING HIGHLIGHT

A few discontinued ICD-10 Codes for 2026

- E78.01 – Familial Hypercholesterolemia (replaced with more detailed codes)
- R10.2 – Pelvic and perineal pain (replaced with more specific flank codes)
- S30.1XXA/D/S – Contusions of abdominal wall, groin, flank (replaced with more specific flank codes)
- R76.8 – Other specified abnormal immunological findings in serum



Monthly humor

Q&A

Q: What is the Medicare annual deductible for 2026?
A: The annual deductible for Medicare Part B for 2026 is $283.00, an increase of $26.00 from 2025

Q: Can I bill G2211 with an E&M performed in a patient's home or an assisted living facility?
A: YES!! Starting in 2026 Medicare has approved HCPCS code G2211 to be billed with the E&M codes associated with Home and Assisted Living codes (99341 – 99350)

Do you have a question you would like answered? Send us your questions at info@ano-rcm.com

"The starting point of all achievement is desire." ~ Napoleon Hill

ADVANCED PRIMARY CARE MANAGEMENT (APCM):

Advanced Primary Care Management (APCM) codes represent a significant revenue opportunity that many providers aren't fully utilizing. These codes allow you to bill for the comprehensive, patient-centered care you're already providing – and get properly compensated for it. APCM aims to shift primary care toward a value-based model, paying PCPs for continuous, proactive care that improves the patient's health and lowers overall costs. These services are Medicare initiatives that bundle comprehensive, patient-centered care, focusing on personalized plans, enhanced communication, and proactive coordination (beyond traditional office visits). This covers all patient risk levels, none, one, or two+ chronic conditions. APCM services include transitional care, 24/7 access, chronic care, medication management, and integration of digital tools, seeking to improve outcomes and reduce costs.

Key Components of APCM Services –

- **Personalized Care Plans:** Creating individual plans tailored to each patient's unique needs.
- **Enhanced Communication:** Offering 24/7 access, digital communication tools, and virtual check-ins.
- **Care Coordination:** Managing care transitions and coordinating with other providers.

- **Medication Management:** Assisting with prior authorizations, adherence, and refills.
- **Population Health:** Analyzing patient data to identify gaps in care.
- **Care Management:** Bundling services like Chronic Care Management (CCM) and Transitional Care Management (TCM).
-

APCM services are billed once per patient per month, ensuring you have met the core requirements. Please note that billing for APCM services precludes billing for CCM or TCM services for that patient in the same month.

Base HCPCS used for APCM services are:

- G0556 (Level 1): Patients with one or fewer chronic conditions; typically used for new patients.
- G0557 (Level 2): Two or more chronic conditions expected to last at least 12 months, high risk for decline.
- G0558 (Level 3): QMB* status with two or more chronic conditions that pose a significant risk of death, functional decline or acute worsening.

Key Requirements and Steps

- **Obtain Consent:** Document verbal or written consent from the patient to participate in APCM, informing them of costs and rights to stop services.
- **Provide 24/7 Access:** Make sure patients have 24/7 access to clinical staff or urgent needs.
- **Initiating Visit:** Perform a comprehensive assessment.
- **Comprehensive Care Management:** Create and utilize a patient-centered care plan, manage medications, and coordinate care transitions.

Billing Specifics

- **Provider:** A Physician, NP, PA or CNS acting as the patient's primary focal point.
- **Date of Service:** Typically the last day of the calendar month, reflecting monthly service provision.
- **Documentation:** Submitting the codes for billing confirm that all requirements were met for that month.

APCM codes open additional opportunities for behavioral health integration, particularly valuable for NPs and PAs treating patients with co-occurring mental health conditions. In 2026, CMS introduced add-on codes G0568 – G0570 for integrated behavioral healthcare and Psychiatric Collaborative Care Model (CoCM) services. CoCM services provide integrated, team-based mental health care within primary care. The team is made up of a PCP, behavioral health care manager (BHCM), and a psychiatric consultant to treat conditions such as depression and anxiety. Psychiatric Collaborative Care Model services involve regular tracking, care coordination, brief interventions, and psychiatric consultation to ensure effective, coordinated treatment. These codes are reported as add-on codes alongside APCM base services.

Add-on codes:

- G0568 (initial CoCM): First calendar month of care, involves patient outreach, initial assessment, treatment planning with a psychiatric consultant, brief interventions and registry use.
- G0569 (Subsequent CoCM): Ongoing months, focusing on tracking, weekly consultations, care coordination, outcome monitoring with validated scales and relapse prevention.
- G0570 (General BHI): Monthly care management services including assessments, planning facilitating treatments and continuity of care.

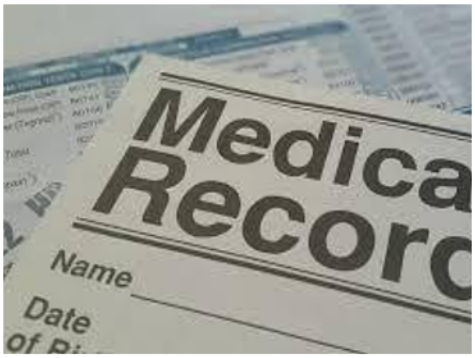
For additional information or clarification please use the websites listed below.

*QMB – Qualified Medicare Beneficiary program that helps low-income individuals pay for Medicare premiums, deductibles, copays, and coinsurance.

**CMS.gov https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services
American Psychiatric Association https://www.psychiatry.org/psychiatrists/practice/professional-interests/collaborative-care/learn
AAPC The Magazine; January issue; *The year ahead: 2026 Medicare policy;* Author Renee Dustmas, BS

PSYCHOTHERAPY DOCUMENTATION

Documentation related to Psychotherapy is one of the most common areas of vulnerability for behavioral health records. Many times, notes only reflect the modality used, such as dialectical behavior therapy (DBT), cognitive behavioral therapy (CBT), or supportive therapy. These notes fail to capture the actual therapeutic discussion that occurred. The progress report does not need to be lengthy; however, it does need to show patient outcome and clinical intent. A well-constructed note will describe what interventions were used, and how the patient responded. *For example, "Used CBT techniques to challenge patient's negative self-talk related to relapse; reinforced progress in identifying triggers."* Short sentences such as this can explain medical necessity and separate the session from a generic entry.



When documenting psychotherapy time, it always needs to reflect the exact duration of the therapeutic interaction. This can be recorded by start and stop times or by total minutes. Evaluation and Management (E&M) and psychotherapy services performed during the same visit are documented differently. The E&M is billed based on medical decision making (MDM), not time and the psychotherapy time needs to be documented separately. Avoid recording the exact same time for every session, this can appear to be a cloned or automated note and can result in a red flag to the payer. Documentation must represent actual face-to-face therapy, not administrative tasks, charting or waiting time. The information should be specific, timely, and patient-centered.

Items to avoid:

- Scheduling timestamps and/or EHR timestamps should never be used to document psychotherapy time.
- Do not copy and paste note entries
- Avoid repeating identical phrases

Always remember that documentation rules differ by state, level of care and place of service. Verify your state's requirements for note completion timelines and signature compliance for group or family therapy notes.

AAPC The Magazine; January issue; *2026 Outlook: Behavioral Health and Drug Dependence;* Author Tracy Smaldino, CPC, CPMA

DANGER IN DIAGNOSING

Artificial Intelligence (AI) tools are becoming valuable assets in healthcare documentation, offering suggestions that can improve coding accuracy and prevent undercoding. However, as with any tool, AI must be used responsibly. Recent enforcement actions highlight the importance of human oversight and proper validation of AI-generated suggestions. Coding that leads to submission of unsupported or inaccurate diagnoses is a False Claims Act (FCA) violation. The legal implications for this practice can be serious. The government is now going after employees and companies for allegedly adding diagnoses that *fraudulently* increase payments to Medicare Advantage plans. Organizations and individuals (including auditors, coders and possibly AI vendors) can be held liable for submitting or causing the submission of false claims under the FCA.

Overall, human reviewers are accountable for final code selection and should utilize MEAT (Monitor, evaluate, Assess/Address, Treat) to ensure accurate and compliant coding. Failure to implement control over any AI tools used can be interpreted as willful ignorance or negligence. Practices, organizations, or individuals that are using AI are responsible for ensuring the AI-generated information is:

- Clinically valid
- Compliant with CMS guidelines
- Auditable

AI can be beneficial and can be used as an assistive tool. Flagging missing MEAT (Monitor, evaluate, Assess/Address, Treat) elements in a providers note or to highlight a potential diagnosis, this can help prevent undercoding and ensure fair reimbursement. It can also help when added into a workflow and overseen by a human or trained with clinical framework and updated regulatory standards.

With all the benefits of AI there can also be pitfalls. AI is not helpful when coders are pressured to accept AI suggestions uncritically or there is no human oversight. Other potential issues can be when organizations prioritize production over accuracy. When codes are autonomously added without review or there is overreliance on AI output instead of clinician documentation.

Be proactive, take steps to ensure ethical use of AI within your practice. Establish a policy for audits, performing regular audits of AI-generated information for compliance. AI-suggested codes should be reviewed and validated by a certified coder. Coding decisions, either AI-generated or human, should be supported by clearly documented clinical confirmation. Legal consequences for FCA violation, such as submitting invalid codes, can be CMS sanctions and reputational damage.

**AAPC The Magazine; November 2025 issue; *Diagnosing Danger;* Author Dannilla Morgan, CPC, CBCS

If you have any questions or would like a specific code highlighted in our next newsletter, please send those requests to info@ano-rcm.com.

Remember to like us on Facebook - https://www.facebook.com/ANORCM2009

You can also leave a Google review for us at - https://g.page/r/CQzX8OlZ6lMsEB0/review

The ANO Revenue Cycle Management Monthly Newsletter is created to assist our clients with brief topic information. The newsletter is not intended to direct any provider, client or practice on how to manage their own practice or services. The information within the ANO Revenue Cycle Management Newsletter is based on the opinion and discretion of the author and may be pieces of a larger topic or subjects. Information for the newsletter is found within several sources, including but not limited to the AAPC Healthcare Business Monthly, AAPC The Magazine, HCPCS book, CPT books, Procedure Desk Reference books, and the internet. As always, we are here to help you navigate these changes and maximize your reimbursement. Do not hesitate to reach out with questions.