Advanced Primary Care Management (APCM) Services FAQ

This document answers frequently asked questions about a set of codes Medicare adopted for physician payment beginning January 1, 2025, for Advanced Primary Care Management (APCM) services, using HCPCS Codes G0056, G0057, and G0058.

1. Which patients need an initiating visit?
    a. All new patients and those who have not been seen by the billing practitioner within 3 years require an initiating visit.
2. What types of visits may serve as APCM initiating visits?
    a. E/M visits Levels 2 through 5 (CPT codes 99212-99215), the face-to-face visit included in Transitional Care Management (TCM) (CPT codes 99495 and 99496), Annual Wellness Visit (AWV) and Initial Preventive Physical Exam (IPPE) all count as initiating visits if APCM is discussed during the visit.
3. What types of patients are eligible for APCM services?
    a. All patients are eligible for APCM services as long as they consent to receive APCM services. Level 1 (G0056) includes patients with zero to one chronic condition, level 2 (G0057) is for patients with two or more chronic conditions, and level 3 (G0058) is for patients who are Qualified Medical Beneficiaries with two or more chronic conditions.
4. Which service elements are required to be performed each month in order to bill for APCM services?
    a. APCM services are designed to be person-centered and focused on the individual patient need, such that the elements provided depend on medical necessity and individual patient need.
5. What does it mean to have the "capability to furnish" each item of APCM each month?
    a. Practitioners must have the ability to furnish all elements for any individual patient during any calendar month that APCM is billed. APCM service elements should be delivered as is medically reasonable and necessary. We believe that maintaining certain advanced primary care practice capabilities and requirements is inherent in the scope of service elements to fully furnish and bill APCM. For example, if a patient with heart failure and chronic kidney disease receiving Level 2 APCM sends in a picture of swollen legs to the practitioner, the practitioner must be able to interpret those images remotely.
6. How do I document the capability to perform all APCM services each month?
    a. We do not expect that the practice-level requirements be documented in each patient's medical record except to the extent they are used to furnish APCM services to a specific patient. By billing APCM services, the practitioner is attesting that the requirements included in the code descriptor have been met. Please see the CY 2025 PFS final rule here for more information.
7. In what settings can APCM be billed?
    a. APCM is priced in both facility and non-facility settings. The POS on the claim should be the location where the billing practitioner would ordinarily provide face-to-face care to the beneficiary.
8. Can the services be provided in an FQHC or RHC?
    a. Yes, APCM services can be furnished in an FQHC and RHC. RHCs and FQHCs can bill for APCM services and receive separate payment for these services with or without a qualifying visit. APCM services are paid at the PFS non-facility rate.