G0558

ADVANCED PRIMARY CARE MANAGEMENT SERVICES FOR A PATIENT THAT IS A QUALIFIED MEDICARE BENEFICIARY WITH MULTIPLE (TWO OR MORE) CHRONIC CONDITIONS EXPECTED TO LAST AT LEAST 12 MONTHS, OR UNTIL THE DEATH OF THE PATIENT, WHICH PLACE THE PATIENT AT SIGNIFICANT RISK OF DEATH, ACUTE EXACERBATION/DECOMPENSATION, OR FUNCTIONAL DECLINE, PROVIDED BY CLINICAL STAFF AND DIRECTED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WHO IS RESPONSIBLE FOR ALL PRIMARY CARE AND SERVES AS THE CONTINUING FOCAL POINT FOR ALL NEEDED HEALTH CARE SERVICES, PER CALENDAR MONTH, WITH THE FOLLOWING ELEMENTS, AS APPROPRIATE: CONSENT; ++ INFORM THE PATIENT OF THE AVAILABILITY OF THE SERVICE; THAT ONLY ONE PRACTITIONER CAN FURNISH AND BE PAID FOR THE SERVICE DURING A CALENDAR MONTH; OF THE RIGHT TO STOP THE SERVICES AT ANY TIME (EFFECTIVE AT THE END OF THE CALENDAR MONTH); AND THAT COST SHARING MAY APPLY. ++ DOCUMENT IN PATIENT'S MEDICAL RECORD THAT

CONSENT WAS OBTAINED. INITIATION DURING A QUALIFYING VISIT FOR NEW PATIENTS OR PATIENTS NOT SEEN WITHIN 3 YEARS; PROVIDE 24/7 ACCESS FOR URGENT NEEDS TO CARE TEAM/PRACTITIONER, INCLUDING PROVIDING PATIENTS/CAREGIVERS WITH A WAY TO CONTACT HEALTH CARE PROFESSIONALS IN THE PRACTICE TO DISCUSS URGENT NEEDS REGARDLESS OF THE TIME OF DAY OR DAY OF WEEK; CONTINUITY OF CARE WITH A DESIGNATED MEMBER OF THE CARE TEAM WITH WHOM THE PATIENT IS ABLE TO SCHEDULE SUCCESSIVE ROUTINE APPOINTMENTS; DELIVER CARE IN ALTERNATIVE WAYS TO TRADITIONAL OFFICE VISITS TO BEST MEET THE PATIENT'S NEEDS, SUCH AS HOME VISITS AND/OR EXPANDED HOURS; OVERALL COMPREHENSIVE CARE MANAGEMENT; ++ SYSTEMATIC NEEDS ASSESSMENT (MEDICAL AND PSYCHOSOCIAL). ++ SYSTEM-BASED APPROACHES TO ENSURE RECEIPT OF PREVENTIVE SERVICES. ++ MEDICATION RECONCILIATION, MANAGEMENT AND OVERSIGHT OF SELF-MANAGEMENT. DEVELOPMENT, IMPLEMENTATION, REVISION, AND MAINTENANCE OF AN ELECTRONIC PATIENT-CENTERED COMPREHENSIVE CARE PLAN; ++ CARE PLAN IS AVAILABLE TIMELY WITHIN AND OUTSIDE THE BILLING PRACTICE AS APPROPRIATE TO INDIVIDUALS INVOLVED IN THE BENEFICIARY'S CARE, CAN BE ROUTINELY ACCESSED AND UPDATED BY CARE TEAM/PRACTITIONER, AND COPY OF CARE PLAN TO PATIENT/CAREGIVER; COORDINATION OF CARE TRANSITIONS BETWEEN AND AMONG HEALTH CARE PROVIDERS AND SETTINGS, INCLUDING REFERRALS TO OTHER CLINICIANS AND FOLLOW-UP AFTER AN EMERGENCY DEPARTMENT VISIT AND DISCHARGES FROM HOSPITALS, SKILLED NURSING FACILITIES OR OTHER HEALTH CARE FACILITIES AS APPLICABLE; ++ ENSURE TIMELY EXCHANGE OF ELECTRONIC HEALTH INFORMATION WITH OTHER PRACTITIONERS AND PROVIDERS TO SUPPORT CONTINUITY OF CARE. ++ ENSURE TIMELY FOLLOW-UP COMMUNICATION (DIRECT CONTACT, TELEPHONE, ELECTRONIC) WITH THE PATIENT AND/OR CAREGIVER AFTER AN EMERGENCY DEPARTMENT VISIT AND DISCHARGES FROM HOSPITALS, SKILLED NURSING FACILITIES, OR OTHER HEALTH CARE FACILITIES, WITHIN 7

CALENDAR DAYS OF DISCHARGE, AS CLINICALLY INDICATED. ONGOING COMMUNICATION AND COORDINATING RECEIPT OF NEEDED SERVICES FROM PRACTITIONERS, HOME- AND COMMUNITY-BASED SERVICE PROVIDERS, COMMUNITY-BASED SOCIAL SERVICE PROVIDERS, HOSPITALS, AND SKILLED NURSING FACILITIES (OR OTHER HEALTH CARE FACILITIES), AND DOCUMENT COMMUNICATION REGARDING THE PATIENT'S PSYCHOSOCIAL STRENGTHS AND NEEDS, FUNCTIONAL DEFICITS, GOALS, PREFERENCES, AND DESIRED OUTCOMES, INCLUDING CULTURAL AND LINGUISTIC FACTORS, IN THE PATIENT'S MEDICAL RECORD; ENHANCED OPPORTUNITIES FOR THE BENEFICIARY AND ANY CAREGIVER TO COMMUNICATE WITH THE CARE TEAM/PRACTITIONER REGARDING THE BENEFICIARY'S CARE THROUGH THE USE OF ASYNCHRONOUS NON-FACE-TO-FACE CONSULTATION METHODS OTHER THAN TELEPHONE, SUCH AS SECURE MESSAGING, EMAIL, INTERNET, OR PATIENT PORTAL, AND OTHER COMMUNICATION-TECHNOLOGY BASED SERVICES, INCLUDING REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION AND INTERPROFESSIONAL TELEPHONE/INTERNET/EHR REFERRAL SERVICE(S), TO MAINTAIN ONGOING COMMUNICATION WITH PATIENTS, AS APPROPRIATE; ++ ENSURE ACCESS TO PATIENT-INITIATED DIGITAL COMMUNICATIONS THAT REQUIRE A CLINICAL DECISION, SUCH AS VIRTUAL CHECK-INS AND DIGITAL ONLINE ASSESSMENT AND MANAGEMENT AND E/M VISITS (OR E-VISITS). ANALYZE PATIENT POPULATION DATA TO IDENTIFY GAPS IN CARE AND OFFER ADDITIONAL INTERVENTIONS, AS APPROPRIATE; RISK STRATIFY THE PRACTICE POPULATION BASED ON DEFINED DIAGNOSES, CLAIMS, OR OTHER ELECTRONIC DATA TO IDENTIFY AND TARGET SERVICES TO PATIENTS; BE ASSESSED THROUGH PERFORMANCE MEASUREMENT OF PRIMARY CARE QUALITY, TOTAL COST OF CARE, AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY

Healthcare Common Procedure Coding System

The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies,products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. HCPCS codes primarily correspond to services, procedures, and equipment not covered by CPT® codes.

G0558 Advanced primary care management services for a patient that is a qualified medicare beneficiary with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: consent; ++ inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ document in patient's medical record that consent was obtained. initiation during a qualifying visit for new patients or patients not seen within 3 years; provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours; overall comprehensive care management; ++ systematic needs assessment (medical and psychosocial). ++ system-based approaches to ensure receipt of preventive services. ++ medication reconciliation, management and oversight of self-management. development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan; ++ care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver; coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from

hospitals, skilled nursing facilities or other health care facilities as applicable; ++ ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. ++ ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated. ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record; enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/ehr referral service(s), to maintain ongoing communication with patients, as appropriate; ++ ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and e/m visits (or e-visits). analyze patient population data to identify gaps in care and offer additional interventions, as appropriate; risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients; be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of certified ehr technology

HCPCS Code	G0558	The Healthcare Common Prodecure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs.The codes are divided into two levels, or groups, as described Below: Level I Codes and descriptors copyrighted by the American Medical Association's current procedural terminology, fourth edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services. **** NOTE: **** CPT-4 codes including both long and short descriptions shall be used in accordance with the CMS/AMA agreement. Any other use violates the AMA copyright. Level II Includes codes and descriptors copyrighted by the American Dental Association's current dental terminology, seventh edition (CDT-2011/12). These are 5 position alpha-numeric codes comprising the d series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha- numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

Code Description	Advanced primary care management services for a patient that is a qualified medicare beneficiary with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: consent; ++ inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ document in patient's medical record that consent was obtained. initiation during a qualifying visit for new patients or patients not seen within 3 years; provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; deliver care in alternative ways to traditional office	Contains all text of procedure or modifier long descriptions. As of 2013, this field contains the consumer friendly descriptions for the AMA CPT codes. The AMA owns the copyright on the CPT codes and descriptions; CPT codes and descriptions are not public property and must always be used in compliance with copyright law.

	visits to best meet the patient's needs, such as home visits and/or expanded hours; overall comprehensive care management; ++ systematic needs assessment (medical and psychosocial). ++ system-based approaches to ensure receipt of preventive services. ++ medication reconciliation, management and oversight of self-management. development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan; ++ care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver; coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable; ++ ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. ++ ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7	

	calendar days of discharge, as clinically indicated. ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record; enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/ehr referral service(s), to maintain ongoing communication with patients, as appropriate; ++ ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and e/m visits (or e-visits). analyze patient population data to identify gaps in care and	

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Short Description	Adv prim care mgmt lvl 3	Short descriptive text of procedure or modifier code (28 characters or less). The AMA owns the copyright on the CPT codes and descriptions; CPT codes and descriptions are not public property and must always be used in compliance with copyright law.
Pricing Indicator Code #1	13	Code used to identify the appropriate methodology for developing unique pricing amounts under part B. A procedure may have one to four pricing codes.
Pricing Indicator Code #1 Description	Price established by carriers (e.g., not otherwise classified, individual determination, carrier discretion). Linked To The Physician Fee Schedule.	Description of Pricing Indicator Code #1
Multiple Pricing Indicator Code	A	Code used to identify instances where a procedure could be priced under multiple methodologies.
Multiple Pricing Indicator Code Description	Not applicable as HCPCS priced under one methodology	HCPCS Multiple Pricing Indicator Code Description
Coverage Code	C	A code denoting Medicare coverage status.
Coverage Code Description	Carrier judgment	HCPCS Coverage Code Description
Berenson-Eggers Type Of Service Code	M5D	This field is valid beginning with 2003 data. The Berenson-Eggers Type of Service (BETOS) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services.
Berenson-Eggers Type Of Service Code Description	Specialist - other	HCPCS Berenson-Eggers Type Of Service Code Description
Type Of Service Code #1	1	The carrier assigned CMS type of service which describes the particular kind(s) of service represented by the procedure code.

Type Of Service Code #1 Description	Medical care	Description of HCPCS Type Of Service Code #1
Anesthesia Base Unit Quantity	0	The base unit represents the level of intensity for anesthesia procedure services that reflects all activities except time. These activities include usual preoperative and post-operative visits, the administration of fluids and/or blood incident to anesthesia care, and monitering procedures. **** NOTE: **** The payment amount for anesthesia services is based on a calculation using base unit, time units, and the conversion factor.
Code Added Date	20250101	The year the HCPCS code was added to the Healthcare common procedure coding system.
Action Effective Date	20250101	Effective date of action to a procedure or modifier code
Action Code	N	A code denoting the change made to a procedure or modifier code within the HCPCS system.
Action Code Description	No maintenance for this code	HCPCS Action Code Description
Status	Actual	
Last Update Date	2025	

Contact Information for HCPCS
HCPCS Email Address: hcpcs@cms.hhs.gov
The PDAC has a toll free helpline
(877) 735-1326
HCPCS-related questions must be submitted online
via the www.codingclinicadvisor.com website

For all questions regarding this bundle please contact Support@DataLabs.Health. Also feel free to let us know about any suggestions or concerns. All additional information as well as customer support is available at https://www.datalabs.health/.