

A photograph of a woman with a floral headband being kissed on the cheek by a young girl with long hair. The image is overlaid with a blue gradient.

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Home-Based Primary Care (HBPC) Masterclass: Enhancing Care, Capturing Value, and Driving Outcomes: Advanced Billing Opportunities for HBPC

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Agenda

1. Objectives
2. Advanced Primary Care Management (APCM)
3. Transitional Care Management (TCM)
4. Advanced Care Planning (ACP)
5. General Behavioral Health Integration (BHI)
6. Q/A

Objectives

- **Identify** the key components and eligibility criteria for APCM, TCM, ACP, and BHI services in longitudinal care.
- **Understand** billing codes, documentation requirements, and reimbursement strategies for each service.



Presenters



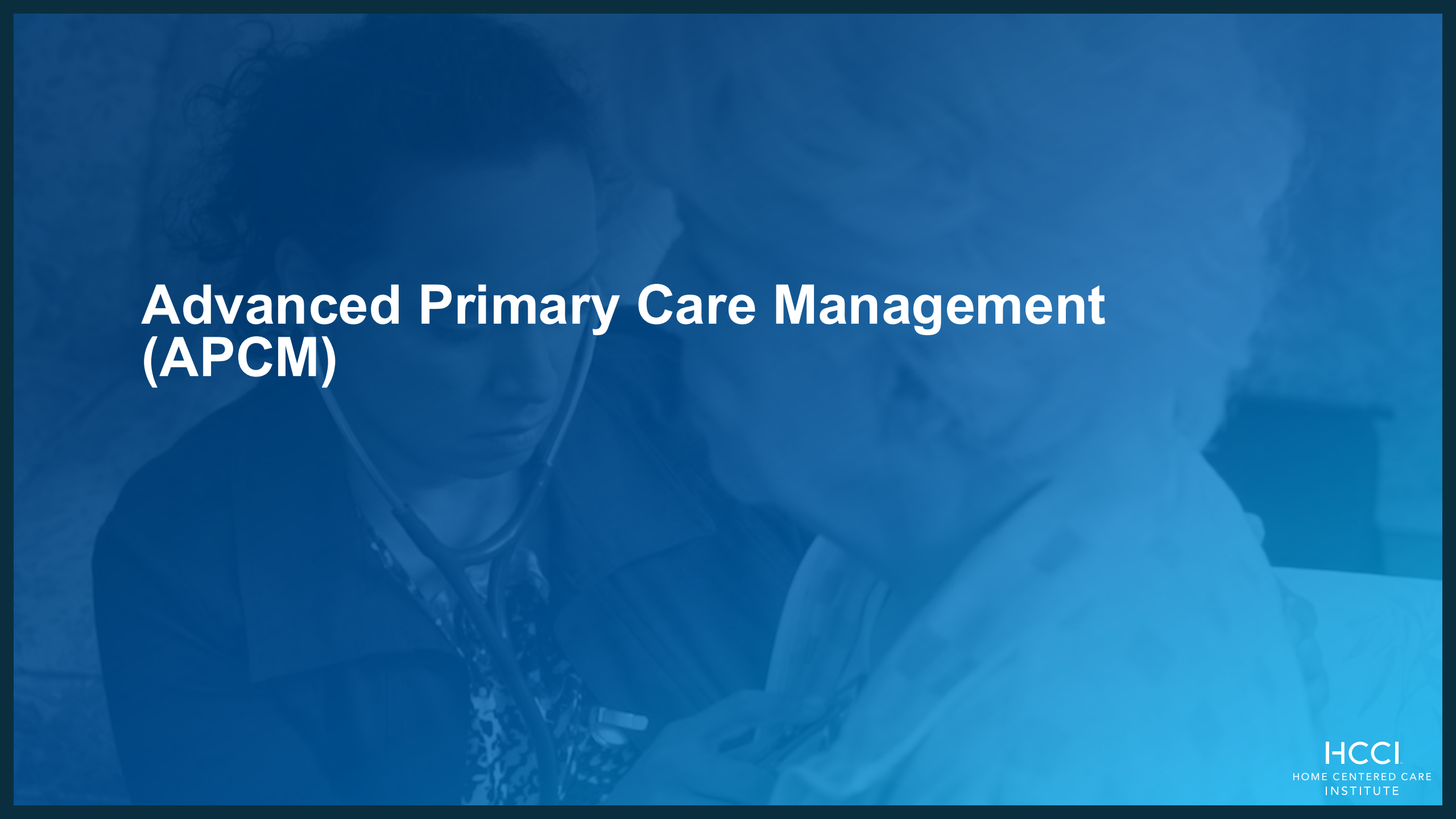
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Advanced Primary Care Management (APCM)

What is Advanced Primary Care Management (APCM)

- Advanced Primary Care Management (APCM) is a comprehensive, team-based approach to delivering coordinated care for patients with chronic and complex conditions. It is designed for individuals with multiple ongoing health issues who may benefit from longitudinal support outside traditional face-to-face encounters. CMS introduced dedicated billing codes in 2025 (G0556, G0557, and G0558) to reimburse practices offering these advanced care management services.
- The model focuses on addressing care gaps, promoting health equity, improving patient satisfaction, and reducing total cost of care. APCM is most often delivered in home-based or post-acute settings for patients who may not benefit from traditional in-office models of care.

Eligibility Criteria

- Patients eligible for separately payable APCM services include Medicare beneficiaries and dually eligible individuals (Medicare and Medicaid) who have medically complex needs and are at high-risk of acute exacerbation, functional decline, decompensation or risk of death.
- Examples of chronic or complex conditions that may qualify include but are not limited to: Alzheimer's disease and related dementias, arthritis, asthma, atrial fibrillation, autism spectrum disorders, cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD), depression, substance use disorders, diabetes, hypertension, and infectious diseases such as HIV/AIDS.

Key Components of APCM

Initiating Visit

- New patients & Annual Wellness Visit may qualify

24/7 Access and Continuity of Care

- Real-time access for urgent needs

Comprehensive Care Management

- Systematic needs assessments, prevention services and medication reconciliation

Individualized Care Planning

- Developing, updating and monitoring

Key Components of APCM

Comprehensive Care Coordination

- Care transitions and specialist referrals including SDoH

Enhanced Communication

- Asynchronous, non-face-to-face

Patient Population-Level Management

- Risk stratification and gaps in care to identify and target services

Measurement and Reporting

- Primary care quality, total cost of care and meaningful CEHRT use via either ACO participation or the Value in Primary Care MIPS Pathway

APCM Billing Practices

As of January 1, 2025, a physician or a non-physician practitioner including Nurse Practitioners, Physician Assistants or Certified Nurse Specialists who are responsible for all the patient's primary care services, is the focal point for all the patient's needed health care services and has obtained either written or verbal consent from the patient.

- Can be billed once per patient per calendar month
- Cannot be billed concurrently with other care management codes

Billing and Coding Requirements

- Obtain and document verbal or written consent
- Conduct an initiating visit
- Ensure around-the-clock access
- Provide ongoing medical and psychosocial assessments
- Maintain and share an electronic care plan
- Support care transitions
- Maintain continuous documentation
- Use secure digital tools
- Use data to identify care gaps and stratify patient risk

APCM Coding

HCPSC Code	Description and Requirements	2025 Medicare National Fee Schedule Payment	85% of MC allowable (NP/PA)
G0556	ACPM services for patients with one chronic condition to last 12 months or until death	\$15.20	\$12.92
G0557	ACPM services for patients with two or more chronic conditions posing significant risk of death, exacerbation, or functional decline	\$59.80	\$50.83
G0558	ACPM services for qualified Medicaid beneficiaries with multiple chronic conditions posing significant risk of death, exacerbation, or functional decline	\$107.07	\$91.01



Transitional Care Management (TCM)

Transitional Care Management (TCM)

- Transitional Care Management (TCM) is a structured, patient-centered approach to managing care transitions from inpatient facilities to community settings. It is designed for individuals with moderate to high medical complexity who require coordinated follow-up to prevent readmissions and ensure continuity of care. TCM supports patients during the critical 30-day post-discharge period through timely communication, medication reconciliation, and comprehensive care planning.
- CMS introduced dedicated billing codes (99495 and 99496) to reimburse providers offering these transitional services, including those in home-based primary care (HBPC) settings.

Eligibility Criteria

- Patients eligible for separately payable TCM services include Medicare beneficiaries and dually eligible individuals (Medicare and Medicaid) who are transitioning from an inpatient facility to a community setting and have moderate to high medical complexity.
- Examples of chronic or complex conditions that may qualify include but are not limited to: Congestive heart failure (CHF), Chronic obstructive pulmonary disease (COPD), diabetes, stroke, cancer, dementia, serious mental illness, post-surgical recovery, infectious diseases (e.g., HIV/AIDS)

Key Components of TCM

Interactive Contact:

- Must occur within 2 business days of discharge.
- Can be via phone, email, or in-person

Face-to-Face Visit:

- Required within 7 days (high complexity) or 14 days (moderate complexity)

Non-Face-to-Face Services:

- Medication reconciliation
- Coordination with community services
- Patient/caregiver education
- Review of discharge information

TCM Billing and Coding Requirements

Eligible Providers:

- Physicians (MDs and DOs, any specialty)
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Clinical Nurse Specialists (CNSs)

Additional Notes

- Providers may deliver both face-to-face and non-face-to-face components of TCM.
- Clinical staff under general supervision may assist with non-face-to-face services
- Only one provider may bill for TCM per patient per discharge
- TCM does not require prior patient consent to bill
- The billing provider does not need to have an established relationship with the patient prior to discharge

TCM Coding

CPT Code	Description and Requirements	2025 Medicare National Fee Schedule Payment	85% of MC allowable (NP/PA)
99495	Transitional Care Mgmt. (Moderate MDM/Complexity, seen within 14 days of discharge)	\$201.20	\$171.02
99496	Transitional Care Mgmt. (High MDM/Complexity, seen within 7 days of discharge)	\$272.68	\$231.78



Advanced Care Planning (ACP)

Advanced Care Planning (ACP)

- Advance Care Planning (ACP) is a voluntary, face-to-face service that enables patients to discuss and document their preferences for future medical care in the event they become unable to make decisions for themselves. These conversations may include advance directives, such as living wills, health care proxies, and medical orders for life-sustaining treatment. ACP is designed to align care with the patient's values and goals, and may involve family members, caregivers, or surrogates.
- CMS reimburses ACP services under CPT codes 99497 and 99498

Eligibility Criteria

- It is recommended that any adult, regardless of their current health status, can and should engage in advance care planning

Key Components of ACP

- **Discussion of Values and Goals:** Exploring the patient's beliefs and preferences for future care.
- **Explanation of Advance Directives:** Reviewing legal documents such as living wills and health care proxies.
- **Documentation:** Completing or updating advance directives when appropriate.
- **Family/Caregiver Involvement:** Engaging surrogates in the conversation to ensure alignment.
- **Review and Update:** Revisiting ACP periodically as health status or preferences change)

ACP Billing and Coding Requirements

- ACP must be voluntary, the provider should document the patient or caregiver's advance consent to voluntarily participate in the advance care planning discussion.
- ACP must be face-to-face and only include the time spent discussing the patient preferences and advance directives; time spent on other aspects of the visit cannot be counted towards this service element.
- The documentation must include the conversation details and the exact amount of time spent discussing advance directives.

ACP Coding

CPT Code	Description and Requirements	2025 Medicare National Fee Schedule Payment	85% of MC allowable (NP/PA)
99497	First 30 minutes, minimum 16 minutes F2F to bill	\$79.57	\$67.63
99498	Each Add 'l 30 minutes, minimum 46 mins to bill	\$68.90	\$58.57



General Behavioral Health Integration (BHI)

General Behavioral Health Integration (BHI)

- General Behavioral Health Integration (BHI) is a structured, team-based care management service designed to support patients with mental, behavioral, or psychiatric conditions within primary care settings. It promotes whole-person care by integrating behavioral health into routine medical care, improving access, outcomes, and continuity.
- CMS reimburses BHI services under CPT code 99484, which covers monthly care coordination activities performed by clinical staff under the supervision of a physician or qualified healthcare professional

Eligibility Criteria

- A patient qualifies for General BHI services if they have at least one mental, behavioral health, or psychiatric condition, including substance use disorders.
- The condition is either pre-existing or diagnosed by the billing practitioner, and in the clinical judgment of the practitioner, it warrants BHI services

Key Components of BHI

- **Initial Assessment and Monitoring:** Using validated tools to assess behavioral health needs and track progress over time.
- **Personalized Care Planning:** Collaborating with the patient to create and revise a tailored treatment plan.
- **Ongoing Care Management:** Maintaining a continuous relationship with the care team for support and follow-up.
- **Behavioral Health Coordination:** Facilitating access to appropriate behavioral health services and specialists.
- **Team-Based Collaboration:** Engaging a multidisciplinary team to deliver integrated, patient-centered care.
- **Patient and Family Engagement:** Involving patients and caregivers in decision-making and care planning.
- **Quality Improvement:** Measuring outcomes and using data to enhance care delivery and effectiveness.

BHI Billing and Coding Requirements

Eligible Providers:

- Physicians
- Clinical Psychologists (CPs)
- Clinical Social Workers (CSWs)
- Nurse Practitioners, and Physician Assistants

Additional Notes

- Initial assessment using validated rating scales (examples – PHQ 9, GAD-7, PDSS-SR)
- Development and revision of care plans
- Coordination of treatment (e.g., psychotherapy, pharmacotherapy)
- Ongoing communication with the care team
- Patient consent must be documented
- Services can be provided outside of face-to-face encounters

BHI Coding

CPT Code	Description and Requirements	2025 Medicare National Fee Schedule Payment	85% of MC allowable (NP/PA)
99484	General Behavioral Health Integration Services; 20 minutes per calendar month	\$53.05	\$45.09

Comparison by Services and Fees

HCPCs and CPT Codes	Description	Fee	
G0556	APCM - one chronic condition / per calendar month	11.97	APCM includes TCM
G0557	APCM - two or more chronic conditions / per calendar month	48.84	
G0558	APCM - QMB with multiple chronic conditions	107.07	
99495	TCM - Mod MDM seen in 14 days	201.20	
99496	TCM - High MDM seen in 7 days	272.68	
99497	ACP - First 30 mins	79.70	
99498	ACP - each additional 30 mins	68.90	
99484	BHI - 20 mins per calendar month	53.05	

Q & A

A group of five healthcare professionals, including three men and two women, are seated around a table in a modern office setting. They are all wearing white lab coats and have stethoscopes around their necks. One man on the right is holding a tablet and gesturing with his hand while speaking to the others. A woman in the center is looking at a laptop screen. The background shows a clean, bright office environment with large windows. The entire image is overlaid with a semi-transparent blue filter.

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