

Care Management for Primary Care

A Practical Guide to CCM, APCM, and GPCM Programs

The Work You're Already Doing (But Not Getting Paid For)

Your patients with diabetes, heart failure, COPD, and depression need more than episodic visits. They need:

- Medication reconciliation between appointments
- Care coordination calls when something changes
- Follow-up after hospital discharges
- Someone answering questions before they become ER visits

You're probably already doing this work.

Medicare has billing pathways that recognize it.

Three Programs, Different Structures

Program	What It Recognizes	Key Requirement
CCM (Chronic Care Management)	Non-face-to-face care coordination for patients with 2+ chronic conditions	≥20 minutes/month , documented with activities and dates
APCM (Advanced Primary Care, new 2025)	Simplified care management based on patient complexity tiers	No time tracking —bill by tier level
GPCM (Proposed for 2026)	Add-on for SDOH complexity, serious illness, community service integration	Awaiting final rule

APCM was the big change for 2025.

No time tracking. No consent forms. Attribution-based.

For practices drowning in CCM documentation, it's a potential game-changer.

The CCM vs. APCM Decision

Factor	CCM	APCM
Time tracking required	Yes (≥20 min)	No

Consent required	Yes	No (attribution model)
Initiating visit required	Yes	No
Minimum conditions	2+ chronic	1+ chronic
Can bill together?	No — mutually exclusive	No

You must choose one per patient per month.

*The right choice depends on your **documentation infrastructure and patient population**.*

The Collision Rules That Trip People Up

Combination	Same Month?	Why It Matters
CCM + APCM	No	Mutually exclusive
CCM + E/M visit	Yes	Distinct services
CCM + CoCM	Maybe	Must be distinct; no time overlap
CCM + TCM	No	TCM covers 30-day post-discharge
APCM + BHI	Maybe	Verify with your MAC

The Core Principle:

No double-counting time or activities. The same staff member doing the same work cannot be billed under two codes.

Care Management for Primary Care: What's in the Zenara's Full Guide

- ✓ CCM eligibility, consent, required elements, and documentation checklist
- ✓ APCM tier definitions and when to use Level 1 vs. 2 vs. 3
- ✓ GPCM preview (proposed 2026 add-ons)
- ✓ Collision rules with BHI, CoCM, and TCM
- ✓ Worked examples with month-by-month scenarios
- ✓ What your tracking system needs to capture

Ready to capture revenue for the care coordination you're already doing?

[Get the Full Guide: Care Management for Primary Care](#)