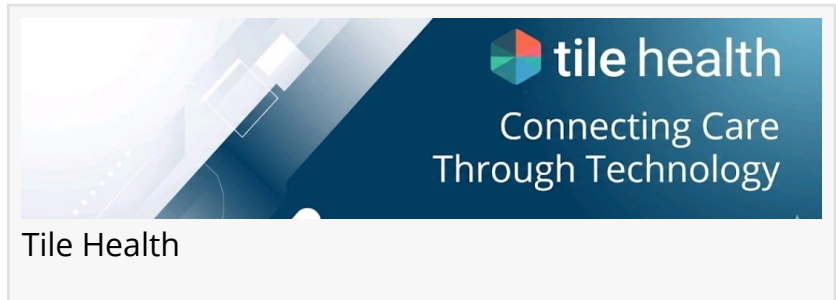


Medicare Introduces APCM in 2025, Creating New Monthly Revenue Stream for Primary Care Physicians

Medicare's 2025 APCM billing update pays primary care physicians a monthly per-patient fee for care management; no time-tracking required.



BETHESDA, MD, UNITED STATES, March 9, 2026 /EINPresswire.com/ -- Medicare Introduces APCM in 2025, Creating

New Monthly Revenue Stream for Primary Care Physicians

[Advanced Primary Care Management](#) (APCM) is Medicare's most significant primary care billing update since the introduction of Chronic Care Management in 2015. Primary care physicians, family medicine providers, and internists with Medicare patients now have access to a new

monthly billing program that could generate hundreds of thousands of dollars in annual revenue currently going uncollected.



APCM is the biggest primary care billing opportunity since 2015; and Tile Health automates the entire workflow so physicians can capture it without the paperwork.”

Ali Elmarsafawy

WHAT IS APCM BILLING?

Advanced Primary Care Management is a monthly billing program introduced by CMS effective January 1, 2025. It pays primary care providers a recurring per-patient fee for comprehensive, ongoing care management -- the coordination work that happens between office visits. APCM bundles elements of three existing programs into

one simplified payment model. Chronic Care Management (CCM) covers patients with multiple chronic conditions. Principal Care Management (PCM) addresses disease-specific complex condition management. Transitional Care Management (TCM) handles coordination after hospital discharge.

Unlike its predecessors, APCM is status-based, not time-based. There is no 20-minute minimum requirement. When a patient meets criteria and the required service elements are provided, the appropriate monthly code is billed.

KEY DISTINCTION

APCM eliminates time-tracking requirements. Billing is based on patient complexity and status -- not on documenting every minute of care time. This represents the biggest operational improvement over CCM.

THE THREE [APCM BILLING CODES](#): G0556, G0557, G0558

G0556 covers patients with zero or one chronic condition, reimbursing approximately \$16.70 per month at the 2026 national average. This code covers foundational APCM service elements including 24/7 access and an electronic care plan, and remains billable for lower-complexity Medicare patients.

G0557 is the most commonly billed APCM code, reimbursing \$53.91 per month at the 2026 national average. It applies to patients with two or more chronic conditions expected to last at least 12 months that place the patient at significant risk of hospitalization, functional decline, or death. This covers the vast majority of complex primary care Medicare patients -- including those with diabetes, hypertension, COPD, heart failure, CKD, and depression.

G0558 reimburses \$117.53 per month at the 2026 national average. It applies to patients who qualify for Level 2 and are also Qualified Medicare Beneficiaries (QMB) -- meaning they are dual eligible for both Medicare and Medicaid. These are typically the highest-complexity patients with the most significant social and medical needs. QMB patients cannot be billed directly for cost-sharing.

WHO CAN BILL APCM?

APCM may be billed by physicians (MDs and DOs), Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs).

The billing provider must be the continuing focal point for all of the patient's primary care services. Only one practice can bill APCM for a given patient in any calendar month.

APCM REQUIREMENTS

CMS requires providers to have the capability to furnish 13 service elements, though not all must be delivered to every patient every month. Key requirements include patient consent obtained once and documented in the medical record, an initiating visit for new patients (an Annual Wellness Visit qualifies), 24/7 access for urgent needs, an individualized electronic patient-centered care plan, medication reconciliation and management, care coordination with specialists, transitional care management following hospitalizations, population-level management capabilities, and performance measurement reporting for MIPS-eligible clinicians.

APCM VS. CCM

APCM and CCM cannot be billed concurrently for the same patient in the same month. For practices with robust care management capabilities, APCM offers several advantages: no time-tracking is required, patient eligibility is broader, documentation requirements are simplified, and APCM Level 3 (G0558) pays significantly more than CCM for dual-eligible patients.

If a provider manages only a single condition for a patient rather than serving as the primary care focal point, PCM codes may still be appropriate.

THE DOCUMENTATION CHALLENGE

The single biggest barrier to APCM adoption is creating and maintaining individualized electronic care plans for every enrolled patient. CMS requires these plans to address medical, functional, and psychosocial needs and be updated continuously.

For a practice with 500 enrolled patients, manual care plan creation and maintenance represents a significant ongoing administrative burden. [Tile Health \(https://www.tilehealthcare.com\)](https://www.tilehealthcare.com) was built to address this challenge. Tile Health's AI generates fully CMS-compliant, individualized care plans from patient records and ongoing triage interactions -- automatically and at scale -- meeting all 13 APCM service element requirements.

HOW TILE HEALTH MAKES APCM BILLING OPERATIONAL

Tile Health is an end-to-end AI platform that automates every step of the APCM workflow. The platform's AI identifies eligible patients and conducts enrollment outreach calls. Automated clinical triage handles patient contacts between visits on a 24/7 basis. Care plans are generated and updated automatically in a CMS-compliant, individualized format. Monthly billing artifacts are generated and ready for the practice to submit directly to Medicare.

Practices retain full control of the Medicare billing relationship. Tile Health charges a flat fee -- not a revenue share -- allowing practices to retain 60 to 70 percent of billed revenue, compared to 30 to 50 percent with traditional vendors.

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