Medicare Care Program Guide for Practices

Original Medicare requirements, code families, and California payment context for CY2026

Prepared by PrimeVital

Public edition 1.1
Effective January 1 through December 31, 2026
Source review completed September 20, 2026

Purpose and limits

This guide helps a practice identify the questions that must be resolved before it enrolls patients, assigns staff, or projects revenue for an Original Medicare care program. It summarizes selected CMS requirements and CY2026 Medicare Physician Fee Schedule information. It is educational reference material, not legal, medical, coding, billing, or reimbursement advice.

The payment figures are non-facility allowed amounts before beneficiary cost sharing, sequestration, deductible effects, MIPS adjustments, secondary insurance, denials, or contract terms. California figures vary by Medicare payment locality, not simply by city. Medicare Advantage and commercial plans use their own contracts and policies; do not substitute these Original Medicare amounts for a plan-specific rate.

PrimeVital reviewed this edition against the CMS sources listed at the end. It has not been certified by an independent healthcare attorney or certified coding professional. Before billing, confirm the current CPT instructions, NCCI edits, Medically Unlikely Edits, Medicare Administrative Contractor guidance, payer policy, and facts of the individual patient and service.

Evidence labels

- **CMS source** means the statement is supported by a cited CMS publication or CMS data file.
- **Calculated from CMS data** means PrimeVital calculated the amount from CMS carrier, RVU, GPCI, and conversion-factor inputs.
- **Practice check** identifies a question the practice should resolve; it is not a CMS rule by itself.

Program overview

Program	Typical clinical use	Core billing structure	First question to resolve
Chronic Care Management (CCM)	Ongoing management of two or more qualifying chronic conditions	Monthly time-based services	Does the patient meet both the condition-duration and significant-risk tests?
Advanced Primary Care	Longitudinal primary care	Monthly, not time based	Can the practice furnish the

Program	Typical clinical use	Core billing structure	First question to resolve
Management (APCM)	delivered by the practitioner responsible for the patient's primary care		required service elements and act as the continuing focal point for care?
Transitional Care Management (TCM)	Thirty-day management after discharge from a qualifying setting	One 30-day service period with contact and visit deadlines	How will the practice learn about a discharge quickly enough to meet the deadlines?
Remote Physiologic Monitoring (RPM)	Connected-device monitoring of physiologic data such as blood pressure, weight, glucose, or oxygen saturation	Setup, device-supply, and treatment-management components	Is the device an appropriate connected medical device, and will it automatically transmit sufficient data?
Remote Therapeutic Monitoring (RTM)	Monitoring therapy adherence or response, including respiratory and musculoskeletal treatment	Setup, device-supply, and treatment-management components	Is RTM clinically appropriate, and which eligible practitioner or therapist will bill it?
Behavioral Health Integration (BHI)	Monthly integration of behavioral health care with medical care	General BHI or psychiatric Collaborative Care Model	Is the practice providing general BHI or the more structured CoCM team model?
Principal Care Management (PCM)	Management of one qualifying complex chronic condition	Monthly practitioner or clinical-staff time	Is the work limited to one condition with a disease-specific care plan?
Principal Illness Navigation (PIN)	Navigation for a serious, high-risk condition	Monthly time-based navigation	Is the service addressing a documented navigation need rather than duplicating another funded service?
Community Health Integration (CHI)	Addressing a social need that interferes with diagnosis or treatment	Monthly time-based service	Was the need identified through the required initiating service, and is the activity separately documented?
Chronic Pain Management (CPM)	Monthly management of chronic pain	Practitioner-led monthly bundle	Can the physician or other qualified professional personally meet the required first 30 minutes?
Medication Therapy Management (MTM)	Part D plan-sponsored medication review and management	Plan-specific Part D program	Is there a plan, PBM, pharmacy-network, or other contract that authorizes the service and rate?

How Medicare payment works

CMS assigns each Physician Fee Schedule service work, practice-expense, and malpractice relative value units. Each component is adjusted by the locality's Geographic Practice Cost Index and multiplied by the applicable conversion factor.

Allowed amount = [(work RVU x work GPCI) + (practice-expense RVU x PE GPCI) + (malpractice RVU x MP GPCI)] x conversion factor

For CY2026, the non-Qualifying APM Participant conversion factor is $33.4009 and the Qualifying APM Participant conversion factor is $33.5675. A county selector is useful in California because each county maps to a payment locality, but claim pricing should use the service location and current CMS locality files, including ZIP or ZIP+4 exceptions when applicable.

The allowed amount is not the amount a practice necessarily collects. Original Medicare generally pays 80 percent of the allowed amount after deductible rules, and the beneficiary or secondary payer may be responsible for the remaining 20 percent. Sequestration generally reduces the Medicare portion by 2 percent. Qualified Medicare

Beneficiary protections prohibit billing the beneficiary for Medicare cost sharing. Assignment, secondary coverage, deductible status, MIPS, claim edits, medical necessity, documentation, and denials can change the actual result.

Chronic Care Management

Eligibility and practice capabilities

CCM applies when a patient has at least two chronic conditions expected to last at least 12 months or until death, and the conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. The practice must establish, implement, revise, or monitor a comprehensive care plan. **CMS source**

Before starting CCM for a new patient, or a patient not seen within the previous year, CMS requires an initiating comprehensive face-to-face E/M visit, Annual Wellness Visit, or Initial Preventive Physical Exam. The initiating visit is separately billable when its requirements are met. G0506 may be reported once as part of an initiating visit when the billing practitioner personally performs extensive assessment and care planning beyond the usual effort. **CMS source**

The practice also needs certified EHR capability, continuity of care, 24/7 access to address urgent needs, a non-face-to-face communication channel, an electronic care plan, processes for sharing care-plan information and managing transitions, and reliable time capture. **CMS source**

Consent and care plan

CMS permits written or verbal consent, documented in the medical record. The patient must be told that CCM is available, cost sharing may apply, only one practitioner may furnish and bill CCM in a calendar month, and the patient may stop the service at any time effective at the end of the month. **CMS source**

The comprehensive care plan may include the problem list, expected outcome and prognosis, measurable treatment goals, cognitive and functional assessment, symptom management, planned interventions, medical management, environmental and caregiver assessments, coordination with outside resources and practitioners, and periodic review. **CMS source**

Code structure and California payment reference

Code	Plain-language role	Time and performer	National amount	California range
99490	Standard CCM	First 20 minutes by clinical staff under general supervision	$66.13	$68.53-$82.16
99439	Standard CCM add-on	Each additional 20 minutes by clinical staff	$50.44	$52.49-$63.45
99487	Complex CCM	First 60 minutes by clinical staff with required decision-making	$144.29	$150.94-$184.06
99489	Complex CCM add-on	Each additional 30 minutes with 99487	$78.16	$81.71-$99.50
99491	Practitioner CCM	First 30 minutes personally by the billing practitioner	$89.18	$92.10-$109.24
99437	Practitioner CCM add-on	Each additional 30 minutes with 99491	See current fee schedule	See county lookup
G0506	Additional initiating-visit care planning	Once as part of the qualifying initiating visit	$66.47	$69.43-$84.38

Amounts are non-facility allowed amounts. **Calculated from CMS data**

Advanced Primary Care Management

APCM is a monthly primary-care bundle. It is not time based, but the billing practitioner must be responsible for the patient's primary care, serve as the continuing focal point for needed services, obtain consent, and furnish the required elements when clinically appropriate. The code may be billed once per patient per calendar month. **CMS source**

Code	Patient tier	National amount	California range
G0556	Zero or one chronic condition	$16.37	$16.90-$20.22
G0557	Two or more qualifying chronic conditions	$53.78	$55.97-$67.49
G0558	Two or more qualifying conditions and Qualified Medicare Beneficiary status	$117.24	$121.84-$146.91

Amounts are non-facility allowed amounts. QMB cost-sharing protections apply to G0558. **Calculated from CMS data; CMS source for QMB protections**

APCM incorporates elements of CCM, PCM, TCM, and selected communication technology-based services. Do not separately report a bundled service by the same practitioner for the same patient and month unless current CMS, CPT, and payer instructions permit it. RPM and RTM are not part of the APCM bundle, but each service must independently satisfy its requirements and no time or work may be counted twice. **CMS source; not an exhaustive edit list**

Transitional Care Management

TCM covers the 30-day period beginning on the date of discharge from a qualifying setting. The practice must complete interactive contact with the patient or caregiver within two business days, a face-to-face visit within 14 calendar days for 99 495 or seven calendar days for 99 496, and medication reconciliation on or before the face-to-face visit. Document unsuccessful contact attempts as well as successful contact. Only one practitioner may report TCM for the patient during the service period. **CMS source**

Code	Plain-language role	National amount	California range
99 495	TCM with moderate-complexity medical decision-making and visit within 14 days	$220.11	$230.35-$280.82
99 496	TCM with high-complexity medical decision-making and visit within seven days	$298.60	$312.78-$381.30

Amounts are non-facility allowed amounts. **Calculated from CMS data**

Remote monitoring

RPM uses a connected medical device that automatically collects and transmits physiologic data. RTM addresses therapy adherence or response and uses a separate code family. For both families, match the code to the clinical service actually furnished, the number of qualifying device days, the management time, and the eligible billing practitioner. **CMS source**

CY2026 added shorter-duration options. For RPM, 99 445 describes device supply for two to 15 days in a 30-day period, while 99 454 describes 16 to 30 days. Code 99 470 describes the first 10 minutes of RPM treatment management, while 99 457 describes the first 20 minutes; current code instructions determine when an add-on may be used. For RTM, 98 984 and 98 985 describe two to 15 days of respiratory and musculoskeletal device supply, and 98 979 describes the first 10 minutes of treatment management. **CMS source**

Treatment-management services require at least one real-time interactive communication with the patient or caregiver during the calendar month. Data review alone does not satisfy that element. RTM services furnished by therapists must follow therapy plan-of-care and modifier rules. **CMS source**

Code	Plain-language role	National amount	California range
99 453	RPM setup and patient education	$21.71	$23.42-$30.70
99 445	RPM device supply, two to 15 qualifying days	$52.11	$56.92-$74.83
99 454	RPM device supply, 16 to 30 qualifying days	$52.11	$56.92-$74.83
99 457	RPM treatment management, first 20 minutes	$51.77	$54.38-$66.68
99 458	RPM treatment management add-on, each additional 20 minutes	$41.42	$43.04-$51.75
98 977	Musculoskeletal RTM device supply, 16 to 30 days	$51.44	$56.19-$73.87
98 980	RTM treatment management, first 20 minutes	$54.11	$57.11-$70.24

Amounts are non-facility allowed amounts. **Calculated from CMS data**

CMS permits either RPM or RTM, but not both, concurrently with a CCM or TCM service. Current CPT, NCCI, and payer rules may impose additional limits. **CMS source; not an exhaustive edit list**

Behavioral Health Integration

General BHI and the psychiatric Collaborative Care Model are different services. General BHI uses a treating practitioner and care manager. CoCM requires a behavioral health care manager, a psychiatric consultant, patient tracking in a registry, validated rating scales, and weekly caseload consultation. **CMS source**

Service	Code family	Core monthly threshold	National amount	California range
General BHI	99 484	20 minutes	$57.45	$59.39-$70.71
CoCM initial month	99 492	First 70 minutes	$160.32	$168.14-$206.10
CoCM subsequent month	99 493	First 60 minutes	$144.96	$150.85-$182.06

Service	Code family	Core monthly threshold	National amount	California range
CoCM add-on	99 494	Each additional 30 minutes	See current fee schedule	See county lookup

Amounts are non-facility allowed amounts. **Calculated from CMS data**

Other program families

Principal Care Management

PCM focuses on one high-risk chronic condition expected to last at least three months and requires a disease-specific care plan. Codes 99 424 and 99 425 use practitioner time; 99 426 and 99 427 use clinical-staff time directed by the billing practitioner. CMS states that another initiating visit is required after one year to continue PCM. **CMS source**

Principal Illness Navigation and Community Health Integration

PIN supports navigation for a serious, high-risk condition. CHI addresses a social need that is significantly limiting diagnosis or treatment. Qualified auxiliary personnel may furnish these services under general supervision when all requirements are met. The practice should verify the initiating-service, consent, personnel, time, documentation, and non-duplication requirements for the selected code. **CMS source**

Representative CY2026 non-facility amounts are $87.18 nationally and $91.60-$112.50 in California for G0023, and $86.17 nationally and $90.50-$111.06 in California for G0019. **Calculated from CMS data**

Chronic Pain Management

G3002 is a monthly bundle for chronic pain that includes the first 30 minutes furnished personally by a physician or other qualified healthcare professional. G3003 reports each additional 15 minutes when its requirements are met. Representative CY2026 non-facility amounts are $86.17 nationally and $88.38-$104.55 in California for G3002. **CMS source; calculated from CMS data**

Medication Therapy Management

Codes 99 605, 99 606, and 99 607 have Physician Fee Schedule status X, meaning no payment may be made for them under the Physician Fee Schedule. Medicare Part D MTM is administered through plan sponsors, which identify eligible beneficiaries and define the delivery and payment arrangement. Do not place a Part B rate beside these codes. **CMS source**

Concurrent billing reference

This table highlights selected CMS statements. It is not a complete billing-edit matrix.

Combination	Public guidance
Standard and complex CCM	Do not report non-complex and complex CCM for the same patient in the same calendar month.
Practitioner CCM and staff CCM	Do not report 99 491 or 99 437 in the same month as 99 487, 99 489, 99 490, or 99 439.

Combination	Public guidance
CCM and TCM	CMS permits 99 487, 99 489, 99 490, and 99 491 during the 30-day TCM period, provided the same time and work are not counted twice.
RPM and RTM with CCM or TCM	CMS permits either RPM or RTM, but not both, concurrently with CCM or TCM.
CCM with home health, hospice, or certain ESRD supervision	CMS prohibits CCM during the same service period as G0181, G0182, or 90 951-90 970.
APCM with separately reported bundled services	APCM incorporates CCM, PCM, TCM, and selected communication services; confirm current same-practitioner and same-month reporting rules before billing separately.
Any two programs	Each service must be medically necessary, independently supported, separately documented, and free of duplicated time or work. CPT, NCCI, MUE, MAC, payer, and CMS-model rules may add restrictions.

Practice review before launch

1. Identify the exact legal entity, practitioner, specialty, site of service, and Medicare enrollment that will bill.
2. Confirm the patient's Original Medicare or plan-specific coverage and do not apply Original Medicare rates to Medicare Advantage or commercial contracts.
3. Verify eligibility, medical necessity, initiating-service, consent, established-patient, and frequency requirements for the selected program.
4. Assign the qualified practitioner, clinical staff, auxiliary personnel, therapist, care manager, or psychiatric consultant required by the service.
5. Configure time, device-day, communication, care-plan, and supervision evidence before outreach begins.
6. Check current CPT instructions, NCCI edits, MUEs, CMS-model duplication rules, and the applicable Medicare Administrative Contractor guidance.
7. Explain potential patient cost sharing and QMB protections accurately.
8. Test the full workflow from enrollment through claim response before scaling.

Version and review

Field	Public edition information
Effective period	CY2026, January 1-December 31, 2026
Version	1.1 public edition
Source review	September 20, 2026
Rate-data build	CMS CY2026 carrier file PFCA26A and PFCA262; July 2026 RVU26C; CY2026 GPCI Addendum E
Independent legal or coding certification	Not completed; obtain practice-specific professional review before reliance
Planned maintenance	Quarterly source review and prompt review after the CY2027 Physician Fee Schedule final rule

Primary sources

- CMS, Chronic Care Management Services, MLN909188, June 2025.
- CMS, Chronic Care Management for Complex Conditions.
- CMS, Advanced Primary Care Management Services.
- CMS, Transitional Care Management Services, MLN908628, August 2025.
- CMS, Remote Patient Monitoring.
- CMS, Therapy Code List 2026 Annual Update, MM14250.
- CMS, Behavioral Health Integration Services, MLN909432, January 2026.
- CMS, Care Management, including CMS materials for CHI and PIN.
- CMS, CY2026 Medicare Physician Fee Schedule Final Rule.
- CMS, CY2026 Carrier-Specific Files, PFCA26A and PFCA262.
- CMS, CY2026 PFS Relative Value Files, RVU26C and GPCI2026.

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