



Comprehensive Guide to Advanced Primary Care Management

In this comprehensive guide, we'll explore everything you need to know about advanced primary care management (APCM), including the concept of APCM itself, who can deliver APCM services, billing, compliance, eligibility, and tips for integrating APCM with remote patient monitoring (RPM). This guide will equip you with the knowledge and tools to make APCM a seamless, clinically and financially valuable addition to your organization.

Introduction to APCM

APCM is Medicare's latest initiative to help primary care providers deliver continuous, proactive care to patients. This program is a significant step by the Centers for Medicare & Medicaid Services (CMS) in bridging traditional fee-for-service (FFS) care with value-based, population-focused care elements. APCM offers a unique opportunity to explore population-based care management without the risk that can often come with value-based initiatives.

Who Can Deliver APCM?

APCM services can only be billed by providers "responsible for all primary care and serve as the continuing focal point for all healthcare services," whether in a clinic, federally qualified health center (FQHC), or rural health center (RHC).

Billing Codes and Requirements

CMS has established three HCPCS codes specifically for APCM, each reflecting the level of patient medical and social complexity:

G0556

For patients with one chronic condition or fewer, reimbursed at approximately \$15 per month for 2025.

G0557

For patients with two or more chronic conditions, reimbursed at around \$50 per month for 2025.

G0558

For high-complexity patients with qualified Medicare beneficiary (QMB) status and two or more chronic conditions, reimbursed at approximately \$110 per month for 2025.

Each code requires that the physician or qualified healthcare professional who is responsible for all primary care and serves as the continuing focal point for all healthcare services (i.e., the individual providing APCM services) make available — and, when appropriate, deliver — the following 13 elements:



1. Patient Consent

Inform the patient about the service, obtain consent, and document it in the medical record.



2. Initiating visit

For new patients or those not seen within three years.



3. Continuity of care

Ensure continuity with a designated team member for successive routine appointments.



4. Alternative care delivery

Care delivery options alternative to office visits, such as home visits and/or expanded hours.



5. Overall comprehensive care management

Conduct systematic needs assessments, ensure receipt of preventive services, manage medications and general clinical oversight.



6. Patient-centered care plan

Develop and maintain a comprehensive electronic care plan accessible to the care team and patient.



7. 24/7 access to care

Provide patients with 24/7 access to the care team/practitioner for urgent needs.



8. Coordination of care transitions

Coordinate transitions between healthcare settings and providers, ensuring timely exchange of health information and follow-up communication.



9. Ongoing communication

Coordinate with various service providers and document communications about the patient's needs, goals, and preferences.



10. Enhanced communication opportunities

Enable communications through secure messaging, email, patient portals, and other digital means.



11. Population data analysis

Identify care gaps and offer additional interventions as appropriate.



12. Risk stratification

Use data to identify and target services to patients.



13. Performance measurement

Assess quality of care, total cost of care, and use of certified EHR technology.

Compliance Best Practices

Ensuring compliance with APCM requirements is critical for ensuring timely, accurate, and complete reimbursement as well as reducing the risk of claim denials or audits. CMS expects practices to meet high standards for documentation, patient engagement, and care plan management.

Best practices for APCM compliance:



Use APCM-compliant software

APCM-compliant software simplifies the documentation and billing process by automating coding and sending compliance reminders for routine tasks.



Regular staff training

Conduct ongoing training sessions for your care team to stay current on APCM requirements, CMS guidelines, and best practices in documentation.



Monthly compliance checks

Monthly checks of APCM documentation, billing, and care plan updates can help ensure all activities align with CMS standards, minimizing the risk of compliance issues.



Monitor patient satisfaction and engagement

Gathering patient feedback can help refine APCM service delivery, meeting CMS's focus on patient engagement and high standards of care.



Thorough documentation

Each patient interaction, care coordination effort, and adjustment to the care plan must be recorded to demonstrate the continuity of care and meet billing requirements.

These compliance practices not only support APCM billing accuracy but also improve overall patient care by confirming that each patient's needs are continuously monitored and addressed.

Eligibility Requirements

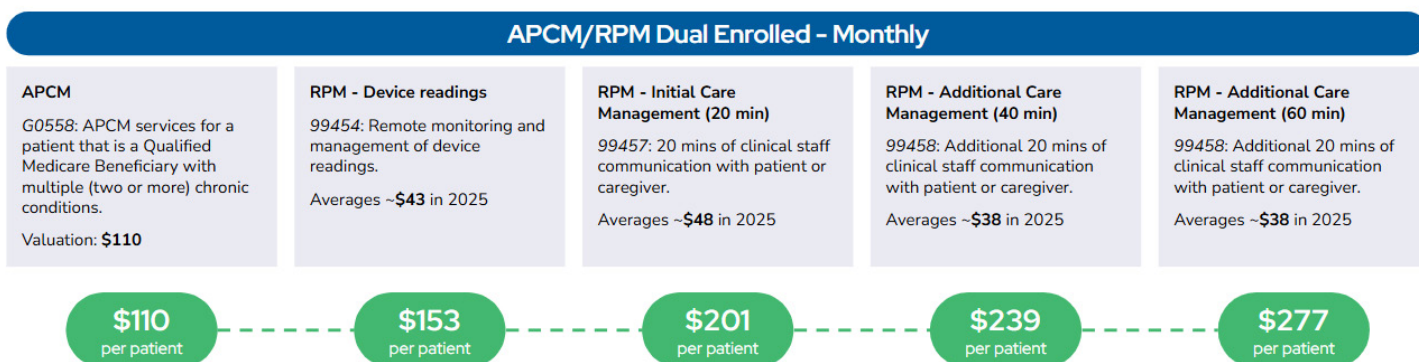
CMS guidelines have set specific eligibility criteria for APCM services. To achieve and maintain compliance, it's essential that practices and FQHCs verify which patients qualify for APCM and document patient consent before services begin. The CMS requirements for APCM eligibility are designed to ensure that the service targets patients who would benefit most from continuous, managed care.

Primary care providers only	Medicare beneficiaries	Patient consent
Only PCPs are eligible to bill for APCM services, as these providers are positioned to deliver holistic, longitudinal care to patients	Patients must be Medicare enrollees to qualify for APCM. As shared earlier, there are specific billing codes based on the level of patient complexity, including for patients with multiple chronic conditions and those with QMB status.	CMS mandates that practices obtain and document patient consent for APCM. This consent must be documented in the patient's record to confirm that the patient understands the nature of the service.

Integrating APCM with Remote Patient Monitoring

APCM and RPM are distinct but complementary services, each with unique strengths that enhance patient care. While APCM focuses on continuous care management through interdisciplinary support, RPM allows providers to monitor key health metrics remotely, enabling early intervention and preventing complications. RPM is a strong complement to APCM and additional service to provide to APCM patients as it allows for the continuous tracking of patient health metrics. Integrating RPM with APCM further supports data-driven care and creates additional revenue opportunities.

Below is what RPM/APCM dual-enrolled coding and billing looks like in 2025:



Disclaimer: This document is for informational purposes only and does not constitute legal, billing, or other professional advice. Billing and coding requirements – especially in the remote care management space – can change and be reinterpreted often. You should always consult a medical billing professional prior to submitting claims for services to ensure that all requirements are met.

Remote Care Management Done Right

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