S.T.A.T

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SELF'S TIPS and TIDINGS

What's Ahead in 2025

IN This Issue

With 2025 just around the corner, healthcare providers need to prepare for significant changes that will impact how they deliver care, bill services, and ensure compliance. Medicare is rolling out several updates aimed at modernizing its approach while addressing the evolving needs of patients and providers.

In this newsletter, we'll explore some of the key changes, including:

New Advanced Primary Care Model (APCM) Codes
Medicare's new APCM codes—G0056, G0057, and G0058—will stratify patients based on their health complexity, with higher reimbursement rates for managing more complex patients. For example, GPCM3 focuses on high-risk, dual-eligible patients requiring significant social determinants of health interventions. Learn how this shift could create opportunities for specialists and primary care providers alike.

Updates to Rural Health Clinic (RHC) Billing
Code G0511, which simplifies reimbursement for RHCs, will undergo adjustments in 2025. These changes aim to make billing more efficient

for underserved areas while maintaining compliance with updated Medicare standards. We'll break down what's changing and how to optimize your billing.

Medicare's New Caregiver Training Codes
Recognizing the critical role caregivers play in patient outcomes, Medicare is introducing codes to reimburse providers for training caregivers. This move aligns with Medicare's focus on improving patient outcomes by equipping caregivers with the tools they need to provide effective support.

Advance Beneficiary Notices (ABNs)
Medicare has extended the validity of its updated ABN form through 2026. Ensuring compliance with ABN requirements is critical for avoiding unnecessary claim denials. We'll provide a downloadable template and tips for proper integration into your workflow.

Opinion: Don Self's E&M and Prolonged Service Slide Rules vs. Coding Advisor
Tools like Don Self's E&M slide rules offer simplicity and precision in billing, but how do they stack up against software solutions like Coding Advisor? We'll dive into the pros and cons to help you decide which tool is best for your practice.

Coding Advisor vs. E&M Slide Rule: Which One Do You Need?

Recently, someone asked us a great question: "If I have the E&M Slide Rule, do I still need the Coding Advisor—or vice versa?"

It's a question worth discussing. So let's break it down.

E&M Slide Rule: Simplicity in Your Pocket

The E&M Slide Rule uses the 2021-2025 E&M Documentation Rules to help determine which level of visit code is supported. These rules replaced the old 1995/1997 guidelines, simplifying the entire process—thanks in part to President Trump's Patients Over Paperwork Initiative. With the new rules, a provider can use the higher of the two components—time or medical decision making (MDM)—to determine the E&M level.

For instance, let's say a doctor spends 24 minutes with a patient but documents a moderate MDM. With the Slide Rule, they'd be billing a 99204 or 99214, even though the time component alone might suggest a 99203 or 99213. It's all about being able to take advantage of the more favorable criteria to justify a higher-level code.

The best part about the Slide Rule? It's simple and portable. It's lightweight, fits in a smock pocket or even in jeans, and gives healthcare professionals an on-the-go tool that makes the decision process fast and easy. You can get your own Slide Rule here: https://donself.com/shop/ols/categories/tools

Coding Advisor: More Power, More Features

Now, if you're looking for something with a little more kick, there's the Coding Advisor—now

featuring AI. Sure, it's not quite as portable, needing a computer, tablet, or smartphone to access, but it more than makes up for it in features.

The Coding Advisor does what the Slide Rule does—and then some. Not only does it help determine the level of E&M, but it also acts as a Claims Scrubber, checking the National Coverage Determinations (NCD) to make sure the procedure codes (CPT or HCPCS) are justified by the diagnosis or whether a modifier is needed. This isn't something the Slide Rule can do—it's a feature exclusive to the Coding Advisor.

Want to see if a procedure and diagnosis combo will work before submitting it to Medicare? The Claims Scrubber is your tool. You can find more about the Coding Advisor here: https://www.medicalcodesolutions.com/products/don-selfs-coding-advisor

Extra Features That Make Coding Advisor Stand Out

Our Coding Advisor has information on hundreds, if not thousands, of codes. It covers RVUs, the Medicare Physician Fee Schedule, and more—broken down by clinic location, since reimbursement varies by locality. You can even switch from physician Medicare allowed amounts to Non-Physician Practitioner (NPP) allowed rates (which are 15% less) with a click of a button.

It also has the Correct Coding Initiative (CCI) edits built in, letting you know which codes can be billed together and which need modifiers. That saves a lot of time when you're trying to maximize reimbursements.

Another handy feature? The search function.

You don't need to remember the precise term—you can look up "ear wax" and get codes like 69209 or 69210 for the procedure, or the H61.20 through H61.23 series if you need an ICD-10 code. You don't even have to spell it perfectly. Just start typing, and the Advisor takes care of the rest.

Which One Should You Use?

If you're thinking it sounds like a good idea to have both tools—you're absolutely right. They complement each other well. The Slide Rule is great for quick use during patient encounters, while the Coding Advisor helps ensure compliance, maximize reimbursements, and make coding as easy as it can be.

Why People Love the Coding Advisor

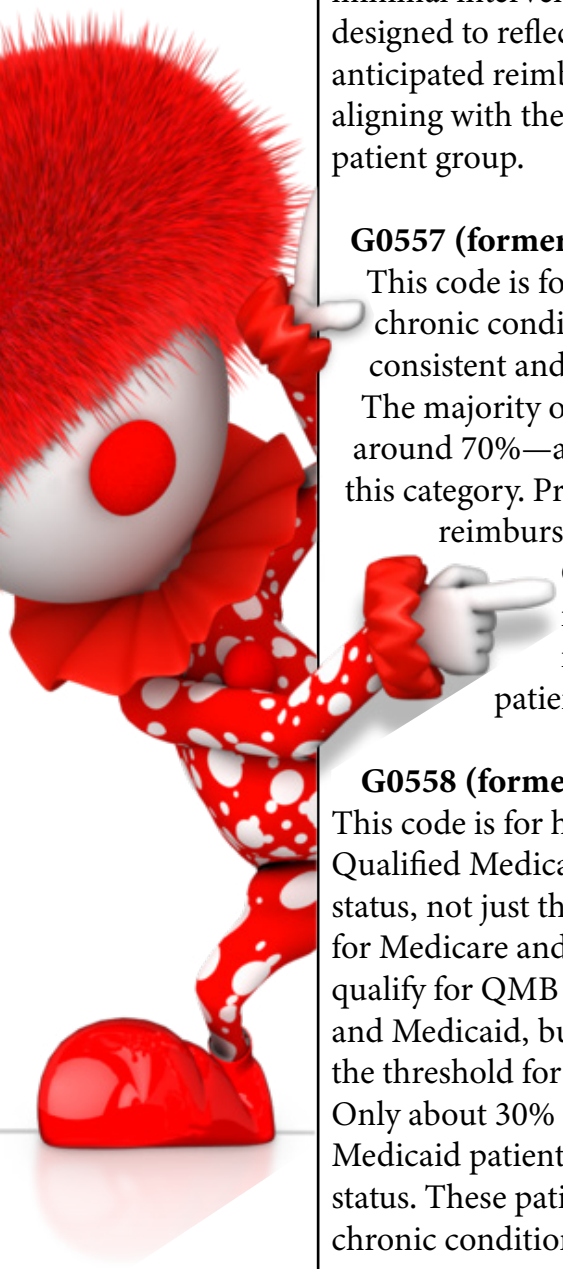
We've had a lot of folks switch over to the Coding Advisor from other, more expensive programs. Here's what they're saying:

"We've stopped buying several expensive books because we know we can quickly find what we need on your site. Thanks to the claim scrubbing feature, we're generating maximum revenue on more involved claims. We wouldn't be without Coding Advisor!"
Tana Cook, Administrative Assistant, Georgia Neurological Surgery, Athens, GA

"I used to use Supercoder, but Don's portal is so much easier to use. I don't have to sort through a bunch of different spots to find what I need, and the claim scrubbing is fantastic. I highly recommend it—whether you're seasoned or new to coding."
Lois Simmons, RHIT, CCS-P, Associated Surgical Group SC

"I switched from SuperCoder to Don's Coding Advisor, and it's the best decision I've made. The scrubber is fantastic, and the features beat out any other coding tool I've used. Plus, it's affordable and integrates easily with my PM software. This is the greatest coding advisor I've seen in years, and I'll never use another."
Barbara Prater, CPC, Largo, FL

New Advanced Primary Care Model (APCM) Codes Explained



Initially referred to as GPCM1, 2, & 3 in the July Federal Register, these codes were finalized before the release of the November 1st Federal Register and are now identified as G0556, G0557, and G0558. These codes are designed to categorize patients based on their health complexity, allowing providers to deliver care that is better tailored to individual patient needs while receiving appropriate compensation for the level of care provided.

Here's a quick breakdown of the new codes:

G0556 (formerly GPCM1):
This code applies to patients with 0-1 chronic conditions. These patients require minimal intervention, and the code is designed to reflect that simplicity. The anticipated reimbursement is modest, aligning with the limited needs of this patient group.

G0557 (formerly GPCM2):
This code is for patients with 2 or more chronic conditions who require more consistent and ongoing management. The majority of Medicare patients—around 70%—are expected to fall into this category. Providers can expect higher reimbursements compared to G0556, reflecting the increased time and effort involved in managing these patients.

G0558 (formerly GPCM3):
This code is for high-risk patients with Qualified Medicare Beneficiary (QMB) status, not just those who are dually eligible for Medicare and Medicaid. Patients who qualify for QMB status have both Medicare and Medicaid, but their income is below the threshold for full Medicaid coverage. Only about 30% of dually eligible Medicare/Medicaid patients meet the criteria for QMB status. These patients often have multiple chronic conditions and significant social determinants of health needs, requiring coordinated care across different services. Reimbursement for G0558 is the highest, reflecting the complexity of care needed for this group.

These new APCM codes are a significant step in Medicare's move toward value-based care. They allow providers—both specialists and primary care physicians—to better tailor care to their patients while being fairly compensated for the time and resources dedicated to managing complex health conditions.

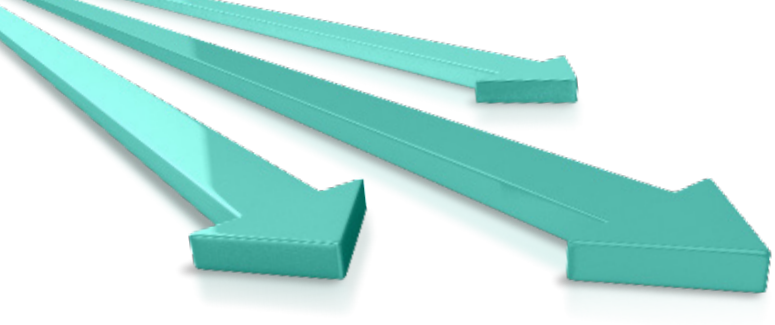
To make the most of these new codes, it's important to review your patient population and identify those who might qualify under G0556, G0557, or G0558. Having a structured approach to assessing patient needs and stratifying them appropriately will help you align with Medicare's new guidelines and maximize your reimbursements.

The APCM codes are intended to reflect the true effort that goes into managing patients with varying degrees of health complexities. By leveraging these codes, practices can align their care delivery with Medicare's evolving focus on patient outcomes while ensuring financial sustainability.

We recently hosted a 1-hour webinar with Chartspan Medical's Founder and Chief Growth Officer, Jon-Michial Carter, covering the APCM code changes in 2025. The webinar provides further insights into what these changes mean for your practice and how to implement them effectively.

You can watch the free webinar here: https://www.youtube.com/watch?v=s1eyS0Dq5FA

If you're interested in Chronic Care Management (CCM) and APCM services for your practice, feel free to schedule a meeting with Don here: https://donself.com/schedule



Code G0511 Updates

If you've been keeping up with Medicare changes, you know that there's a valuable opportunity here for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), especially for those looking to dive into Remote Patient Monitoring (RPM). Recent updates make it easier than ever for clinics to take advantage of RPM codes and earn extra revenue without the headaches of doing it all in-house.

G0511 and RPM: A Perfect Match

Starting in 2024, G0511 was expanded to include RPM codes 99453, 99454, and 99457, which allow for monitoring services, device supply, and patient interaction time. The latest update for 2025 now adds 99458, which covers each additional 20 minutes of service time. G0511 pays just over $72 per unit, which represents a substantial opportunity for RHCs and FQHCs that choose to implement RPM.

Here's where it gets exciting: if a patient tests more than 16 days per month and has enough monitored service time, you can bill up to three units of G0511 monthly. That's more than $200 per patient—good money that your clinic shouldn't leave on the table, especially given the demand for better patient monitoring and preventive care.

Leveraging RPM Without Extra Workload

Implementing RPM doesn't have to overwhelm your clinic staff. One key benefit of working with an RPM partner is that much of the patient interaction, monitoring, and documentation work can be outsourced. You can maximize your clinic's cash flow without shouldering the operational burdens that often come with launching a new service. In this model, clinics can focus on patient outcomes while still capturing the financial rewards associated with RPM.

Changes Coming Mid-2025

However, it's important to stay up-to-date on the changes coming soon. By mid-2025, Medicare will phase out the use of G0511, shifting clinics to bill using individual codes like 99453, 99454, 99457, and 99458. While the payment rates will change slightly to align with the Medicare Physician Fee Schedule (MPFS) rates, the overall revenue opportunity is still strong. Even with lower individual rates, the combined billing potential for RPM—especially when bundled with a proactive patient monitoring approach—makes it worthwhile.

We highly recommend that clinics take full advantage of the enhanced billing opportunities with G0511 from January through June 2025, before the changes take effect. This period represents an optimal time to maximize revenue and lay the groundwork for a smooth transition to the new codes.

Why RHCs and FQHCs Should Get Involved Now

If you haven't jumped into RPM yet, this expanded opportunity is the perfect time to do so. The potential to bill multiple units of G0511 per patient for minimal additional work represents a great way for clinics to enhance their financial health. Moreover, these changes are in line with Medicare's broader vision of preventive, value-based care, making RPM an ideal program to improve patient outcomes while ensuring clinic sustainability.

Even with the upcoming change to individual codes in 2025, RPM will remain a valuable tool for clinics that want to maximize their reimbursements while providing attentive, ongoing care for their patients. Being able to adapt early and implement RPM before G0511 phases out means you're well-prepared to make the most of the 99xxx codes next year.

Get Paid for Caregiver Training in 2025

2025 is bringing some pretty big changes, and one that's worth paying attention to is Medicare's new caregiver training codes. These new codes are a game-changer, allowing healthcare providers to bill for time spent training caregivers—the people who are on the frontlines with your patients at home. Let's be real: most of the time, these caregivers are the difference between a patient thriving or ending up right back in the ER.

What These New Codes Mean
These new caregiver training codes recognize that teaching a caregiver how to handle a patient's care is just as critical as treating the patient in the clinic. Medicare finally gets that. When a caregiver knows how to give the right meds, use the equipment, recognize warning signs, or even provide emotional support—that's when real progress happens. With these codes, you can actually get paid for this kind of training, instead of just crossing your fingers and hoping the patient's family figures it out.

Billing and Coding Details
Medicare has introduced three specific CPT codes for caregiver training services:

- **CPT 97550: Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community, face-to-face without the patient present; initial 30 minutes.**
- **CPT 97551: Each additional 15 minutes of caregiver training (use in conjunction with 97550).**
- **CPT 97552: Group caregiver training, face-to-face with multiple sets of caregivers.**

The key here is that these codes allow providers to bill for time spent training caregivers without the patient present, recognizing that effective caregiver training directly impacts patient outcomes.

Frequently Asked Questions

1. How many 97551 units will Medicare allow on each claim?
Medicare does not explicitly limit the number of 97551 units (each representing an additional 15 minutes of caregiver training) that can be billed per claim, as long as the service is medically necessary and thoroughly documented. However, it's crucial that each additional unit is justified. The documentation should clearly support why the extra time was needed and how it benefitted the caregiver and patient. Be sure to provide a clear, concise explanation for every additional unit billed.

2. Can you bill CPT 97550 and 97552 together?
Generally, you cannot bill 97550 (individual caregiver training) and 97552 (group caregiver training) together for the same patient on the same date of service. These codes reflect different service types (individual versus group), so they cannot both be billed for the same patient on the same day. When planning caregiver training, you will need to decide whether to provide individual training (billed as 97550) or group training (billed as 97552).

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TeleCARE
REMOTE PHYSIOLOGIC MONITORING

Remote Patient Monitoring (RPM)

Remote Patient Monitoring (RPM) empowers healthcare providers to make timely, data-driven decisions by continuously monitoring patients' health metrics. Devices like blood pressure monitors, glucose meters, pulse oximeters, and scales transmit real-time data to healthcare providers, offering a comprehensive view of patient health.

HOW RPM WORKS

Device Assignment: Patients are assigned devices that monitor their health metrics. Medicare and commercial insurances reimburse providers for the testing supplies as needed using CPT code 99453.

Data Transmission: Daily readings are automatically transmitted to TeleCare USA's portal where the provider's office has access 24/7. Our devices transmit data via a 4G cell signal built into the device (or through an app on a patient's smartphone) via Bluetooth. The 4G cell signal is especially convenient for older patients.

Provider's Review: Providers can view data in real-time and in visual graphs to understand trends and adjust treatments as needed.

Billing & Reimbursement: Medicare provides a national average monthly reimbursement of $220.55 for codes 99454, 99457, and three units of 99458, and most commercial payors also cover RPM services.

MEDICAL BENEFITS

Enhanced Decision Making: Continuous, real-time data allows for more accurate diagnoses and timely adjustments to treatment plans.

Improved Patient Outcomes: Early detection of health issues leads to better management of chronic conditions and reduced hospital admissions.

Increased Efficiency: Reduces the need for frequent clinic visits which saves time for both patients and healthcare providers.

Accurate Health Insights: Provides reliable health data that patients might otherwise forget or misreport during office visits.

TECHNOLOGY HIGHLIGHTS

Our devices are FDA approved, validated, and clinically tested to ensure the highest standards of patient care. The TeleCare USA portal, available 24/7, provides detailed insights into each patient's health. It displays individual readings, weekly averages, monthly averages, 3-month averages, and plotted visual graphs for any date range the provider wishes to see. These comprehensive data points enable healthcare providers to make informed medical decisions, monitor patient progress effectively, and adjust treatments promptly.

To learn more about how TeleCare USA can benefit your practice and patients, reach out to us. Our team is ready to help you implement RPM and take your patient care to the next level. We work on a month-to-month basis with no long-term contracts, providing flexibility and peace of mind.

info@telecare-usa.com

www.telecare-usa.com

3. Can you use CPT 97552 for a group of caregivers?
Yes! If you conduct a group caregiver training session for multiple caregivers—each representing a different patient—you can bill CPT 97552 for each of those patients, provided the training is medically necessary for each one. This means that if you have a group of 10 caregivers, each representing a different patient, you can bill 97552 for each of those patients. This is an efficient way to provide standardized education for caregivers while still being reimbursed for each patient represented.

Billing Considerations
- Patient Consent: Be sure to obtain consent from the patient or their representative to provide caregiver training without the patient present. Document this consent in the patient's medical record.
- Documentation: Thorough documentation is essential. You need to clearly document the training provided, including the duration, content, and the caregivers involved. This ensures compliance and supports reimbursement claims.
- Telehealth: It's important to note that these caregiver training services are currently not eligible for telehealth, so services must be provided face-to-face.

Reimbursement Rates
The national average reimbursement rates for these codes are as follows:

- **CPT 97550: Approximately $48.45**
- **CPT 97551: Approximately $24.18**
- **CPT 97552: Approximately $19.88**

Why This Matters to Your Practice
Caregivers are often the unsung heroes in healthcare, and with these new codes, Medicare is starting to give them the spotlight they deserve. You, as the provider, get reimbursed for providing them with training, and this directly leads to better outcomes for the patient. Think about it: if a caregiver knows what to do, there are fewer complications, fewer readmissions, and less hassle for everyone involved.

But let's not forget: if you're providing the training, you need to document everything clearly. If it's not documented, it didn't happen, and you won't get reimbursed. Simple as that.

How You Can Make This Work for Your Practice
Start by figuring out which patients need this the most—those with chronic conditions, recovering from surgery, or any patient who relies heavily on caregiver support. The new codes can be billed for specific training sessions that cover medication management, how to use medical devices, or even how to help the patient move around safely. You can bill for these sessions during regular visits or through specific caregiver training appointments.

The goal here is to make sure that caregivers are well-prepared to help your patients and that you're being compensated for the effort you put into making that happen. This is all part of Medicare's broader push towards value-based care—and if they're willing to pay you for doing the right thing, why wouldn't you take them up on it?

Advanced Beneficiary Notice Updates

If you've been in healthcare long enough, you know that the Advance Beneficiary Notice of Noncoverage (ABN) is one of those forms that tends to fly under the radar until it bites you in the backside. With 2025 right around the corner, now's the time to make sure your ABNs are up-to-date and that your staff knows when and how to use them—because believe me, when it comes to compliance, you do not want to be caught napping.

What Is an ABN, and Why Should You Care?
An ABN is that little heads-up Medicare makes you give your patients when you think Medicare might not cover a particular service. It's there to let them know, "Hey, you might have to pay out-of-pocket for this." If you don't give that heads-up and Medicare denies the claim, guess who's stuck eating that cost? That's right—you are.

Getting this right is key to keeping your practice compliant and your cash flow healthy. Don't get lazy about ABNs, or it will cost you—one way or another.

Key Updates for 2025: New ABN Validity Period
Good news for once—Medicare has actually made the validity period for ABNs a little simpler. For 2025, CMS has rolled out an updated ABN form that's valid through 2026. Translation: You can use the current form without worrying about another update for at least a year. But don't think that means you can relax—make sure you're using the latest version or that little mistake might just come back to haunt you.

When and How to Use the ABN Properly
Here's the deal: You have to use the ABN under specific circumstances, and you'd better do it right.

- **Non-Covered Services:** If you think Medicare won't cover something due to medical necessity, frequency, or diagnosis, you must give the patient an ABN before performing the service. However, if Medicare never covers the service—such as acupuncture—an ABN isn't required.
- **Services Exceeding Benefit Limits:** If a service is likely to go beyond Medicare's benefit limits, provide the patient with an ABN.
- **Medical Necessity Denials:** When Medicare doesn't see a service as medically necessary, an ABN is required.

The key is to present the ABN before the service is performed, giving patients time to make an informed decision. If you don't, and Medicare denies the claim, you're stuck holding the bag.

ABN Updates in Practice: A Real-Life Example
Let's say you've got a patient who needs a follow-up lab test that, based on their history, you know Medicare loves to deny. If you perform the service without an ABN, you're the one paying the price if the claim gets denied. But if you hand them that ABN, they're now making an educated decision—either they'll move forward and take the risk, or they'll decline the service. Either way, you're covered.

This isn't just about compliance; it's about being upfront with your patients and building trust. They deserve to know what they're getting into, and so do you.

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How to Train Your Staff on the ABN Updates
Let's face it—new updates mean new headaches. Your staff needs to be on board, and they need to know exactly when and how to use the ABN.

Make sure they know:

- When the ABN is required.
- How to fill it out correctly—no shortcuts.
- Why patients need time to think it over.

Get your team trained up, and you'll save yourself a world of hurt later on. Don't leave this to chance. The ABN is one of the biggest compliance hot spots, and it's worth getting it right.

Get Your Updated ABN Form
The latest version of the ABN form, valid through 2026, is available for download from the CMS website: https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-abn

Don't put this off—double-check now that you're using the correct version. It could save you from a nightmare down the line.

The Bottom Line
The Advance Beneficiary Notice is one of those things that can make or break your practice's financial stability, especially when it comes to services that Medicare might not cover. These latest updates make compliance a bit easier—but only if you stay on top of it. Take the time now to ensure your ABNs are up-to-date and that your staff knows the ins and outs, because when it comes to staying compliant, it's a whole lot better to be proactive than scrambling to clean up a mess later.

2025 Medicare Parts A & B Premiums and Deductibles

On November 8, 2024, CMS released the updated premiums, deductibles, and coinsurance amounts for Medicare Parts A and B in 2025.

Medicare Part B:
The annual deductible will increase to $257 in 2025, up from $240 in 2024.

Medicare Part A Inpatient Hospital:
The deductible for inpatient hospital stays will be $1,676 in 2025 (an increase of $44 from 2024). Coinsurance amounts are as follows:

- $419 per day for days 61-90 of hospitalization (previously $408)
- $838 per day for lifetime reserve days (previously $816)