Patient Diagnostics PLLC

CREATED FOR PHYSICIANS, by a PHYSICIAN

RPM/CCM/RTM/CPM/BHI/TCM/PCM 2023

www.patientdiagnosticspllc.com

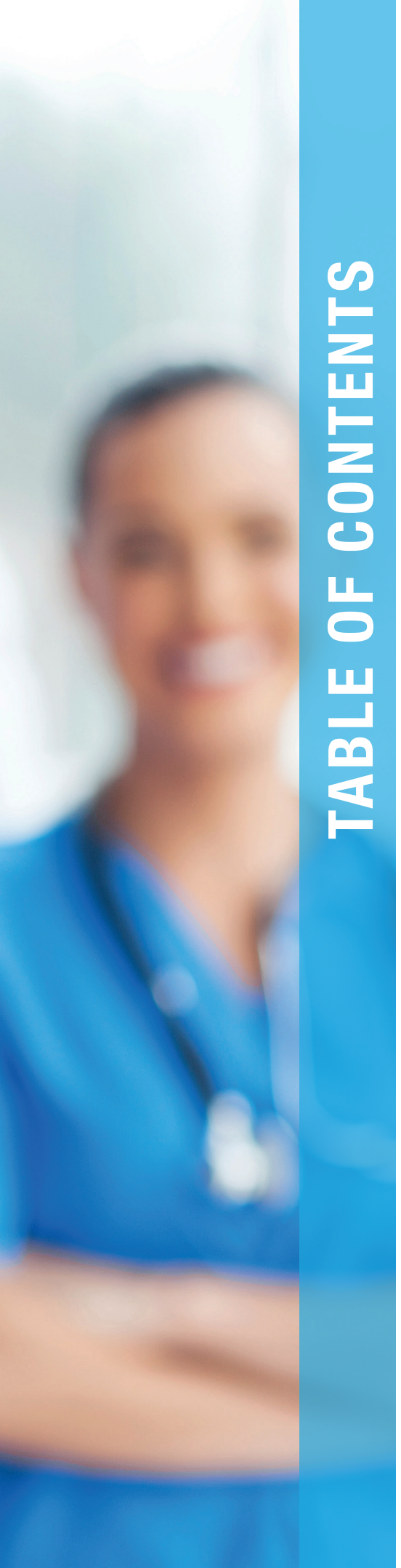


TABLE OF CONTENTS

M&Y CARE, LLC
Home Health Services
Est 1999

The Case for Outsourcing

Remote Patient Monitoring/Chronic Care Management to a trusted 3rd party M&Y CARE LLC

CCM	RPM
24/7 Access call center M&Y CARE acts as an extension of your care coordination team so that your patients with chronic conditions have access to a clinician, 24/7.	Monitoring program collects wide range of health data from the point of care, vital signs, weight, blood pressure, blood sugar, blood oxygen, heart rate, and electrocardiograms.
Certified Medical Staff	Certified Medical Staff
M&Y CARE will develop a comprehensive care plan per Medicare regulations for CCM.	Equipment works on Cellular network no need for patient to have internet service.
Facilitating communication between all of health-care providers and patients.	Installation and Ordering of RPM Equipment and Setting up the equipment in patients home.
MONTHLY CALLS INCLUDE: 1. Review of medications 2. Discussion of test results 3. Exercise and therapy options 4. Scheduling regular or unanticipated office visits with the primary provider 5. Referrals to specialists, as needed 6. Provide Education on the patients Chronic Conditions	

MEDICAL Offices Benefits:

- Keep your workflow No Staff, No Space or Scheduling from your staff needed
- Reduce scheduling burden from front office
- Immediate Revenue
- New Income Stream
- Improve your MIPS Score
- Able to provide Telemedicine Visits on patients who are participating in M&Y CARE RPM/CCM program
- Increase Patient Satisfaction

How to Get Started:

1. Practice discusses with patient if Patient is interested in RPM and/or CCM program.
2. Practice by fax or online intake submits an initial order for RPM and/or CCM with the patient H&P.
3. We will contact each patient on your behalf and explain the CCM and RPM program.
4. The patient must opt into CCM and RPM program by signing a consent.
5. The patient can also opt out of the program at any time, at the end of the calendar month.
6. We will go to patients' home explain and educate on the program and obtain the signature on the consent forms.
7. We will order and install all the equipment in the patient's home.
8. RPM/CCM services are done under Prescribing Physician General Supervision**see bellow CMS definitions*
9. Only the prescribing physician can bill for the RPM/CCM Service.
10. M&Y CARE can bill for CCM/RPM directly on physician behalf.
11. The required time for RPM/CCM will be documented in the EHR system of M&Y CARE.
12. The EHR System is cloud based and the Physician shall have complete access to his patient charts.
13. At Physician discretion M&Y CARE can upload and document the patient encounters in the Physician current EHR system. We can also provide electronic documentation to the Physician staff, for Physician staff to update the patient chart in Physician EHR.

* CCM and RPM qualify as designated care management services under 42 CFR 410.26(b)(5), Meaning these services can be furnished under the general supervision (as opposed to direct supervision) of a physician or practitioner.

Billing practitioner may arrange to have clinical staff external to the practice (e.g., a case management company) provide care management services for his or her patients, but only if all requirements for "incident to" billing are satisfied, including general supervision.

Clinical Staff: a person who works under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.

Incident to Billing: physician or other practitioner billing for the service must be the same individual who provides general supervision of the clinical staff.

General Supervision: general supervision (i.e., physician or other practitioner available by telephone to provide assistance as required).

Chronic Care Management

Overview

What is Chronic Care Management?

Chronic Care Management (CCM) offers personal support to patients with complex needs. This added level of care and service leads patients to a healthier lifestyle by proactively managing their care and providing a trusted clinical resource they can reach around-the-clock.

CCM is designed for patients with two or more chronic conditions that are anticipated to last at least 12 months or until the patient's death.

Patients enrolled in CCM services benefit from an entire care team focused on their needs, increased communication with their provider and improved care coordination.

CCM Benefits

Two thirds of patients on Medicare have two or more chronic conditions, which means many patients can benefit from CCM services. CCM can help your clinic deliver coordinated care to patients that need additional time and resources between appointments. Benefits to your clinic include:

Better Patient Outcomes

Patients gain a supportive healthcare team dedicated to creating a comprehensive care plan.

Improved Patient Satisfaction

Patient care is focused on prevention to keep patients out of the hospital by supporting patients between visits.

Improved Care Coordination

Referral coordination helps keep patients out of the hospital and prevents patients from "falling through the cracks."

Increased Revenue

CCM Increases Income for the clinic by billing CCM services.

Chronic Care Management (CCM) is a new Medicare program that offers significant monthly reimbursement for the time providers and their staff spend helping patients between office visits.

Who Can Perform CCM Services?

- Registered Nurses (RNs)
- Licensed Practical Nurses (LPNs)
- Medical Assistants (MAs)
- Medical Doctors (MDs) or Doctors of Osteopathic Medicine (DOs)
- Physician Assistant - Certified (PA-Cs)
- Advanced Practice Registered Nurses (APRNs)
- Contracted third party vendors

In 2015, The Centers for Medicare & Medicaid Services (CMS) unveiled a new code, **CPT 99490 - Chronic Care Management Services**, that reimburses primary care providers and chronic disease specialists for 20+ minutes of non-face-to-face clinical staff time spent on care coordination for Medicare patients with multiple chronic conditions. CMS studies have confirmed that CCM contributes to better outcomes and higher patient satisfaction.* Therefore, CMS has since expanded the program to include 6 billing codes that offer **$42-$139+ per patient per month.**

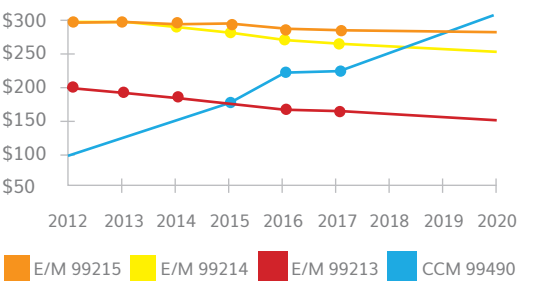
CCM enables billing for previously unreimbursed activities such as:

- making phone calls
- answering questions
- triaging symptoms
- refilling medication
- reviewing lab results
- scheduling appointments
- coordinating referrals
- care planning
- reviewing charts
- arranging transportation
- following up with patients
- managing overall patient care

Chronic Care Management results:*

- -5.6% Hospitalizations
- -4.2% ER visits
- +70% ROI for CMS

CCM reimbursement is steadily increasing while E/M visit reimbursement is declining:



**Mathematical Policy Research, «Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report,» November 2, 2017*

Who is Eligible?

If you live with two or more chronic conditions, CCM can help you manage your care. Some examples of chronic conditions include, but are not limited to:

- Alzheimer's and Related Dementia
- Arthritis
- Asthma
- Cancer
- COPD
- Heart Failure
- Depression
- Diabetes
- Hypertension
- Osteoporosis

What is a Chronic Condition?

The Centers for Disease Control and Prevention (CDC) defines a chronic condition as. "Conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States."

https://www.cdc.gov/chronicdisease/about/index.htm

PERSONALIZED
Comprehensive Care Plan

First, a member of the patient CCM team will complete a full assessment that includes:

- How is the patient feeling physically and emotionally.
- Whether patient have access to resources like food, transportation and/or medications.
- A review of all the medicatoins patient is taking and how patient is taking them.

Once the assessment is complete, the CCM team will create a plan that helps patient with specific activities each month such as:

- Ensuring patient are up-to-date and active with patient medications.
- Facilitating communication between all of patient health-care providers.
- Offering tips and techniques on how to deal with problems associated with chronic health conditions like pain, fatigue, frustration and getting a good night's sleep.
- Helping patien connect with community resources.
- Assisting with goal-setting, problem solving and overcoming barriers.
- Providing resources to help patient better manage his or her symptoms.

Overall, CCM helps you take an active role in patient care. It increases the likelihood that patient will get healthier and moves patient closer to achieving patient health-care goals.

CCM vs. Complex CCM

There are two different types of CCM. Classic chronic care management and complex chronic care management. Standard CCM can be distinguished from complex CCM by the respective CPT code. Complex CCM uses codes 99487 and 99489. Complex CCM patients' care teams must have a significant establishment or revision of the care plan and typically communicate more with the care team staff in a calendar month.

Billing Code	Code Description	Summary Requirements	Average Payment
HCPCS G0506	Comprehensive Assessment & Care Planning	• Patient enrolled in person • Systematic assessment & care planning personally performed by the billing provider • Add-on code to the standard E&M code (99212-99215). AWV or IPPE initiating visit	$63
CPT 99490	Standard CCM	• 20+ minutes of care management outside of office visits performed by clinical staff • Care plan established and regularly reviewed	64.07
CPT 99439	Non-Complex Add-on	• Additional 20 minutes of "non-complex" CCM • Reportable up to 2x per month (after 99490)	48.17
CPT 99487	Complex CCM	• 60+ minutes of care management outside office visits • Care plan created and/or significantly revised	$134.27
CPT 99489	Complex Add-on	• Billed incrementally for each additional 30 minutes spent beyond the first 60 minutes for Complex CCM case	$70.60

PROFESSIONAL RESOURCE

Chronic Care Management

Patient Scenarios

Chronic Care Management (CCM) offers personal support to patients with complex needs. This added level of care and service leads patients to a healthier lifestyle by proactively managing their care and providing a trusted clinical resource they can reach around-the-clock.

CCM is designed for patients with two or more chronic conditions that are anticipated to last at least 12 months or until the patient's death. Patients enrolled in CCM services benefit from an entire care team focused on their needs, increased communication with their provider and improved care coordination.

The patient scenarios below help demonstrate how CCM services and billing work on a monthly basis: *Reference the chart to find the correct billing code for each example.*

SAMPLE PATIENT ONE: Liam • 67 years old • Medicare

Liam has been diagnosed with Type 2 diabetes and hypertension
Liam began CCM services at his Medicare Annual Wellness Visit

Activity Log	Time Spent	
A nurse calls Liam two days after his E&M visit and discusses lab results	10 minutes	MONTH ONE
Liam calls his CCM nurse with blood sugar levels and questions	20 minutes	
CCM Billing • Bill 99490 (non-complex CCM) for month one	20 minutes •Bill 99490	

NOTE: The 20-minute phone call Liam makes to his nurse counts for CCM However, the 10-minute phone call from Liam's nurse does not count because it was directly related to the E&M visit.

SAMPLE PATIENT ONE: Liam • 67 years old • Medicare

Liam has been diagnosed with Type 2 diabetes and hypertension
Liam began CCM services at his Medicare Annual Wellness Visit

Activity Log	Time Spent	
The CCM nurse calls Liam to discuss diet education	10 minutes	MONTH TWO
The CCM nurse calls Liam to discuss blood sugar review	7 minutes	
CCM Billing • CANNOT BILL for month two **NOTE:** Unable to bill for CCM because the time spent was less than 20 minutes.	17 minutes • Cannot Bill	
The CCM nurse corresponds with Liam via email about his blood sugar	25 minutes	MONTH THREE
The CCM nurse calls Liam to discuss blood pressure review	10 minutes	
CCM Billing • Bill 99490 (non-complex CCM) for month three.	35 minutes •Bill 99490	

SAMPLE PATIENT TWO: Amelia • 72 years old • Medicare

Amelia has been diagnosed with Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Hypertension. She recently was hospitalized with CHF and COPD exacerbation. Amelia's chronic issues and recent hospitalization requires moderate or high complexity medical decision making.

Activity Log	Time Spent	
Amelia is billed for transitiond care management after returning from the hospital	30 minutes	MONTH ONE
The CCM nurse calls Amelia and she gives consent to start CCM services	10 minutes	
CCM Billing • CANNOT BILL for month one **NOTE:** Bill for Code 99495 (transitional care management. CCM code cannot be billed In the same month as TCM	0 minutes • Cannot Bill	
Amelia colls her CCM nurse and discusses her questions concerning salt in her diet	10 minutes	MONTH TWO
The CCM nurse made calls coordinating Amelia's care with her PCP, Cardiology and Pulmonology providers. Once completed, the CCM nurse made changes to Amelia's comprehensive care plan	30 minutes	
The CCM nurse calls Amelia and completes medication reconciliation	20 minutes	
Amelia calls the CCM nurse to discuss core to prevent her having to go to the hospital	30 minutes	
CCM Billing • Bill 99487 (complex CCM) for month two **NOTE:** Since there was a total of 90 minutes of CCM services add 99489 when billing for the additional 30 minutes of complex CCM services	90 minutes • Bill 99487 + 99489	

SAMPLE PATIENT TWO: Amelia • 72 years old • Medicare

Amelia has been diagnosed with Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Hypertension. She recently was hospitalized with CHF and COPD exacerbation. Amelia's chronic issues and recent hospitalization requires moderate or high complexity medical decision making.

Activity Log	Time Spent	
The CCM nurse runs and reviews several reports to schedule patients for immunizations and check ups. • Amelia is on two of the lists for needed immunizations	30 minutes	MONTH THREE
The receptionist contacts Amelia and schedules immunizations	10 minutes	
The CCM nurse calls Amelia and reviews her most recent blood pressure readings	15 minutes	
CCM Billing • CANNOT BILL for month three	**15 minutes • Cannot Bill**	

NOTE: CCM cannot be billed this month because only 15 of the 25 minutes spent was by an appropriate CCM provider.

- The time spent running and reviewing reports to schedule patients for immunizations by the CCM nurse cannot be used as CCM time because It was not specific to Amelia.
- The time spent scheduling Amelia for Immunizations does not count because receptionists cannot perform CCM services.

SAMPLE PATIENT THREE: Jose • 66 years old • Medicare

Jose has been diognosed with Rheumatoid Arthritis (RA) and Asthma. Jose began CCM services at his Medicare Wellness Visit

Activity Log	Time Spent	
The CCM nurse speaks with Jose over the phone about a new asthma inhaler	10 minutes	MONTH ONE
Dr. Smith calls Jose to discuss a new RA medication that she would like Jose to try	20 minutes	
Dr. Smith coordinates the prescription, completes medication reconciliation and medication delivery with the pharmacist for the new RA medication for Jose	15 minutes	
CCM Billing • BILL 99491 for month one	**45 minutes • Bill 99491**	

NOTE: 99491 is billed because the MD spend a minimum of 30 minutes on non-face to face CCM services in month one.

Featured Products

Hub Solution

Open solution, unlimited scalability.

emergency
provides a simple to use help button to users at home and away from home.

The MobileVitals Classic system gives patients access to personal emergency response services plus the benefits of monitoring important aspects of their health.

Pulse Oximeter

Indie Health Digital
Pulse Oximeter

Pulse Oximeter

Nonin Connect™ Wireless
Fingertip Pulse Oximeter

Thermometer

Indie Health Infrared Two in
One Thermometer

Blood Glucose Meters

Veridian Healthcare Oh'Care®
Lite Smart

Blood Glucose Meters

Trlvidia Health™
TRUE METRIX® AIR

Spirometer

MIR Spirobank®
Smart

Weight Scales

A&D Medical Premium Wireless
Weight Scale

Weight Scales

A&D Medical Premium Wireless
Weight Scale with Extra Wide Base

Weight Scales

Indie Health Digital Weight
Scale

Blood Pressure

A&D Medical Premium Wireless

Blood Pressure

Indie Health Blood Pressure Arm Monitor

Quadruple Aim Targeted

Improve Patient Outcomes

Remote Patient Monitoring (RPM) allows for continual education and monitoring outside the 4 walls, improving health and reducing the risk of admission.

Lower Cost of Care

Implementing RPM for at-risk patients and high utilizers lowers costs and delivers better continual care.

Improve Care Team & Provider Experience

Remote care on a quality connected care platform provides timely and relevant data to care providers when they need it the most, reducing alert-fatigue and burnout.

Improve Patient Experience

The remote care platform allows patient monitoring and treatment to be performed wherever the patient is at scheduled times that are convenient to them.

Your practice can provide better services to keep your chronic care patients healthy with connected devices covered by insurance using Patient Diagnostics and **M&Y CARE RPM's full-service Remote Patient Monitoring program.**

Full-Service Remote
PATIENT MONITORING

Remote patient monitoring (RPM) uses digital technologies to collect medical and other forms of health data from individuals in one location (usually the home) and electronically transmits that information securely to health care providers in a different location for assessment and recommendations. This type of service allows a provider to continue to track healthcare data for a patient once released to home or a care facility, reducing readmission rates.

Monitoring programs can collect a wide range of health data from the point of care, such as vital signs, weight, blood pressure, blood sugar, blood oxygen levels, heart rate, and electrocardiograms.

Monitoring programs can also help keep people healthy, allow older and disabled individuals to live at home longer and avoid having to move into skilled nursing facilities. RPM can also serve to reduce the number of hospitalizations, readmissions, and lengths of stay in hospitals—all of which help improve quality of life and contain costs.

Remote Patient Monitoring

REQUIREMENTS

Q. What level of supervision is required for services furnished by clinical staff?

A. CPT 99457 and 99458 qualify as designated care management services under 42 CFR 410.26 (b)(5), meaning these services can be furnished under the general supervision (as opposed to direct supervision) of a physician or practitioner.

Q. What documentation must be included in the beneficiary's medical record to support a claim for CPT 99453 and 99454? What date of service and place of service should be listed on such claim?

A. CMS has not stated any requirements, nor offered any guidance, regarding the documentation necessary to support a claim under CPT 99453 or 99454, or the appropriate date or place of service to be listed on the claim form. Absent such direction, we recommend the following:

- The documentation for CPT 99453 would include: (a) a practitioner order for deployment of the device; (b) the condition for which the beneficiary is being monitored and the medical necessity of the monitoring device; (c) the beneficiary's consent for RPM services; (d) identification of the device; (e) date of delivery of the device to the patient/caregiver; ond (f) date(s) on which training is provided to patient/caregiver.
- The documentation for CPT 99454 would be sufficient to demonstrate monitoring occurred for at least 16 days in a 30-day period.
- The date of service for CPT 99453 would be the date on which the device records the 16th day of data in a 30-day period following initiation of the service (or the last date of that 30-day period).
- If the device records and transmits data for at least 16 days, but not more than 30 days, the date of service for CPT 99454 would be the last day the device records data and transmits it to the provider.
- If the device records and transmits data for more than 30 days, the date of service for the first instance of CPT 99454 for a given beneficiary would be 30 days following the delivery of the device or completion of training (whichever occurred later). The date of service for each instance thereafter would be 30 days from the prior date of billing, provided the use of the device continued at least 16 days after the prior date of service.

• Based on CMS' guidance regarding CCM, the place of service for both codes would be the location at which the billing practitioner maintains his or her practice (i.e., physician office vs. hospital outpatient department).

Q. How does one count time for CPT 99457 and 99458?

A. While CMS has not provided specific guidance on counting minutes for RPM, CMS has provided the following rules with respect to counting 20 minutes for CCM, we assume CMS would apply the same rules to RPM CPTs 99457 and 99458:

1. Time spent providing services on different days, or by different clinical staff members in the same calendar month, may be aggregated to total 20 minutes.

2. If two staff members are furnishing services at the same time (e.g., discussing together the beneficiary's condition), only the time spent by one individual may be counted.

3. Time of less than 20 minutes during a calendor month cannot be rounded up to meet this requirement (e.g., if only 18 minutes, no billable service; if only 38 minutes, bill CPT 99457, but not 99458).

4. Time in excess of 20 minutes (but less than the 20 minutes necessary to bill CPT 99458) in one month cannot be carried forward to the next month.

5. For CCM, one may count time a practitioner or clinical staff member spends with more than one beneficiary (e.g., educating two beneficiaries at the same time) toward the total minutes for all participating beneficiaries; presumably, the same would be true for treatment management services.

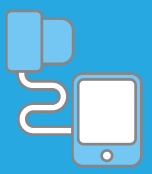
Remote Patient Monitoring

FOR CHRONIC CONDITIONS

One of the most effective treatments for chronic conditions is using Remote Patient Monitoring with Patient Diagnostics RPM connected devices. These connected Remote Patient Monitoring devices can be used to monitor chronic conditions like Diabetes, Hypertension, and even acute conditions like COVID-19. By using Remote Patient Monitoring for Diabetes, Remote Patient Monitoring for Hypertension and Remote Patient Monitoring for COVID-19, those who suffer from chronic conditions will know early when possible problems begin.

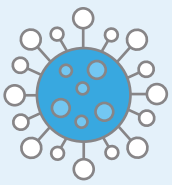
Chronic Patient Monitoring for Diabetes

A key aspect of controlling a patient's issues with diabetes is to ensure the patient's blood sugar remains at an acceptable level. Using Patient Diagnostics RPM's Remote Patient Monitoring for Diabetes, a physician can quickly tell if a blood sugar level is of concern. By using Patient Diagnostics RPM's Remote Patient Monitoring for Diabetes, patients receive
an easy-to-use connected glucose meter monitored by M&Y CARE RPMs team of care specialists. Treating diabetes is not easy but staying connected through Patient Diagnostics with M&Y CARE RPM's Remote Patient Monitoring for Diabetes makes it a bit easier.



Chronic Patient Monitoring for Hypertension

Hypertension can be fatal. If a patient's blood pressure becomes too high, the risk is great for a heart attack or a stroke. By utilizing Patient Diagnostics RPM's Remote Patient Monitoring for Hypertension, it is easy to monitor your patients blood pressure and be alerted if a fatal event may be starting. Every patient who uses RPM's Hypertension Remote Patient Monitoring receives an easy-to-use connected blood pressure cuff, monitored by M&Y CARE RPM's team of care specialists. Patient Diagnostics with M&Y CARE RPM's Remote Patient Monitoring with full service solutions for Hypertension helps save lives through today's technology.



Chronic Patient Monitoring for COVID-19

With COVID-19 treatments, it has been shown to be critical to know your health care statistics, especially with oxygen. While not a chronic condition, Patient Diagnostics RPM's Remote Patient Monitoring for COVID-19 allows patients to receive much needed health care monitoring without leaving the comfort of their home. Patient Diagnostics RPM's COVID-19 Remote Patient Monitoring can provide an easy-to-use connected oximeter. Monitoring COVID-19 conditions is a critical step in treatment of this deadly disease and Patient Diagnostics with M&Y CARE RPM's team of health care practitioners can ensure COVID-19 patients received that critical care.

Q. Which beneficiaries are eligible for RPM??

A. CMS has not identified the specific circumstances in which it will make payment for RPM other than to indicate the monitoring should be reasonable, medically necessary, and 'used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition.' Such justification for RPM should be documented in the patient's medical record.

Remote Patient Monitoring

CAN ALSO BE USED FOR THESE CHRONIC CONDITIONS

Patient Diagnostics **RPM can also be used for the Remote Patient Monitoring of the following conditions.**

- Alcohol Abuse
- Alzheimer's Disease and Related Dementia
- Arthritis (Osteoarthritis and Rheumatoid)
- Asthma
- Atrial Fibrillation
- Autism Spectrum Disorders
- Cancer (Breast, Colorectal, Lung, and Prostate)
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Drug Abuse/ Substance Abuse
- Heart Failure
- Hepatitis (Chronic Viral B & C)
- HIV/AIDS
- Hyperlipidemia (High cholesterol)
- Hypertension (High blood pressure)
- Ischemic Heart Disease
- Osteoporosis
- Schizophrenia and Other Psychotic Disorders
- Stroke

Advantages of Incorporating

TELEHEALTH & RPM INTO DIABETES CARE MANAGEMENT

An important factor to note is the economic toll diabetes has on both patients and the healthcare system.

For people with diabetes, medical costs are more than twice as high as those without diabetes. In 2017, the total cost of diagnosed diabetes was $327 billion in the US. Telehealth can help curb these figures by optimizing clinical efficiency, reducing office visits and their associated costs, decreasing costs associated with transportation, reducing costs associated with disease exacerbation (due to improved outcomes), and decreasing readmission and unnecessary healthcare facility utilization.

Like other chronic diseases such as CHF, COPD, and hypertension, telehealth can serve as a valuable tool for both diabetic patients and their providers.

Incorporating **telehealth and RPM** into diabetes care management can improve HbA1c and comorbidities, improve patient self-management skills, enhance positive behavior change, **expand access to care**, and increase patient adherence. Advantages to incorporating telehealth and RPM into diabetes care management include:

1. Improved HbA1c

a. Track and trend a patient's blood sugar and make more timely interventions to address any variances.

b. Accurate indicator of the patient's compliance with their treatment plan and goals.

c. Closely monitoring and managing those parameters can achieve a HbA1c of 7 or less, or an average BS over the last 3 months of about 150, the recommended goal.

d. Common comorbidity of diabetes is depression. Individuals with diabetes are 2-3x more likely to suffer from depression than those without diabetes. Depression, in addition to the many factors listed above, can be managed and monitored virtually through telehealth.

2. Improved Patient Self-Management

a. Successful patient self-management and patient **engagement** is critical to managing chronic disease and telehealth is a powerful self-management tool.

b. Following an individualized meal plan, getting physical activity, avoiding tobacco use, adhering to medications, and regularly monitoring blood sugar are **essential factors** to prevent diabetes complications.

c. Patient Diagnostics Software along with M&Y CARE helps patients retain and maintain these behaviors by providing nutrition and smoking cessation education, enabling activity tracking through wearables, and facilitating virtual consults with specialists and sessions with coaches and dietitians. When individuals understand why and how they need to change their behavior, they are more likely to do so. Telehealth first helps build this understanding then helps the patient maintain the necessary habits.

3. Increased Adherence

Adherence is a critical component of diabetes care management. When a patient adheres to their care plan, they are more likely to see positive results and avoid disease complications. The patient must be in the driver's seat to effectively manage their condition but telehealth helps ensure they are comfortable behind the wheel.

Telehealth improved adherence by allowing patients to report their daily blood glucose readings easily and facilitated regular communication between the patients and the nurse case manager. Additionally, the telehealth program enabled nurses to respond quickly to a patient's status and titrate medications when necessary.

Incorporating telehealth into diabetes care management can lead to increased access to care, improved adherence, better managed symptoms, and can also facilitate lifestyle modifications and behavior change. Additionally, telehealth can enhance clinical efficiency, clinical decision making, and patient-self management skills, while reducing costs to the healthcare system.

Cardiac Health Program

HEART-CENTERED REMOTE CARE

A review of 128 studies involving nearly 100,000 people who've had a heart attack, angioplasty, or heart failure found that those who participated in cardiac health programs were far less likely to be hospitalized and had a much better quality of life than those who did not.

According to the American Heart Association, healthcare costs have soared significantly as chronic diseases are highly prevalent, accounting for nearly 90% of all healthcare spending in the United States. Additionally, it costs 3.5 times more to treat chronic diseases than treating other conditions while accounting for 80% of all hospital admissions.

Why Remote Monitoring Is Essential to Manage High Blood Pressure

Nearly half of US adults suffer from hypertension, and only 1 out of 4 have it under control. As one of the leading risk factors for heart disease, stroke, and many other often dire conditions, it's essential that patients have the resources to control their hypertension. Remote patient monitoring (RPM) is a fantastic tool for patients with high blood pressure.

The most common barrier to adequate blood pressure management, as noted by the American Medical Association are:

1. Poor or inconsistent blood-pressure measurement techniques
2. Masked hypertension, which causes patients to appear to have a normal BP in the office, but high BP at home
3. Clinical inertia, which occurs when the patients' care team does not initiate or intensify treatment when the patients' BP isn't at goal
4. Lack of use of evidence-based treatment protocols by the care team
5. Poor patient participation in self-management

Remote Monitoring Can Help

RPM can help with each barrier mentioned above. It can help patients develop a consistent measurement technique, change their behavior when it comes to management, and record their readings consistently (as opposed to just when they visit their provider in the office).

For providers, it offers data-driven insights into the patient's blood pressure trends over time, helping the provider make informed decisions driven by trends. Through RPM, providers can be alerted in real-time when a blood pressure reading moves out of the patient's ideal range. When alerted, the provider can contact that patient to understand why the change occurred, and what next steps are to get the patient's BP under control. Simply, RPM enables providers to proactively treat their patients.

5 Examples of How RPM Can Work for Blood Pressure Management:

1. **Bluetooth biometric monitoring** - patient records their blood pressure throughout the day as directed by their provider

2. **Medication reminders** - patient receives medication reminders to ensure patient remain adherent to their medication plan, ensuring compliance to new and existing medications

3. **Symptom surveys** - patient provides insight into their symptoms, helping the provider understand trends behind blood pressure and other changes

4. **Education modules** - through hypertension specific education, the patient can understand how they can control their BP at home, and what actions they can take to promote better outcomes

5. **Virtual visits** - the patient and provider can communicate in real time if a blood pressure reading is out of range, if symptoms are exacerbated, or if the patient simply has questions about their care plan

By tracking data over time, RPM can help to spot abnormalities in reading including low or high blood pressure. It can help providers understand how new and existing prescriptions are working.

Blood Pressure Home Monitoring Supported in the Research

Researchers have long been exploring the efficacy of remote monitoring for blood pressure management. A recent study out of Brigham and Women's Hospital found that blood pressure home monitoring is an effective way to manage hypertension. 130 patients with uncontrolled blood pressure were enrolled in the pilot study. Enrolled patients were provided with a Bluetooth-enabled blood pressure device which they used to measure their BP twice daily. Patient navigators received the readings in real-time via a dashboard. They used the data to provide day-to-day management of the patients' condition.

The patient navigators educated the patients on lifestyle changes, and provided motivation to assist with necessary behavior changes. The patient navigators were also provided with a treatment algorithm adapted by the hospital's hypertension specialists, based on established protocols.

According to researchers, the study's overall BP control rate was achieved in 81% of patients who participated in the pilot.


Hypertension
High Blood Pressure
Diabetes
Obesity
Physical Inactivity
Smoking

Key Features:

Patient Engagement & Education

- Health and motivational tips throughout the program
- Encourage a healthy lifestyle
- Customized educational content for each patient
- Exercise videos

Improve Outcomes with Connected Monitoring

- Daily check-ins and monitoring for blood pressure, heart rate, weight, and pedometer readings
- Mental health
- Medication adherence
- Higher patient satisfaction

Allow Early Intervention & Coaching

- Providing signs to watch for
- Timely clinical intervention
- Appropriate nurse reviews and proactive clinical response
- Reduce errors in communication

Improve Provider Experience

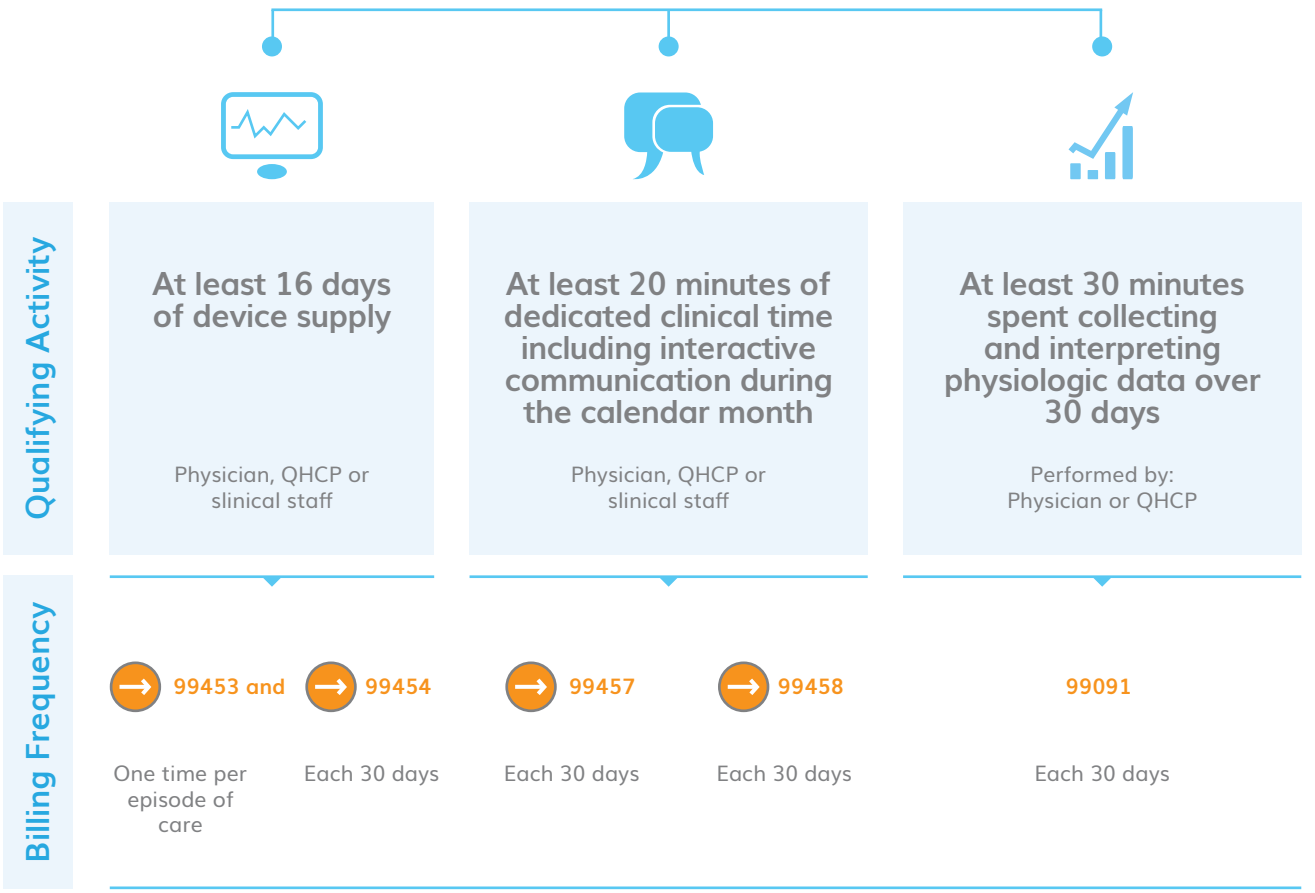
- Decrease unplanned ER visits and hospital admissions
- Improve clinical care and patient retention
- Reduce the administrative burden
- Improve ROI

Medicare CPT Codes

By providing Remote Patient Monitoring, also known as Remote Physiologic Monitoring, a practice not only provides better healthcare but also improves healthcare practice revenues. Using connected devices, physicians can monitor patients with diabetes, hypertension, COPD and more remotely and receive reimbursement through CMS's CPT codes for Remote Patient Monitoring.

RPM Billing

First Month	Monthly			
Initial Enrollment	**Base Monthly RPM**	**Care Management (20 min)**	**Care Management (40 min)**	**Care Management (60 min)**
99453: Initial patient setup and enrollment into RPM program.	99454: Remote monitoring and management of device readings. Averages $64.	99457: 20 minutes of clinical staff time communicating with patient or caregiver. Averages $55.	99458: Additional 20 minutes of clinical staff communication with patient or caregiver. Averages $44.	99458: Additional 20 minutes of clinical staff communication with patient or caregiver. Averages $44.
$21	$51	20 min $100	+20 min $139	+20 min $178



Potential Revenue

The Office of the Inspector General (within the Department of Health and Human Services), is allowing physicians and other healthcare providers **to waive patient** cost-sharing payments for **telehealth services** and other non-face-to-face services like **monthly remote care management** and **remote patient** monitoring for the duration of the public health emergency.

RPM MONTHLY

Code	Note	Medicare Bill Rate est	Co-Pay 20%	Actual Medicare Reimbursement		
99457	First 20 min	$49.49	$9.89	$39.59		
99458	Additional 20 min	$40.42	$8.08	$32.34		
99458	Additional 20 min	$40.42	$8.08	$32.34		

Code	Note	Time	Medicare Bill Rate est	Co-Pay 20%	Actual Medicare Reimbursement		
99091	QHP- Only MD,NP, PA	30 min	$56.87	$11	$45		

Possible RPM per patient monthly = $181
****Before RPM Devices fees, software, and calling managed services***

CPT CODE 99091

Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days)

Data Analysis and Interpretation (CPT 99091)

Q. For what services does CPT 99091 provide reimbursement?

A. According to CMS, '[a]fter the data collection period for CPT 99453 and 99454, the physiologic data that are collected and transmitted may be analyzed and interpreted os described in CPT 99091…'

Q. Who can perform 99091 services? What level of supervision is required?

A. This work may be performed by a physician or non-physician practitioner or by clinical staff if the requirements for 'incident to' billing are satisfied. Those requirements include **direct supervision** of the clinical staff by the billing physician or practitioner, i.e., that physician or non-physician practitioner must be physically present in the same suite of offices and immediately available to provide assistance and direction when the service is performed.

Due to the COVID-19 public health emergency, CMS will permit direct supervision be accomplished using interactive audio/visual real time communications technology through December 31, 2021. The agency will consider whether to extend this permission in the 2022 rulemaking process.

Q. What work must bo performed to bill for CPT 99091?

A. CPT 99091 is a time-based code, meaning 30 minutes of services furnished over a 30-day period must be documented to bill for this service. CMS notes the valuation for CPT 99091 includes 40 minutes of work, including 5 minutes of pre-service work (e.g., chart review) and 5 minutes of post-service work (e.g., chart documentation). Stated another way, the pre- and post-service work cannot be counted toward the 30-minute requirement.

CCM MONTHLY

Code	Note	Medicare Bill Rate est	Co-Pay 20%	Actual Medicare Reimbursement		
99490	First 20 min	$64.02	$12.80	$51.21		
99439	Additional 20 min	$48.45	$9.69	$38.76		
99439	Additional 20 min	$48.45	$9.69	$38.76		

Complex CCM

99487	First 60 min	$135.36	$27.07	$108.29
99489	Additional 30 min	$71.80	$14.36	$57.44

Possible Reimbursable CCM payment per patient monthly = $162*

Before CCM Software and calling/managed services


SICKNESS