Complete Guide to Furnishing Profitable CCM & RPM

INSIDE • CHRONIC CARE MANAGEMENT • REMOTE PATIENT MONITORING • CASE STUDIES • IMPLEMENTATION • WHO CAN BILL • FAQS • EVIDENCE-BASED COORDINATED CARE

USE SMARTPHONE CAMERA TO UNCOVER POTENTIAL REVENUE →

VitalHealthLinks

Introduction

A GUIDE MADE FOR YOU *FROM THE CEO*

We made this guide with the intent of helping you leverage Chronic Care Management (CCM) and Remote Patient Monitoring (RPM) to maximize your ability to improve outcomes for patients, practitioners, and your practice.

At Vital Health Links, our CCM and RPM programs are led by clinicians who understand what it takes to help you increase revenue, provide quality care to more chronic patients, and improve the quality of life for practitioners. We have been combining these outcomes for almost as long as CCM has existed.

Since 2016, healthcare administrators, doctors, and other providers have trusted our team to carry out coordinated, personalized care just as they would for their chronic patients—while providing relief from increasing workloads.

No matter where you are in the process of assessing CCM or RPM, this guide will answer your questions—and if it doesn't, please reach out to me for help.

Until then, take care.

Saurin

HOW TO CONTACT, CONNECT, OR SEE A DEMO

The team at Vital Health Links has been providing reimbursable full-service doctor-led chronic patient care since 2016. Headquartered in Minneapolis, MN, VHL Care Coordinators have manages more than 16,000 patients across 14 U.S. states, from the Rio Grande across the great plains up to the Great Lakes.

DEMOSTRATION OF CCM/RPM PROGRAMS:

Dr. Saurin Patel

Contact 888-515-8450

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GENERAL QUESTIONS/ CLIENT SERVICES

Derek Thomas

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CEO Saurin Patel, MD, MBA

"(Vital Health Links) emphasizes improving patient care outcomes, providers' health, and practice sustainability."

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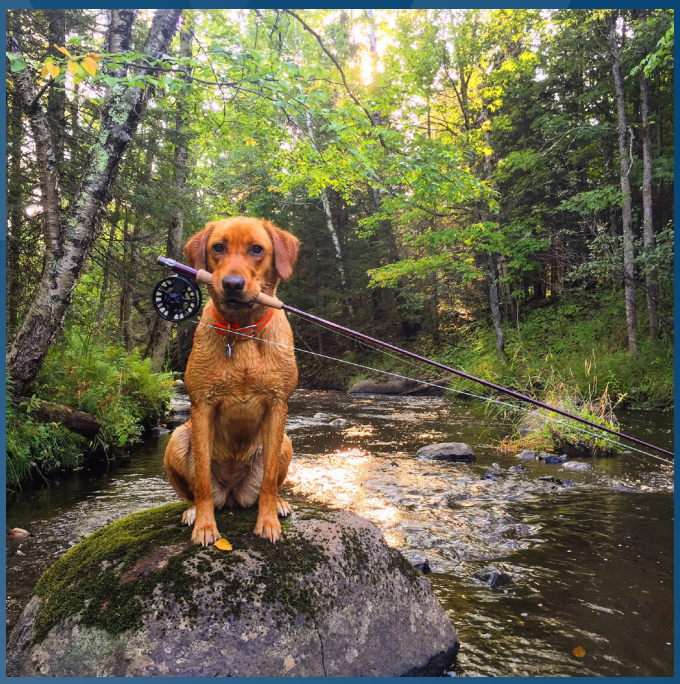


(City) Minneapolis/St. Paul, MN; (Dog) Minnesotan “Buddy”; (Woman) Multiple chronic Illness patient feeds a pony at the state fair.

Perspective

DATA ON CCM & RPM OUTCOMES

Hospitalizations

↓ 25%

Source: Health Quality Partners

ER Visits

↓ 26%

Source: Health Quality Partners

Readmissions

↓ 36%

Source: University of Pennsylvania

Skilled Nursing Facility Days

↓ 26%

Source: Johns Hopkins University

Home Health Episodes

↓ 29%

Source: Johns Hopkins University

Walking in Your Shoes

Hi, I am Derek Thomas, client services manager for Vital Health Links.

Since Chronic Care Management began, VHL doctors have led a team that has proven what chronic patient care can achieve more:

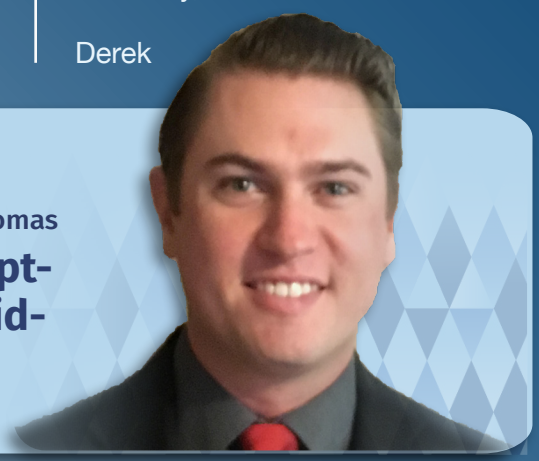
- It can be turn-key and feel personalized;
- Both patient- and practitioner-centered;
- And provide the financial benefits of a 3rd party solution while being driven by your doctors' directives.

We have outlasted other CCM early adopters and outperformed upstart RPM providers with the most robust program in the market.

But I think our doctors' priorities set VHL apart. Their experience walking in your shoes has led to thoughtfully constructed CCM & RPM programs. They are economically and operationally sound, but driven to help clinicians improve healthcare outcomes.

Sincerely,

Derek



Client Services Mgr. Derek Thomas

"We have outlasted other CCM early adopters and outperformed upstart RPM providers."

Contact 888-515-8450 | derekthomas@vitalhealthlinks.com

CCM CPT Codes 2022

Reimbursement Values & Requirements

With the right partner, The Center for Medicare and Medicaid Services' CCM and Remote Patient Monitoring programs will help practices achieve their missions while creating bottom-line growth. These programs also enhance practitioners' ability to impact and empower patient success.

CPT Code	Chronic Care Management	Requirements	2022 Reimbursement
99490	Initial chronic care management services, directed by a physician or other qualified healthcare professional	• 20 minutes or more time in calendar month, multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; • Chronic conditions place the patient at significant	$63.47
99439	Subsequent 20 mins. by clinical staff	• Each additional 20 mins of clinical staff time spent providing non-complex CCM directed by a physician or other qualified healthcare professional. Billed in conjunction with CPT code 99490.	$49.36
G0511	General Chronic Care Management for useby Rural Health Clinics and Federally Qualified Health Centers (RHC & FQHC)	20 mins or more clinical staff time for CCM services (RHC & FQHC)	$84.29

Calculate Your Expanded Revenue Potential

Medicare CMS's reimbursements for CCM and RPM provide even more support for practices to expand care for chronic illness patient populations in 2022.

SCAN HERE

Vital Health Links

The Secret to Outcomes

Better Connections, Better Compliance

It takes more than disease management to affect patient participation in clinical outcomes: meaningful patient engagement is required. VHL's clinical care management feels personalized to your patients. Coordinators are dedicated to your panels, adding consistency and familiarity—which leads to detection of and addressing social determinants, participation in education, and help with quality metrics.

- Meaningful CCM starts with workflows customized to the practitioners' directives and patient needs.
- Quality patient care continues between clinic visits with personalized attention on your behalf.
- Patient EHR records are current with timely, relevant updates for practitioners.
- Continuous preventative and responsive care through planned intervention & symptom management based on your pathways and evidence-based methodology.
- Identifying and addressing social determinants like access to trasportation, medication, food and other factors.
- Available monitoring of physiological data for elevated care-plan engagement.
- Scheduling with regular or intervening clinic visits make for fewer trips to the emergency room.

Medical Director Nilay S. Patel, M.D.

"It takes more than disease management to affect patient participation in clinical outcomes."

Furnishing Profitable CCM

Everything You Want to Know

The Centers for Medicare and Medicaid Services (CMS) emphasizes that chronic patients' healthcare outcomes improve when care is virtually continuous—rather than mostly treated at the point of care, making Chronic Care Management (CCM) that takes place beyond the clinic's walls necessary and complementary.

Medicare PFS Lookup Tool

Find payment information for *your* specific geographic location by code.

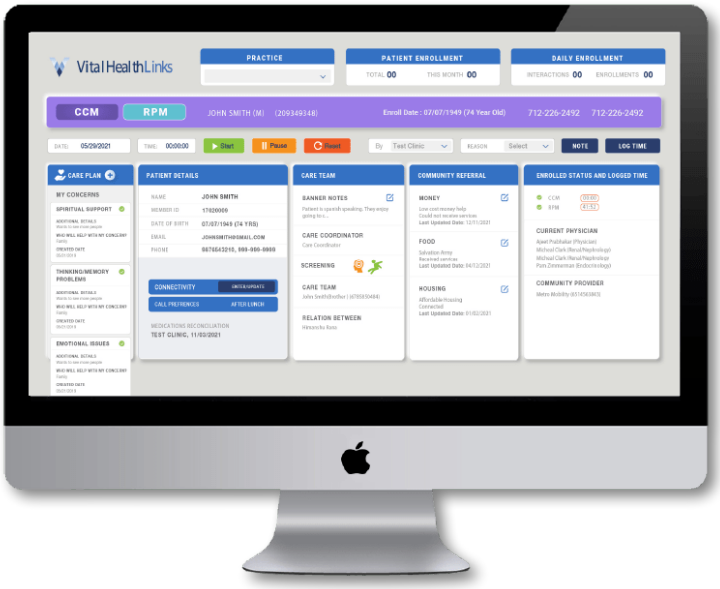
SCAN HERE

What is required for enrollment?

CMS requires the billing practitioner to furnish an annual wellness visit (AWV), initial preventative physical examination (IPPE), or comprehensive evaluation and management visit to the patient before billing the CCM service and to initiate the CCM service as part of this exam/visit. CCM can be billed for this first month if the consent form is signed and the required elements are performed.

Who Can Bill for CCM Services?

CCM services are directed by a physician or other qualified healthcare professional. Physicians and some non-physician practitioners: certified nurse-midwives; clinical nurse specialists, nurse practitioners; and physician assistants may bill for CCM services. Specialty practitioners may provide and bill for CCM. *(text continued on page 19)*



Medicare: The Defining Characteristics of CCM

The Centers for Medicare and Medicaid Services (CMS) recognizes the importance of more continuous care for patients, preventatively and beyond the point of care. Therefore, CCM services tend to complement face-to-face patient visits, focusing these characteristics of advanced

- **A continuous relationship with a designated care coordinator**
- **Extended patient access to care and health information**
- **Preventive care**
- **Patient support to achieve health goals**
- **Patient, caregiver engagement**
- **Timely sharing and use of health information**

Vital Health Links' Clinically-trained care coordinators conduct non-facility CCM services to increase chronic illness patient compliance, billing, and reimbursements. According to the directives of the overseeing doctors and standardized methodology recommended by the American Medical Association and American Heart Association, patients, providers, and practices each benefit from end-

Consent Requirements

Communication/Documentation

The Centers for Medicare and Medicaid Services (CMS) emphasizes that chronic patients' healthcare outcomes improve when care is virtually continuous—rather than mostly treated at the point of care, making Chronic Care Management (CCM) that takes place beyond the clinic's walls necessary and complementary. Practitioners are required to inform patients of the following (and document):

- The availability of CCM services (Description of program and how services will be provided)
- Only one practitioner can furnish and be paid for CCM services during a calendar month
- Applicable cost-sharing involved (copays or deductibles apply)
- The patient has the right to stop the CCM services at any time

Consent Requirements

How is CCM Initiated?

CCM initiation must happen during a face-to-face visit with the billing practitioner, such as an Annual Wellness Visit or Initial Preventive Physical Exam for new patients or patients who had not been seen within a year of beginning CCM services. In other cases, enrollment of eligible beneficiaries may take place by phone.

Vital Health Links partners benefit from a dedicated enrollment specialist to optimize enrollment without exhausting a practice's

Structuring Patient Health Information

Structured recording of a patient's demographics, problems, medications, and medication allergies are necessary using certified Electronic Health Record (EHR) technology. A version of certified EHR is acceptable under the EHR Incentive Programs as of December 31 of the calendar year preceding each Medicare PFS payment year. A complete list of problems, medications, and medication allergies in the EHR must inform the care plan, coordination, and ongoing clinical care. Vital Health Links CCM keeps practitioners in complete and timely compliance with CMS regulations.

The Dedicated Effect

Patients crave consistency and familiarity, making live, dedicated coordinated care a vital tool to engage chronic patients between clinic visits.

See how VHL's personalized care leads to better patient compliance and enrollment in Meaningful CCM.

CCM For FQHCs & RHCs

Satisfying Needs of Community Providers

In 2016 Federally Qualified Health Centers and Rural Health Clinics could finally participate in CCM, however non-face-to-face care coordination services had to be furnished by clinical staff under direct supervision. The three changes CMS made benefitting practitioners and patients in our community centers.

FQHCs & RHCs

By 2016, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) could participate in CCM. However, non-face-to-face care coordination services had to be furnished by clinical staff under direct supervision—they had to provide these services while present in the same office as the supervising practitioner, who had to be immediately available to assist.

For most RHCs and FQHCs, this presented considerable challenges:

- The clinical staff was overwhelmed by trying to make time for CCM during regular office hours.
- Practitioners were burdened with providing direct supervision after-hours
- CCM requirements felt to be unrealistic given their practice's budget, human resources, and time constraints.

CMS made changes to CCM requirements recognizing the need to remove obstacles to widespread implementation of CCM. They also wanted to ensure requirements were not more burdensome than requirements under PFS. *(text continued on page 19)*

FQHCs and RHCs now recieve $101,148/100 chronic patients

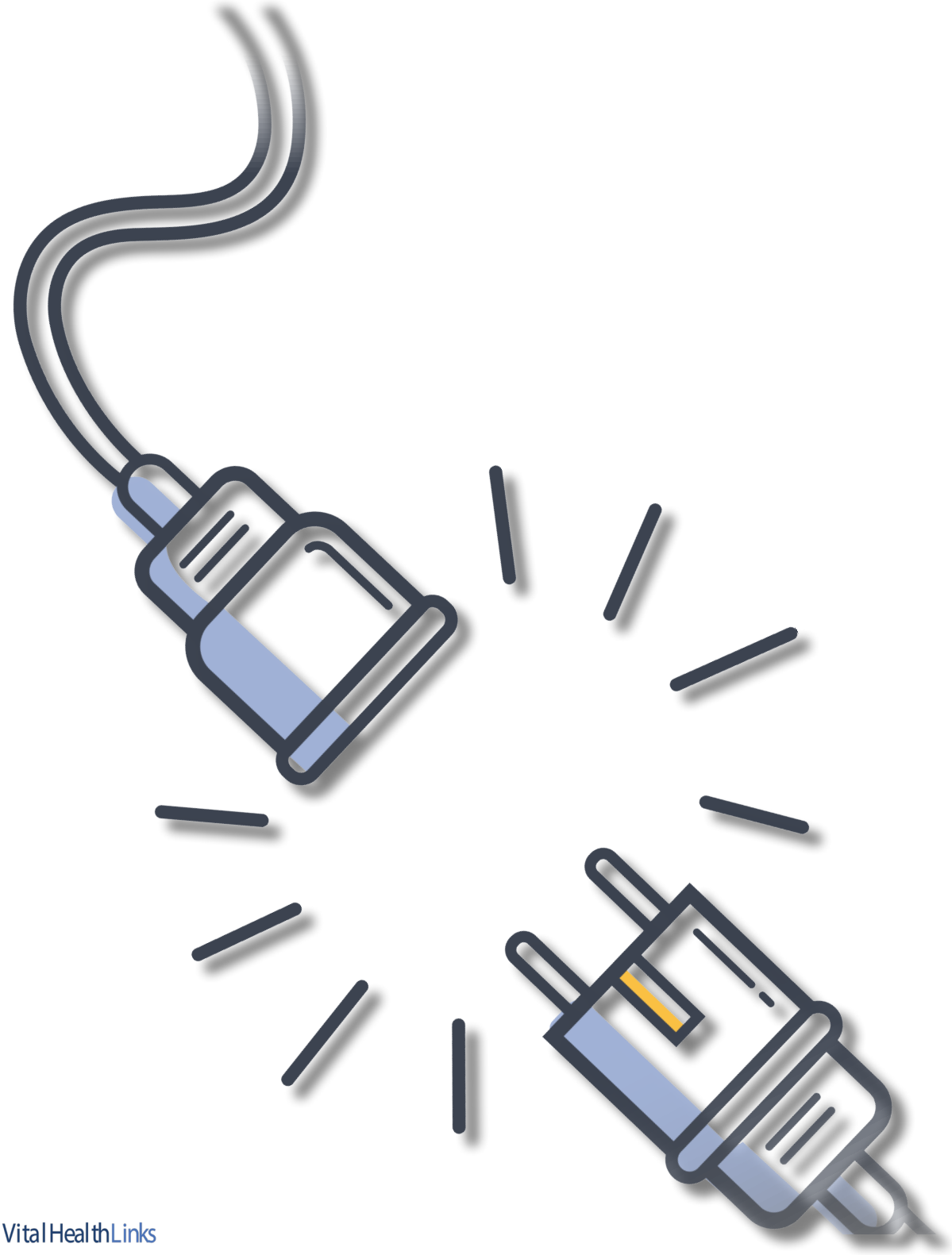
Optimization vs. Automation

Vital Health Links' Coordinators manage all aspects of CCM as each practitioner would—applying the practitioner's directives and evidence-based care throughout patient management. CCM automation (call-center or Automated Intelligence) is detrimental to patient compliance and enrollment.

CCM Case Study

Practice Has Better Compliance, Workflows

After an independent practice's in-house CCM program drained too many resources, they turned to Vital Health Links' physician-led program for integrated, personalized care management their patients need.



Vital Health Links

CCM Case Study

The senior Medicare patients of an Iowa family practice had been very responsive to the extra attention received since enrolling in the clinic Chronic Care Management program. But the clinic's ability to make the program productive was problematic. Despite the patient benefits, the internally run program bogged down their workflows, making it untenable.

That is when Clinic Director Erin F. engaged Vital Health Links, a doctor founded and led CCM provider. She and the board of directors felt assured by VHL's use of quality measures for coordinated care guidelines after unfortunate experiences with 3rd party vendors.

"After using our own, internal CCM program, we found that using VHL was a better fit for our productivity and workflows. VHL handles these services well. Patients like to talk regularly. Having VHL allows us to reach out to patients more. And they're excellent at listening and documenting. Patients also have someone to call if they cannot get through to us."

Vital Health Links dedicated care management helps the clinic's practitioners with continuous, meaningful connections with acute patients without burdening workloads or care quality.

The family practice and Vital Health Links have continued to have a successful CCM partnership, achieving more income delivering added value to over 1100 patients, without any additional burden. They have also launched a Remote Patient Monitoring program, affording more care to their acute chronic illness patients population.

> "Patients really like to talk on a regular basis. Having VHL allows us to reach out to patients more."

CCM: They Adapted, Others Closed

Clinics Sustained Revenue Amid COVID-19

Vital Health Links' CCM has helped clinicians continuously engage with more chronic patients through clinically coordinated care that does not impair their workloads. It has also helped COOs with sustainable revenue that helps address factors that lead to employee burnout, layoffs, or clinic closure.

“If it wasn’t for (VHL) Chronic Care Management, we might not have been able to survive. It bridged the gap for us—that’s a bridge to revenue, as well as patient communication that really helped us.”

Among healthcare providers today, there are two kinds of COOs: those looking for sustainable answers for revenue, high-quality care, and staffing; and those who already have them. Due to his clinic’s partnership with VHL, Mark’s team cut no jobs while COVID-19 ravaged many providers’ abilities to reach their patients and earn revenue.

As COO of a private practice that values its independence, Mark believes that the lessons from COVID-19 prove the value of CCM and hybrid patient care. *(text continued on page 20)*

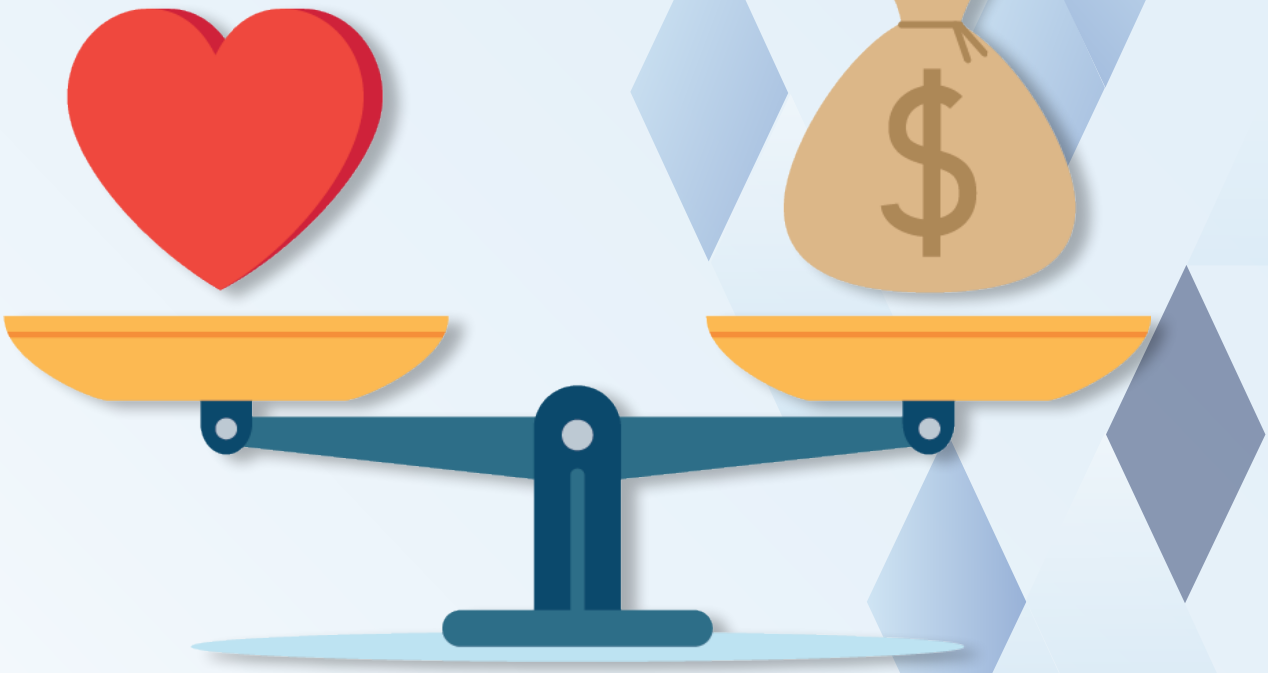
Connie, Clinician

“Their Care Coordinators have gone above-and-beyond to assist our patients in maintaining their highest quality of life at home.”

MIPS & MACRA Today

Improving Patient Compliance & Outcomes

The Medicare Access and CHIP Reauthorization Act, (MACRA) and Medicare Merit-based Incentive Payment System (MIPS) help improve patient care and outcomes while managing the costs of services patients receive from clinicians. **(Text continued on p.**



RPM CPT Codes 2022

Final Ruling Remote Patient Monitoring

With the right partner, The Center for Medicare and Medicaid Services' CCM and Remote Patient Monitoring programs will help practices achieve their missions while creating bottom-line growth. These programs also enhance practitioners' ability to impact and empower patient success.

CPT Code	RPM: Description	Requirements	2022 Reimbursement
99453	Initial setup: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respira - tory flow rate)	Patient education on use of equipment.	$22.16 *One-time reimbursement
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/ regulation (when applicable)	Required minimum of 30 minutes of time, each 30 days	$55
99454	Remote monitoring of physiologic parame- ter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission	Reqired minimum of 16 days of data transmission per 30 days	$49.36
99457	Remote physiologic monitoring treatment management services by a clinical staff/physician/other qualified health care professional.	Initial 20 minutes interactive communication with the patient/caregiver during the month;	$51.71
99458	Remote physiologic monitoring treatment management services by a clinical staff/physician/other qualified health care professional.	Additional 20 minutes interactive communication with the patient/caregiver during the month;	$40

Calculate Your Expanded Revenue Potential

Medicare CMS's reimbursements for CCM and RPM provide even more support for practices to expand care for chronic illness patient populations in 2022.

SCAN HERE

Your Practice, Without Boundaries

RPM in 5-Steps

Activation & Implementation to Reimbursement

Your research is complete—you are ready to initiate the only Remote Patient Monitoring program backed by full service, turn-key coordinated care program led by doctors and directed by your pathways. Initiation is simple and cost-free: call 1-888-515-8415 or click here to schedule activation

01

00

Remote Patient Monitoring

Patients get more dedicated attention preventatively and when they need it most, following the directives of practitioners and clinical methodology standards recommended by the American Medical Association and American Heart Associations.

RPM in 5 Steps

02

Enrollment & Setup

No more doctor-time needed: dedicated VHL enrollment specialists identify and enroll patients.

03

Personalized Support from the Start

Care Coordinators facilitate personalized onboarding and support for patients and your practice, making startup comfortable and seamless.

04

Data, Management & Ongoing Engagement

Care Coordinators facilitate data collection, analysis, personal care-plan compliance and intervention.

05

Billing & Reimbursement

FURNISHING CCM

About Patient Co-Payment

A regular co-pay does apply, making it about eight dollars per month for the patient. For many, supplemental insurance will cover this co-pay. Additionally, we are waiting on the final ruling from CMS, but legislatures in Washington are working to eliminate co-payment requirements.

Who is Eligibility to Administer CCM?

CCM services are directed by a physician or other qualified healthcare professional.

Physicians and some non-physician practitioners: certified nurse-midwives; clinical nurse specialists, nurse practitioners; and physician assistants may bill for CCM services.

Specialty practitioners may also provide and bill for CCM.

How is VHL Coordinated Care Different?

Clinically-trained care coordinators facilitate CCM and RPM services in a personalized manner to increase chronic illness patient compliance, billing, and reimbursements between clinic appointments. VHL's proven care methodology is actively guided by our physicians and based on your directives and evidence-based care standards recommended by the American Medical Association and American Heart Association.

About Payment

CMS pays for CCM services separately under the Medicare PFS. Access the Medicare PFS Look-Up Tool to find payment information for a specific geographic location by code. Additional payers in include payers for dual-eligible Medicare/Medicaid beneficiaries, Medicaid and Medicare Advantage Plans.

MIPS & MACRA

The 2015 Medicare Access and CHIP Reauthorization Act, known as MACRA, ended the Sustainable Growth Rate (SGR) formula for providers—the SGR would have resulted in a significant cut to payment rates for clinicians participating in Medicare.

In response, the Centers for Medicare & Medicaid Services (CMS) created a federally mandated Medicare program, the Quality Payment Program (QPP), seeking to improve patient care and outcomes while managing the costs of services patients receive from clinicians. Under QPP, clinicians providing high value/high-quality patient care are rewarded payment increases through MACRA or the Medicare Merit-based Incentive Payment System (MIPS). While clinicians not meeting performance standards have a reduction in Medicare payments.

MACRA and CCM are closely linked as practitioners can more easily demonstrate and benefit from the quality and performance-based measures.

FQHCS AND RHCS

The first change gave RHCs and FQHCs the ability to supervise clinical staff, which allowed them to contract with third parties to deliver effective CCM programs and services on their behalf under HCPCS code G0511.

The second change extended 24/7 access to auxiliary personnel who have the means to contact practitioners, as opposed to requiring 24/7 access to RHC/FQHC practitioners.

The third change combined all care management services, including Transitional Care Management, Chronic Care Management, and Behavioral Health Integration, into one HCPCS code G0511, billed once per month. With these changes in place, RHCs and FQHCs are now much better positioned to improve the overall health of their patients and generate new revenue.

LESSONS FROM COVID-19

About CCM and Net Revenue

"We get a list of our charges for $65 and we have 1400 of them—if it weren't for CCM we wouldn't be able to give raises ...Every dollar that comes in is a dollar profit."

About Personalized, Coordinated Patient Care

"Neighbors are talking to each other. (They're saying) 'my care coordinator Shelly is calling me every month'— and since they're getting the same coordinator every month, patients have been more apt to tell them if there's something new in their life."

About Enrollment, Retention

"Our drop rate is under 10% year over year. Patients are finding value."

About VHL Patient Care

"High performance relationship...delivers consistency to patients at a good rate"

RPM Case Study

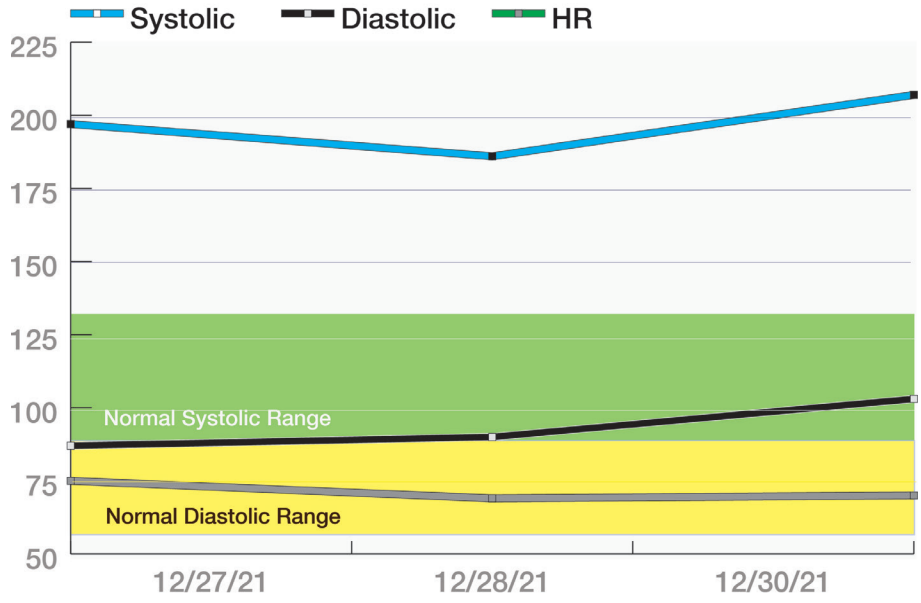
Coordinated RPM Helps Providers Intervene Sooner

Physiological data analysis from Remote Patient Monitoring (RPM) combined with Coordinated Chronic Care Management (CCM) helps providers to address potential hypertensive crisis before symptoms set in and manage patient back into range.

"C.M." is a 71-year-old female patient with obesity, hypertension and out-of-control BP measurements.
She has a history of, CHF, type 2 diabetes, CAD, and low compliance. Anti-hypertensive medications: lisinopril, metoprolol, and amlodipine.

—Fig 1.0—

Early intervention: patient's high blood pressure detected by RPM before symptoms



> “In real-time, the Coordinated RPM showed that the medication was not working.”

Providers Use RPM to Adjust in Real-Time

Provider prescribes 50mg metoprolol BID.

12/27/21

Provider increases metoprolol to 100mg BID.

12/30/21

Provider adds lisinopril 40 mg, one tab daily 12/28, increased metoprolol dosage from 100 mg to 150 mg 12/30.

01/05/22

Amlodipine 5 mg started once daily. Furosemide 20 mg, one tablet daily started (CHF).

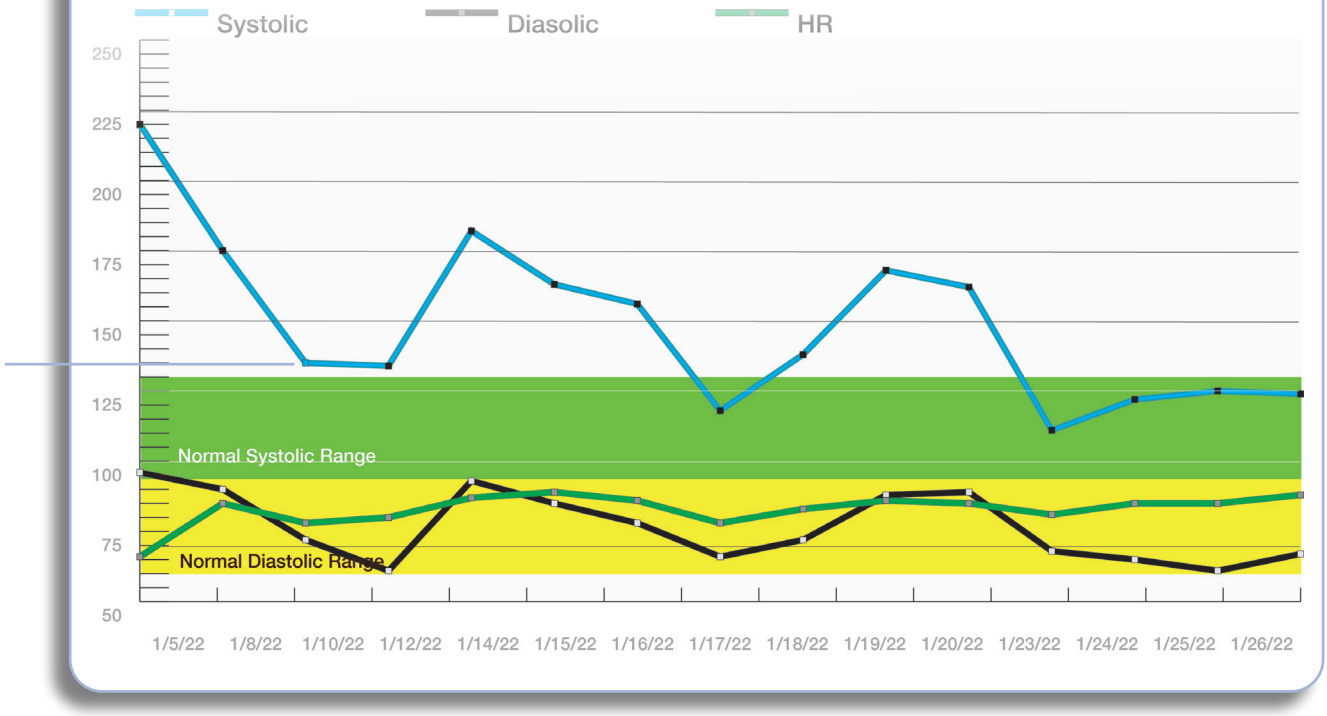
01/14/22

Per cardiology recommendation: d/c metoprolol 100 mg/ begin carvedilol 6.25 mg 1 tablet BID. (twice daily)

(CONT’D ON NEXT PAGE)

—Fig 2.0 —

1/14/22: Provider discontinues metoprolol/ begins carvedilol 6.25 mg 1 tablet BID (twice daily).



In real-time, the Coordinated RPM showed that the medication was not working. As a result, providers could change course and accelerate the interventions.

01/26/22

BP is managed with correct medication combination & medication adherence.

> “...Coordinator collaborated with the insurer to facilitate medications being mailed directly to “C.M.” on a schedule.

MORE THAN DATA ANALYSIS

CARE COORDINATION ASSISTS PROVIDERS IN BRIDGING BARRIERS TO ADHERENCE

02/21/22

Message sent to staff regarding RPM alert from 2/20 and 2/21. Amlodipine increased from 5 mg to 10 mg.

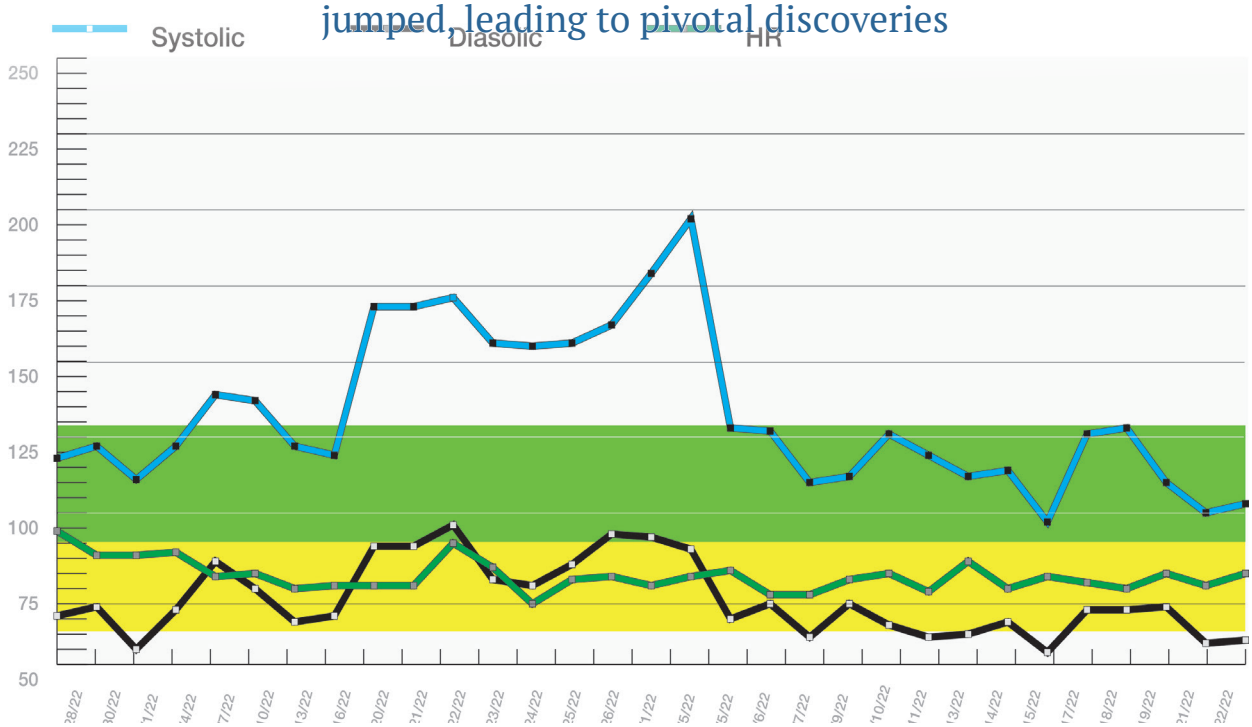
03/15/22

Message sent to staff advising of low BP - provider decreased amlodipine from 10 mg to 5 mg.

All BP meds have been filled and the patient is taking them as prescribed, resulting in BP being under control.

—Fig 3.0 —

Before symptoms would, RPM data showed that systolic measurements jumped, leading to pivotal discoveries



Following the providers' direction, "C.M.'s" care coordinator alerted them of high systolic measurements on consecutive days *(Fig. 3.0: 2/20/22, 2/21/22)*.

The RPM coordinator again alerted the provider that systolic measurements were very high on 3/5/22.

Her Care Coordinator was then able to leverage their consistent relationship to identify and advise providers that the patient had run out of carvedilol days earlier, on 3/1.

The Coordinator got into action, calling the pharmacy to have "C.M.'s" prescription refilled.

Additionally, after identifying barriers to the patient retrieving and differentiating between her medications, the Coordinator collaborated with the insurer to facilitate medications being mailed directly to "C.M." on a schedule.

Cost-Free Devices Backed by Docs

Vital Health Links offers practices the only cost-free Remote Patient Monitoring (RPM) devices backed by doctor-led, personalized care. Dedicated turn-key enrollment is just one of the benefits....

$745.92	$1,212.84	$1,011.48
ANNUALLY/PER PATIENT	ANNUALLY/PER PATIENT	ANNUALLY/PER PATIENT
CPT CODE 99490 MONTHLY CCM SERVICES	CPT CODE 99454 & 99457 MONTHLY RPM SERVICES	CPT CODE G0511 MONTHLY CCM FOR FQHCS/RHCS

REDUCED COST

Turn-key program that relieves you from infrastrucure, technology development, and even enrollment and implementation expenses.

FREE DEVICES

Because clinical decisions—not devices—change health outcomes.

IMPROVED COVERAGE

Devices are cellularly based; no wi-fi required.

PERSONALIZED PATIENT ENGAGEMENT

Your patients get consistent, personalized care from dedicated RPM Coordinators.

GUIDELINES-BASED

Care Coordinators care use provider and evidence-based guidelines at each patient touchpoint.

"BECAUSE CLINICAL DECISIONS *NOT DEVICES* CHANGE HEALTH OUTCOMES."

SCAN ME FOR DETAILS!