

# The Complete Guide to APCM Billing Codes: G0556, G0557, and G0558

*A complete breakdown of APCM billing codes G0556, G0557, and G0558 - eligibility requirements, reimbursement rates, and billing rules for 2025.*

BETHESDA, MD, UNITED STATES, March 9, 2026 /EINPresswire.com/ -- What Practices Need to Know Before Billing APCM in 2025

The [Advanced Primary Care Management](#) program introduced three new HCPCS G-codes effective January 1, 2025, under the final 2025 Medicare Physician Fee Schedule. These codes represent CMS's most ambitious restructuring of care management reimbursement in years --

consolidating [Chronic Care Management](#), Principal Care Management, and Transitional Care Management into a streamlined, risk-stratified monthly payment model.

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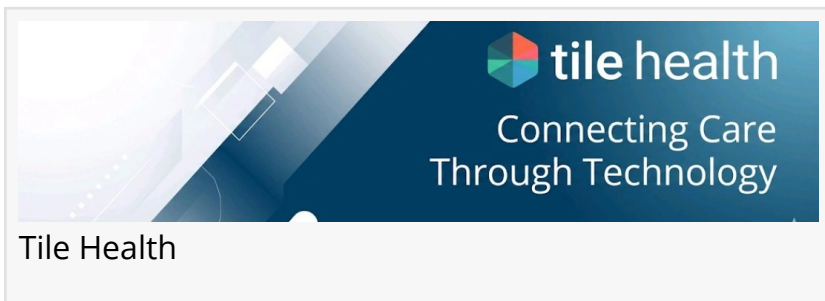
*Ali Elmarsafawy, CEO, Tile Health*

For practice administrators and billing staff navigating these codes for the first time, the following guide covers patient eligibility, service requirements, reimbursement rates, billing rules, and the compliance documentation practices need to avoid claim denial.

The Three APCM Codes: Eligibility and Rates  
G0556 (APCM Level 1) covers Medicare beneficiaries who

have zero or one chronic condition. The 2025 national average reimbursement is approximately \$15.20 per patient per month. This level was specifically designed to expand the addressable population of care management beyond the traditional CCM threshold -- for the first time, practices can bill for care management services for patients with fewer than two chronic conditions.

G0557 (APCM Level 2) covers patients with two or more chronic conditions and reimburses approximately \$48.84 per patient per month. This is the most commonly applicable code for typical Medicare patient panels and is the direct functional equivalent of the non-complex CCM service previously billed under CPT 99490.



G0558 (APCM Level 3) covers patients with two or more chronic conditions who are also Qualified Medicare Beneficiaries -- individuals who qualify for Medicaid assistance with Medicare premiums and cost-sharing. The 2025 national average reimbursement is approximately \$107.07 per patient per month, reflecting the higher complexity and social risk associated with this population.

### The 13 APCM Service Elements

Unlike CCM, which bills based on documented clinical staff time, APCM reimburses based on the practice's capacity to provide 13 defined service elements on an as-needed basis each month. Billing a G-code represents attestation that the practice has the systems in place to deliver all 13 elements. The elements are:

- Initiation of the APCM service with patient consent
- Comprehensive care management, including care plan development and revision
- 24/7 access to clinical staff for urgent care needs
- Continuity of care with a designated practitioner
- Comprehensive care planning addressing all health issues
- Management of care transitions between settings or providers
- Coordination with home- and community-based service providers
- Patient and caregiver education and engagement
- Medication reconciliation and management
- Documentation of all APCM services in a certified EHR
- Beneficiary consent and documentation of that consent
- Health risk assessment (required annually)
- Identification and communication of available community resources

CMS does not require practices to document time spent on each element. The attestation that these services are available and being provided is sufficient for billing compliance -- a fundamental departure from the CCM documentation model.

### Key Billing Rules and Restrictions

Several billing rules govern APCM that differ materially from CCM and can cause claim denials if misunderstood.

**No concurrent CCM billing.** A patient enrolled in APCM cannot also receive CCM services billed under CPT 99490, 99439, 99491, 99487, or 99489 in the same month. The two programs are mutually exclusive at the patient level on a monthly basis.

**No concurrent TCM billing.** Transitional Care Management services (CPT 99495 and 99496) are bundled into the APCM global payment and cannot be billed separately for an APCM patient in the same month.

Patient consent is required. Written or verbal consent from the beneficiary must be documented

before APCM services begin. The consent process must explain the nature of the services, the associated cost-sharing, and the patient's right to stop participating at any time.

One APCM bill per patient per month. Only one G-code can be billed per beneficiary per calendar month, and only by one billing provider. If a patient sees multiple providers, only the designated APCM provider bills the monthly code.

FQHCs and RHCs face a transition deadline. Federally Qualified Health Centers and Rural Health Clinics currently billing the all-purpose care management code G0511 are expected to transition to individual APCM and CCM codes by October 2025. Practices in these settings should begin planning the transition immediately.

#### Revenue Implications and a Common Miscalculation

A widespread misunderstanding among practices reviewing APCM is treating G0557 as a direct revenue upgrade from CPT 99490. The comparison is incomplete. A practice billing both CPT 99490 (\$60.49) and the add-on CPT 99439 (\$45.93) for a single patient generating 40 minutes of CCM contact collects approximately \$106 per month. Under APCM, that same patient generates \$48.84 per month -- a reduction of more than 50 percent.

The break-even comparison only favors APCM for practices whose patient panels include substantial numbers of QMB-eligible beneficiaries (G0558 at \$107.07) or for practices that have been unable to consistently reach the 20-minute CCM time threshold and have therefore been billing far less than the theoretical maximum.

For practices just entering care management for the first time, APCM's simplified structure -- no time clock, no per-minute documentation -- may lower the operational barrier enough to make program launch viable. Automated platforms designed for care management, such as [TileHealthcare.com](https://www.tilehealthcare.com), handle patient outreach, check-ins, and compliance documentation regardless of whether a practice is billing under CCM or APCM codes.

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