healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Advanced Primary Care Management (APCM) Services		
Policy Number:	PO-RE-144v1		
Effective Date:	01/01/2025	**Last Approval Date:**	5/19/2025

I. Policy Description

This reimbursement policy outlines the guidelines and procedures for billing and reimbursement of Advanced Primary Care Management (APCM) services. APCM services integrate various care management and communication technology-based services designed to enhance patient care for individuals with complex chronic conditions. This policy aims to ensure that eligible practitioners are appropriately compensated for delivering comprehensive and coordinated care that addresses the unique needs of their patients.

The information below applies to the following lines of business:

- Medicare Advantage
- Medicare PPO
- Medicaid Advantage Plus/MAP (CompleteCare)

Policy Scope

This policy applies to all Medicare-enrolled practitioners providing Advanced Primary Care Management services, including but not limited to:

- Physicians
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Clinical Nurse Specialists

Auxiliary personnel (e.g., registered nurses and pharmacists) may also participate in the provision of APCM services under the supervision of eligible practitioners. This policy covers the reimbursement of services related to Principal Care Management (PCM), Transitional Care Management (TCM), Chronic Care Management (CCM), and communication technology-based services such as virtual check-ins and remote evaluations.

Reimbursement Guide

Eligibility and Billing

1. Eligible Providers:
   Only Medicare-enrolled practitioners are authorized to furnish and bill for the services are eligible to submit claims for APCM services.

2. Frequency of Billing:
   APCM services may only be billed once per month for each patient by the practitioner who assumes the care management role during that billing period**.**

   Individual care management codes have time-based billing requirements, where you need to document every minute you spend on care management, and you must meet certain thresholds each month to bill those services. APCM services aren't time based, and you can bill using an APCM HCPCS code once per month when you meet the billing requirements.

3. Conduct an initiating visit (paid separately) for new patients. You don't need to conduct this visit if you or another provider in your practice have:
   - Seen the patient within the past three (3) years
   - Provided another care management service (APCM, CCM, or PCM) to patient within the past year.

4. Documentation Requirements:
   Practitioners must document the following in the patient's medical record to support reimbursement:
   - Patient discharge date
   - Date of first interactive contact with the patient or caregiver
   - Date of face-to-face visit
   - Level of medical decision making (moderate or high)

5. Patient Consent:
   Get written or verbal consent from the patient to participate in APCM services, and document it in the patient's medical record. The consent must inform your patient that:
   - Only 1 provider can furnish and be paid for APCM services during a calendar month
   - They have the right to stop services at any time
   - Cost sharing may apply to the patient

6. Concurrent Billing Restrictions:
   APCM services cannot be billed concurrently with the following services:
   - Principal Care Management (PCM)
   - Transitional Care Management (TCM)
   - Chronic Care Management (CCM)
   - Interprofessional consultations
   - Communication technology-based services (e.g., virtual check-ins)

7. Quality of Care:
   Participating practices are required to demonstrate the quality and effectiveness of APCM services through established performance metrics.

Adjudication and Appeal Process

1. Reimbursement for APCM services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. Claim submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

4. Reimbursement is subject to member eligibility, program coverage, and medical necessity at the time the service is provided.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

II. Applicable Codes

Code	Description	Comment
G0556	Patients with one or fewer chronic conditions	
G0557	Patients with two or more chronic conditions	
G0558	Patients with two or more chronic conditions and who are Qualified Medicare Beneficiaries	

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description

N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Advanced Primary Care Management Services | CMS

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.