HEALTH Endeavors

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High-Value FFS Toolkit: Part 1

Leveraging select "high-value" FFS codes can help to support value-based care efforts by enabling providers to receive reimbursement for services that improve patient outcomes and reduce costly utilization, aiding in both short-term revenue and long-term savings. In this practical resource, **Part 1 of a three-part series**, we explore high-value FFS codes to support enhanced care management services, detailing eligibility and service requirements, billing, and best practices.

Introduction

High-value fee-for-service (FFS) codes represent a subset of billing codes that reimburse providers for **services that support longitudinal, patient-centered care** known to improve patient outcomes, enhance care coordination, and reduce costly utilization (e.g., emergency department visits, inpatient admissions). Examples of high-value FFS codes include:

- Providing enhanced care management (i.e., Principal Care Management (PCM), Chronic Care Management (CCM), Transitional Care Management (TCM), Advanced Primary Care Management (APCM) services)
- Integrating behavioral health services (e.g., Psychiatric Collaborative Care Model (CoCM), other Behavioral Health Integration (BHI) services)
- Collecting remote patient data (e.g., Remote Patient Monitoring (RPM), Remote Therapeutic Monitoring (RTM) services)
- Supporting key prevention activities (e.g., Annual Wellness Visits (AWVs, screenings (e.g., depression, etc.), behavioral counseling (e.g., obesity, CVD)
- Addressing health-related social needs (e.g., caregiver training, SDOH risk assessment, community health integration (CHI), Principal Illness Navigation (PIN) services)

High-value FFS codes serve as a practical on-ramp to value-based care (VBC) by enabling providers to deliver services that align with the goals of VBC while still operating within a FFS framework. Additionally, for organizations participating in ACOs, high-value FFS codes offer an immediate and predictable revenue stream, helping providers invest in necessary care delivery transformation activities without the need to wait for shared savings reconciliation payments. While these high-value FFS revenues may reduce future shared savings, this is more than offset by the savings generated by reducing utilization in high-cost settings, such as avoidable emergency department visits, hospitalizations, and readmissions.

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Recognizing the power of FFS codes for driving behavior, CMS is increasingly expanding reimbursement opportunities for high-value activities through the Medicare Physician Fee Schedule.

Part 1 of this Toolkit covers high-value FFS code opportunities to provide **enhanced care management**, Part 2 will cover **integrating behavioral health services** and **collecting remote patient data**, and Part 3 will cover **supporting key prevention activities** and **addressing health-related social needs**.

Providing Enhanced Care Management

Enhanced care management codes support providers in delivering coordinated, patient-centered services for individuals with complex or chronic conditions, as well as patients experiencing transitions of care. These codes enable reimbursement for non-face-to-face care activities that improve outcomes and reduce healthcare costs.

Chronic Care Management

Chronic Care Management (CCM) codes were created to **allow practices to bill for the typically non-face-to-face time spent managing care for patients with chronic conditions**.

Patient Eligibility

To be eligible for CCM, a patient must meet the following requirements:

- The patient must have **two or more chronic conditions** that are expected to last at **least 12 months or until their death**
- The chronic conditions must place the patient at significant **risk of death, acute exacerbation/ decompensation, or functional decline**

Non-exhaustive list of the types of services that can be included in CCM:

- Phone calls/communication with the patient
- Coordination and exchange of health information with other physicians or providers
- Coordination with community-based services providers
- Referrals to other physicians or providers
- Chart reviews
- Medication management
- Facilitating post-discharge follow-up visits
- Self-management education and support

Service Requirements

- An **Initiating Visit** is required for new patients or patients who haven't seen the billing practitioner in past year. The initiating visit must include **discussion of CCM** and should occur during a comprehensive face-to-face Evaluation and Management (E&M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE).

Tip: If the time spent developing a care plan in support of CCM requirements exceeds the description of the code used for the initiating visit, code *G0506: Comprehensive assessment of and care planning by the physician or other qualified health care practitioner for patients requiring CCM services* can be billed as an add-on code. This is most commonly the case when the initiating visit is a lower level E&M code (e.g., Level 2, 3).

Tip: The initiating visit and CCM visit can happen on the same day, but time spent on each service cannot be double counted – billing must make clear that the services were separate

- The patient must provide **verbal or written consent** at the onset of services, which must be documented in the patient's medical record. Patients must be informed of (1) the availability of CCM, (2) any cost-sharing responsibilities, (3) their ability to stop receiving CCM services at any time, and (4) that only one practitioner can bill CCM services for them in a calendar month. Patient consent must only be obtained at the onset of services, but **if the patient changes billing practitioners, consent must be obtained again.**
- A **comprehensive care plan** must be established, implemented, revised, and monitored. This plan is a person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, environmental (re)assessment, and inventory of resources and supports. This plan **must be available both within and outside the practice** billing for CCM and must be made available to patients (or caregivers) if requested.

CMS does not have strict requirements for what must be included in a comprehensive care plan, though they do identify a list of typically included elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and providers

- Relatedly, the patient must be provided with **comprehensive care management** (e.g., systemic needs assessment, preventive services, medication management, coordination with other providers) and have access to **24/7 access to physicians, other qualified practitioners, or clinical staff** able to provide CCM services.

Tip: Meeting this 24/7 access requirement is commonly done by partnering with a vendor that provides a 24/7 clinical staff hotline.

- Patient data (e.g., demographics, problems, medications, medication allergies) must be **recorded in a certified EHR**.
- Providers are required to **manage care transitions**, including creating continuity-of-care documents.

Billing

CCM CPT codes vary by (1) **how much time** is spent on care management, (2) **who provides the service** (i.e., clinical staff[1] or the billing physician/eligible non-physician provider (NPP)[2]), and (3) **patient complexity.** Only one "set" of CCM codes can be billed each month.

- **Set 1:** Codes 99490 and add-on code 99439 (**Non-complex** CCM services **delivered by clinical staff** under general supervision[3] of the billing physician/eligible NPP)
- **Set 2:** Codes 99487 and add-on code 99489 (**Complex** CCM services **delivered by clinical staff** under general supervision of the billing physician/eligible NPP)
- **Set 3:** Codes 99491 and add-on code 99437 (**Non-complex** CCM services **delivered by the physician or NPP**)

[1] Eligible clinical staff include (but is not limited to) medical assistants, LPNs, and RNs

[2] Eligible NPPs include Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners, and Certified Nurse Midwives

[3] ***General supervision*** means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service.

Code	Description	Reimbursement* Non-Facility / Facility	Key Billing Notes
99490	**Non-complex** CCM services; first 20 minutes	$60.49 / $47.87	• 99439 can only be billed up to two times per month • Time spent by the billing physician/NPP can be used to bill these codes if not used to bill 99491/99437
+ 99439	**Non-complex** CCM services; each additional 20 minutes	$45.93 / $32.99	
99487	**Complex** chronic care management services; first 60 minutes	$131.65 / $87.01	• To bill these codes, medical decision making must be of moderate or high complexity as determined by the physician/eligible NPP. Services can still be delivered by clinical staff.
+ 99489	**Complex** chronic care management services; Each additional 30 minutes	$70.52 / $47.23	
99491	**Non-complex** CCM services delivered by physician/NPP; first 30 minutes	$82.16 / $72.46	• No clinical staff time can be used to count towards the billing of this set of codes
+ 99437	**Non-complex** CCM services delivered by physician/NPP; Each additional 30 minutes	$57.58 / $47.87	

* National Medicare Allowed 2025

Billing Considerations

- Since only one series of CCM codes (i.e., 99490/99439, 99487/99489, or 99491/99437) can be billed per patient per month, be sure to evaluate which option provides the highest reimbursement while still adhering to billing guidelines (see example to the right).
- Documentation should clearly distinguish between time spent on CCM and other time-based services, including the time spent on an initial visit. Time counted for CCM services cannot be used to bill for other codes (e.g., time-based RPM codes, other E&M services).
- Complex CCM and prolonged E&M codes cannot be billed in the same month.
- CCM also cannot be billed during the same service period as G0181, G0182 (home health care/hospice supervision) or 90951-90970 (certain ESRD services), or Transitional Care Management (TCM) services.

Example: If your clinical staff spend 60 minutes on chronic care management services for a patient in a month that qualifies for coding under the complex CCM codes, you may still want to bill the non-complex code option because it's a higher total reimbursement and simplifies billing complexity.

- Noncomplex: 99490 + 99439 x 2 = $152.35
- Complex: 99487 = $131.65

Principal Care Management

While CCM is limited to patients with two or more chronic conditions, Principal Care Management (PCM) is used for patients with a **single, complex chronic condition.**

Patient Eligibility

To be eligible for PCM, a patient must meet the following requirements:

- The **chronic condition must be expected to last at least 3 months**, that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- The condition must be one that **requires frequent adjustments in the care plan**, medication, etc.

The types of services covered under the PCM umbrella align with those performed for CCM services.

> Tip: Generally speaking, PCM is more suited for specialists (e.g., a cardiologist with a patient that has congestive heart failure, a pulmonologist with a patient that has COPD) while CCM is geared more towards primary care providers.

Service Requirements

PCM has many of the same requirements as CCM, including the requirement for **patient consent** and an **initiating visit** as described for CCM. One notable difference with the initiating visit requirement is that unlike with CCM, **an initial visit must be obtained annually**.

Like CCM, PCM also requires that providers **engage in communication and coordination with other providers** treating the patient and **develop a care plan**, with the notable difference that **this care plan is specific to the condition for which PCM services were initiated**.

> Tip: If CCM and PCM are provided concurrently, two separate care plans would be required.

Billing

Similar to CCM, PCM codes vary based on **(1) time spent** and **(2) who is providing the service**.

Code	Description	Reimbursement* Non-Facility / Facility	Key Billing Notes
99424	PCM services; first 30 minutes provided by a **physician/NPP**	$80.87 / $72.13	• No clinical staff time can be used to count towards the billing of this set of codes
+ 99425	Each additional 30 minutes	$58.87 / $49.17	
99426	PCM services; first 30 minutes of **clinical staff time** directed by a physician/NPP	$61.78 / $47.55	• Time spent by the billing physician/NPP can be used to bill these codes if not used to bill 99424/99425
+ 99427	Each additional 30 minutes	$50.46 / $34.29	

* National Medicare Allowed 2025

Billing Considerations

- While PCM and CCM can be billed for the same patient, the **same provider cannot bill for both services**.

Transitional Care Management

Transitional Care Management (TCM) services are designed to **support patients recently discharged from an inpatient stay in transitioning smoothly back to a community-based care setting**. The goal of these codes is to reduce subsequent readmissions and improve patients' experiences and outcomes of care.

Patient Eligibility

Patients are eligible for TCM during the **30-day period** that begins the day of discharge from a qualifying inpatient setting.

Qualifying Inpatient Settings	Qualifying Community Settings
• Inpatient acute care hospital • Inpatient psychiatric hospital • Inpatient rehabilitation facility • Long-term care hospital • Skilled nursing facility • Hospital outpatient observation or partial hospitalization • Partial hospitalization at a community mental health center	• Home • Domiciliary (like a group home or boarding house) • Nursing facility • Assisted living facility

Service Requirements

TCM consists of both **face-to-face visits** and **non-face-to-face services**. Some components can be performed by only the billing physician/NPP while others can be performed by clinical staff.

	Physician/NPP only	Clinical Staff or Physician/NPP
Face-to-Face/Interactive	• Face-to-face visit (including via telehealth) within specified time frame (7 or 14 days)	• Initial contact within 2 days of discharge (in-person, telephone, or electronic communication)
Non-Face-to-Face	• Review discharge information and patient follow-up needs • Interact with other health care professionals • Educate patient, family, guardian, or caregiver • Manage referrals to providers or community resources • Help schedule required community providers and services follow-up	• Communication with patient • Communication with agencies and community service providers • Educating patient, guardian, or caregiver to support self-management, independent living, and activities of daily living • Assess and support treatment adherence, including medication management • Identify available community and health resources • Help the patient and family access needed care and services

Billing

Billing for TCM is a bit different than for PCM and CCM, differing based on **medical complexity**.

Code	Description	Reimbursement* Non-Facility / Facility	Key Billing Notes
99495	TCM services; **moderate** medical complexity requiring a face-to-face visit within **14 calendar days** of discharge	$201.20 / $134.24	• Both codes require communication with the patient or caregiver (via direct contact, telephone, or electronically) within 2 business days of discharge
99496	TCM services; **high** medical complexity requiring a face-to-face visit within **seven calendar days** of discharge	$272.68 / $182.43	

* National Medicare Allowed 2025

Billing Considerations

- Only one physician/NPP can report TCM services and services can only be reported once per patient during the 30-day TCM period.
- The healthcare professional discharging the patient is also permitted to bill TCM services.
- The face-to-face visit cannot take place on the same day as the discharge.
- TCM services cannot be billed if the patient is within a post-operative global surgery period.
- Minimum documentation should include: patient discharge date, date of first interactive contact with patient or caregiver, face-to-face visit date, medical decision making.
- The face-to-face visit may not also be reported separately with an E&M code (though other medically necessary E&M services may still be reported during the 30-day TCM period).
- CCM and RPM codes are permitted to be billed with TCM services, but PCM are not.

Advanced Primary Care Management

Advanced Primary Care Management (APCM) services **bundle elements of PCM, CCM, TCM, and other communication technology-based services** (e.g., virtual check-ins, remote evaluations). The key benefit of using APCM codes over other care management codes is that these services can be **billed without tracking time spent**.

CMS introduced APCM services as part of the 2025 Medicare Physician Fee Schedule. APCM codes are a step forward in incorporating the principles of value-based payment in a fee-for-service setting, regardless of a provider's ACO participation.

Read our analysis of the VBC-related provisions in the 2025 MPFS here.

Patient Eligibility

Unlike PCM and CCM, even beneficiaries with **no chronic conditions can qualify** for (the lowest level) of APCM services.

Service Requirements

The service requirements align with other care management codes, with a few notable differences and a couple additions. Crucially, CMS clarifies that providers **do not need to provide all services each month** to bill.

- **Patient Consent:** Similar to CCM and PCM requirements.
- **Initiating Visit:** Similar to CCM and PCM requirements, though if the billing provider or another provider in the practice has seen the patient within the past three years or has already provided another care management service (e.g., PCM, CCM) within the past year, this requirement can be waived.

Same as CCM/PCM	APCM-specific Requirements
• Provide 24/7 access and continuity of care • Provide comprehensive care management • Develop, implement, revise, and maintain an electronic patient-centered comprehensive care plan • Coordinate care transitions	• Conduct patient population-level management (analyze patient population data to identify gaps in care, risk stratify practice population • Measure and report performance either by (1) reporting the Value in Primary Care MIPS Value Pathway (MVP) under MIPS or (2) participate in an MSSP ACO or REACH ACO

Billing

Like other care management codes, **physicians and eligible NPPs can bill for services**, with clinical staff eligible to provide services, where appropriate. However, one key difference is the requirement that **the clinician billing for APCM services must be the one primarily responsible for the patient's primary care services**.

Code	Description	Reimbursement* Non-Facility / Facility	Key Billing Notes
G0556	APCM services for patients with one or fewer chronic conditions	$15.20 / $11.97	• This is the only care management code available for patients with no chronic conditions
G0557	APCM services for patients with two or more chronic conditions	$48.84 / $36.23	
G0558	APCM services for patients with two or more chronic conditions and who are Qualified Medicare Beneficiaries	$107.07 / $79.90	• A Qualified Medicare Beneficiary (QMB) is a low-income Medicare beneficiary that has applied for the QMB program, which provides assistance with premiums and cost sharing requirements

* National Medicare Allowed 2025

Billing Considerations

- APCM services can be billed once per patient per month.
- APCM services cannot be billed in conjunction with CCM or TCM services for the same patient by the same clinician in the same month.

Best Practices

- Identify high-needs patients who would benefit from ongoing care management, prioritizing patients with frequent ED or hospital visits, dual eligible patients, or with a high number of specialist visits. While only APCM services require this effort, this is best practice for all care management services.
- After developing this list, determine which care management codes are best suited to the individual patient's needs, considering their diagnoses, how much care management time is expected, and which provider(s) they are regularly seeing.
- Develop efficient workflows. Identify whether any additional staff are needed to implement these services. A practice may consider having higher risk patients work with the physician or NPP while lower risk patients work with other clinical staff.
- Regularly perform internal audits to identify issues with documentation or compliance. Common issues include inaccurate documentation of time, inadequate care plan documentation, and missing patient consent.
- Consider how to incorporate remote patient monitoring (RPM) services, where relevant, as part of a patient's holistic care plan.
- Remember, patient cost sharing applies to these services under Traditional Medicare rules, so check to see if the beneficiary has supplemental insurance (Medigap) or qualification for the QMB Program that might cover the cost sharing amount. Also, ACO providers should consider whether to leverage any available waivers of Part B cost sharing.

Additional Resources

Chronic Care Management Services | CMS

Chronic Care Management Frequently Asked Questions

Connected Care Toolkit | CMS

Requirements for Reporting Principal Care Management | AAPC

Transitional Care Management | AAFP

Transitional Care Management Services Booklet | CMS

Advanced Primary Care Management Services | CMS

Coding for Advanced Primary Care Management | AAFP