Tile Health Releases Guide on Medicare's APCM and CCM Billing Codes for Primary Care Practices

APCM vs. CCM: what every primary care practice needs to know before switching; rates, rules, revenue impact, and who actually benefits from the new codes.

Tile Health

BETHESDA, MD, UNITED STATES, March 9, 2026 /EINPresswire.com/ -- A New Program, New Codes, and a Decision Every Primary Care Practice Must Make

On January 1, 2025, the Centers for Medicare and Medicaid Services quietly launched one of the most significant changes to primary care reimbursement in the past decade. The new Advanced Primary Care Management program, known as APCM, introduced three new billing codes that do not replace Chronic Care Management so much as they reframe it -- bundling more services, eliminating time-based documentation requirements, and potentially changing the financial calculus for tens of thousands of independent practices across the country.

> “For practices entering care management for the first time, APCM's simplified structure — no time clock, no per-minute documentation — lowers the barrier to program launch.”
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> *Ali Elmarsafawy, CEO, Tile Health*

For physicians and practice administrators already running CCM programs, the question is not whether APCM exists. The question is whether switching to it makes sense -- and the answer, it turns out, is far more nuanced than CMS's rollout materials suggest.

WHAT APCM ACTUALLY IS

APCM consolidates elements of Chronic Care Management, Principal Care Management, and Transitional Care Management into three risk-stratified monthly billing codes. Code G0556 covers patients with zero to one chronic condition and reimburses approximately $15 per patient per month. Code G0557 covers patients with two or more chronic conditions at roughly $49 per patient per month. Code G0558 applies to patients with two or more chronic conditions

who also qualify as Qualified Medicare Beneficiaries -- the lowest-income Medicare recipients -- and pays approximately $107 per patient per month.

Unlike CCM, which requires documented clinical staff time of at least 20 minutes per month, APCM uses a flat monthly payment tied to risk level. Practices are expected to provide a defined set of 13 service elements -- including care planning, medication management, 24/7 access to care, and health risk assessments -- but are not required to track time to the minute.

That last point is significant. For practices that have struggled with CCM's time-documentation burden, APCM's elimination of the clock requirement sounds like relief.

THE REVENUE REALITY IS MORE COMPLICATED

For many practices currently billing CCM, a switch to APCM could actually reduce monthly revenue. The average CCM reimbursement through CPT 99490 runs approximately $60 per patient per month at national rates. A practice billing an additional 20-minute add-on under CPT 99439 can collect close to $106 per patient per month. Under APCM, that same patient would generate $49 per month under G0557 -- a reduction of more than 50 percent.

For reference, current national average rates are as follows. CPT 99490 (CCM, non-complex, first 20 minutes) reimburses $60.49 per month. CPT 99439 (CCM add-on, each additional 20 minutes) reimburses $45.93 per month. G0557 (APCM Level 2, two or more conditions) reimburses $48.84 per month. G0558 (APCM Level 3, QMB plus two or more conditions) reimburses $107.07 per month. Source: CMS 2025 Physician Fee Schedule. Rates are national averages.

The exception is G0558. For practices with a substantial population of Qualified Medicare Beneficiaries -- a demographic more common in community health centers, rural practices, and safety-net clinics -- the $107 monthly rate matches or exceeds what most CCM programs generate. For those practices, APCM Level 3 could represent a material revenue improvement.

THE RULES THAT MAKE SWITCHING IRREVERSIBLE, MONTH TO MONTH

A critical compliance point that many practices miss: a patient cannot be enrolled in both APCM and CCM during the same calendar month. There is no partial billing or parallel enrollment. If a practice transitions a patient to APCM, it must bill exclusively under the APCM G-codes for that patient going forward for that month. The two programs cannot be layered.

Additionally, APCM eliminates separate billing for Transitional Care Management and communication technology-based services -- codes that many practices have used to supplement CCM revenue. Those payments are now bundled into the APCM global rate.

WHO SHOULD SWITCH AND WHO SHOULD WAIT

Healthcare finance analysts have largely converged on a segmented recommendation: practices with high concentrations of low-income Medicare patients eligible for G0558 stand to benefit most from APCM. Community health centers, rural health clinics, and practices serving Medicaid-

Medicare dual eligibles should model their patient panels against APCM Level 3 rates before dismissing the new codes.

For practices with typical Medicare patient populations where most patients qualify under G0557 rather than G0558, the math currently favors remaining in CCM -- especially those that have built efficient time-documentation workflows. The time investment required to reach the 20-minute CCM threshold can, in many cases, be offset by billing the add-on code, yielding per-patient revenue that APCM cannot currently match.

A third group -- practices that have never successfully launched a CCM program due to staffing barriers -- may find APCM's simplified structure more accessible. Removing time-tracking requirements reduces the operational overhead that causes an estimated 38 percent of CCM programs to fail within six months.

WHAT TECHNOLOGY MAKES POSSIBLE

The most significant development in the CCM and APCM landscape for 2025 is not the new billing codes themselves -- it is the maturation of AI-powered automation platforms that address the enrollment and documentation barriers that have kept most practices from participating in either program.

Fewer than 25,000 of the nation's approximately 295,000 primary care providers have ever billed CPT 99490, according to Medicare claims data. The gap is not lack of eligible patients -- roughly 23 million Medicare fee-for-service beneficiaries qualify for some form of care management -- but lack of operational infrastructure to reach them. AI voice agent platforms like https://www.tilehealthcare.com are automating patient outreach calls, monthly check-ins, care plan updates, and compliance documentation, allowing practices to run full-scale programs without adding clinical staff.

Whether a practice chooses CCM or APCM, the program only generates revenue when patients are enrolled and monthly contacts are completed. For most practices, that is the operational problem that needs solving first.

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