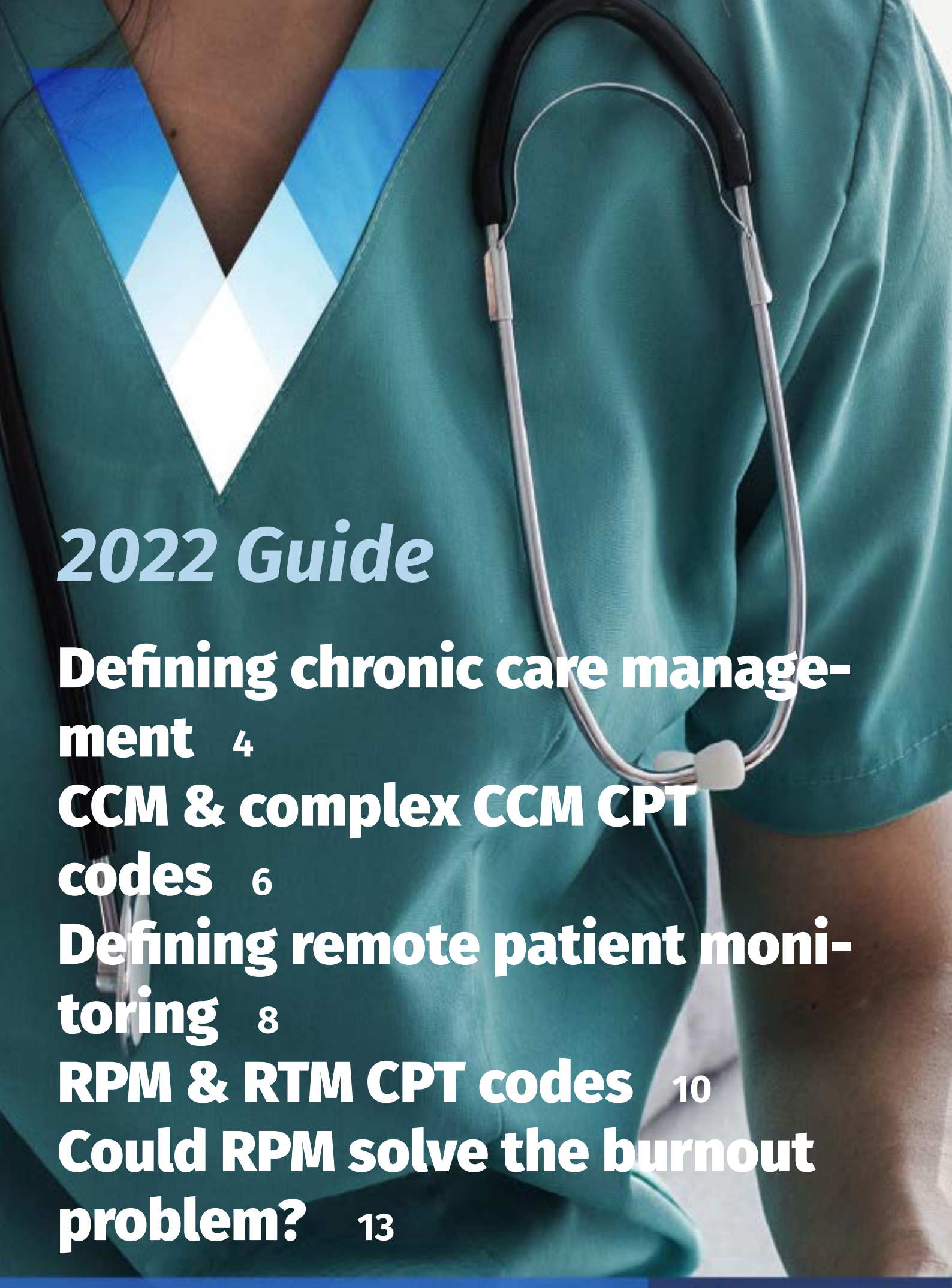


2022 Guide

Defining chronic care management in 2022

Vital Health Links CCM (chronic care management) and RPM (remote patient/physiological monitoring) programs maximize revenue growth while optimizing your patient care. Vital Health Links care coordination value only begins with new CCM and RPM Medicare reimbursements.

Our CCM and RPM services are turn-key to relieve you of up-front costs from personnel, infrastructure, or technology research and development. In addition, our systems adapt to your processes—from software to standards of care.

More on Chronic Care Management

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-to-end care.

Visualize End-to-End CCM & RPM

End-to-end care starts with workflows customized to the provider physician's directives and patient panels.

Qualified patients are identified and enrolled if they would benefit from regular, proactive care.

Care coordinators keep patient documents current, provide notes for doctors, and extend quality care to the patients between visits.

Dedicated care coordinators engage patients in regular, planned intervention & symptom management based on the doctor's directives. The continuous extension of care on your behalf is crucial to the success of the program.

Care coordinators remove barriers to maintaining health by addressing social determinants, adding a critical layer to end-to-end care.

Dedicated care coordinators monitor and elevate physiological data for smart care-plan engagement.

Continuous, coordinated care means more patients making regular returns to your waiting room and fewer trips to the emergency room.

2022 CCM & complex CCM CPT codes

Chronic Care Management

Summary

There are notable increases in Medicare reimbursement for CCM and Complex CCM services in 2022

CPT Code	Description	2021 Payment	2022 Payment
99490	Initial 20 mins: Chronic Care Management, clinical staff	$41.17	$62.16 (+$20.89)
99439	Subsequent 20 mins: CCM, clinical staff	$37.69	$47.04 (+$9.35)
99491	30 mins: CCM, physician/NPP	$82.53	$82.66 (+$1.13)
99437	*Subsequent 30 mins: physician/ NPP*	*New*	*$59.47*

Complex CCM & Primary Care Management

Summary

Finalized increases in Medicare reimbursement for Complex CCM and new PCM (primary care management) services

CPT Code	Description	2021 Payment	2022 Payment
99487	CCCM, clinical staff, 60 min	$91.77	**$130.37** (+$38.60)
99489	CCCM, clinical staff, additional 30 min	$43.97	**$68.51** (+$24.54)
99424	*(Formerly G2064) PCM, physician or NPP, first 30 min.*	*New*	*$80.98*
99425	*PCM, physician or NPP, additional 30 min*	*New*	*$58.46*
99426	PCM, clinical staff, first 30 min.	$38.73	**$61.49** (+22.76)
99427	*PCM, clinical staff, additional 30 min*	*New*	*$47.04*

Defining remote patient monitoring in 2022

In four steps, Vital Health Links responsive RPM (remote patient/physiological monitoring) adds financial, operational, and personal value to data monitoring for doctors, practices, and health systems.

More on Remote Patient Monitoring

Non-facility RPM services include physiological analysis and responsive patient care conducted by dedicated care coordinators, resulting in more attention for chronic illness patients where they need it most, compliance, and provider reimbursements. VHL 's end-to-end remote patient care coordination follows the directives of our partners' physicians and clinical methodology standards recommended by the American Medical Association and American Heart Associations.

01

Consent, Order, Education & Setup

Doctor and chronic illness patients agree to the health benefits of increased connection through RPM.

02

Cellular Transmission, Collection of Physiological Data

Essential patient physiologic data is collected by a remote device and analyzed by care coordinators.

03

Evaluation, Management & Engagement

Vital Health Links RPM care coordinators facilitate personal care-plan engagement and intervention based on physician and national guidelines.

04

Billing & Reimbursement

RPM has proven so beneficial that Medicare programs compensate practices ≈ $138 per qualified chronic illness patient per month to achieve benchmarks.

2022 RPM & RTM CPT codes

RPM is intended to collect data that is physiological from chronic medical conditions. However, RTM deals with non-physiologic patient data, including respiratory system status, musculoskeletal system status, therapy/medication response, therapy/ medication adherence, and pain.

Remote Therapeutic Monitoring

Summary

New RTM services involve self-reported patient non-physiologic data reported to a billing practitioner in a 30-day period, or calendar month.

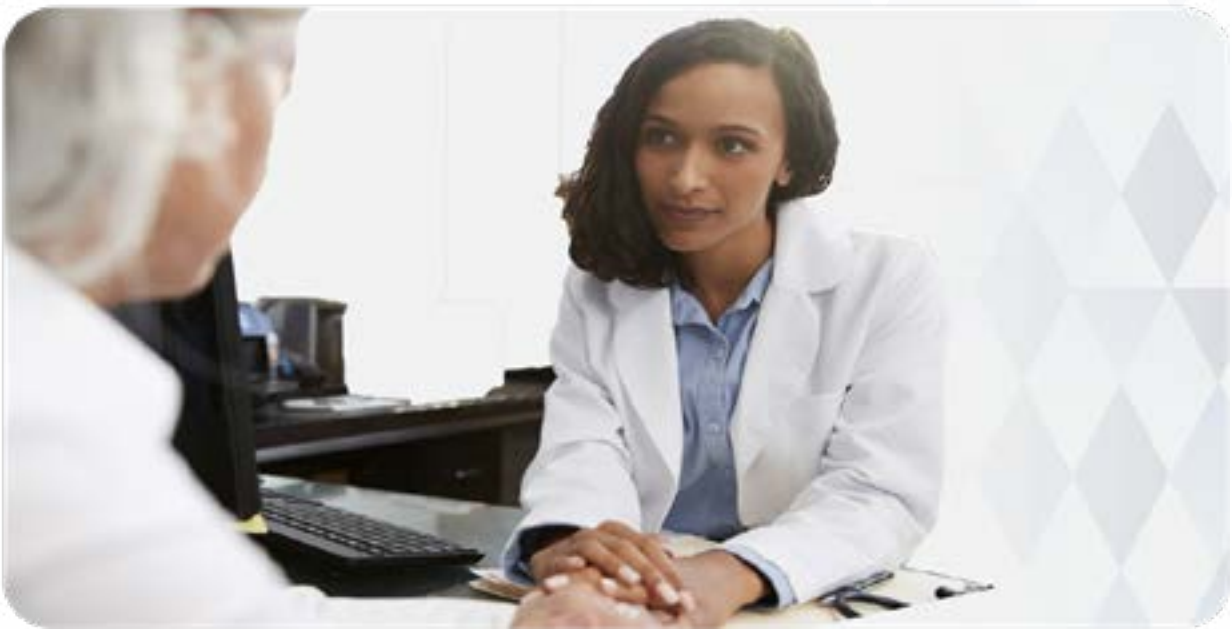
CPT Code	Description	Requirements	2022 Payment
98975	Patient education on use of equipment	Initial setup and education	$18.82
98976	Device(s) supplied daily transmission — monitor respiratory system	Each 30 days	$54.10
98977	Device(s) supplied daily transmission — monitor musculoskeletal system	Each 30 days	$54.10
98980	Subsequent 20 mins treatment management services, clinical staff	Interactive communication; Each calendar month	$48.72
98981	Each subsequent 20 mins treatment management services, clinical staff	Each calendar month	$38.65

Remote Patient/Physiological Monitoring

Summary

RPM services involve physiologic data transmission in a 30-day period, or calendar month

CPT Code	Description	Requirements	Reimbursements
99091	30 mins: interpretation and analysis	Every 30 days (that do not require interactive communication)	$54.77
99453	Monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate	Initial setup	$18.48
99454	Device supplied daily recording(s) or programmed alert(s) transmission	Min. 16 of 30 days	$54.10
99457	20 mins: Treatment and management services, clinical staff	Every 30 days (including interactive communication)	$48.72
99458	Subsequent 20 mins: Treatment and management services, clinical staff	Every 30 days	$39.65



Data: Chronic & Remote Care Change Outcomes

After only one year of chronic care management programs, new data indicated significant returns from preventative programs: improved health outcomes, cost savings, and even examples of CCM helping save lives. This was only the beginning.

↓25%

Hospitalizations

Source: Health Quality Partners

↓26%

ER visits

Source: Health Quality Partners

↓36%

Readmissions

Source: University of Pennsylvania

↓26%

Skilled nursing facility days

Source: Johns Hopkins University

↓29%

Home health episodes

Source: Johns Hopkins University

The Tipping Point: 2020

Telehealth and Remote Patient Care reached a tipping point in 2020, as face-to-face care became more complicated, and data shows no signs of this trend slowing down.

Could RPM solve the burnout problem?

How a smart RPM (remote patient/physiological monitoring) program can indirectly solve workload relief for over-extended physicians and providers, and five more benefits that include patient compliance and healthcare costs.

Pervasive Challenges

81% of physicians feel overextended or at full capacity

People with chronic diseases account for **81%** of hospital admissions

86% of U.S. health-care spending goes to the treatment of chronic diseases

Up to **50%** of patients don't comply to medical treatment

60% of health systems rank improving patient outcomes as a critical priority

Disengaged patients are **3x** more likely not to report medical needs and **2x** more likely to delay medical care

Effective Solutions

RPM provides physicians with cellularly-transmitted, physiological patient data between clinical visits. Combined with coordinated care, RPM adds continuous value to patient care.

Weight Scales

Blood Pressure Cuffs

Pulse Oximeter

Blood Glucose Monitor

Real-time RPM data can enhance patient engagement: 20-mins of care coordinator coaching helps patients track & achieve wellness goals.

Remarkable Financial & Health Results

50% of Americans supplemented care with telehealth visits in 2020*

29% Reduction in heart failure-related hospitalizations (NCBI)**

24% of practices have RPM technology *(American College of Physicians)*

23M Americans used RPM in 2020; up from 7M in 2016*

43% of patients listed "greater convenience" as top benefit (MSI, June '21)

Ask our physicians about clinical, turn-key RPM and its uses.

Sources: *https://www.mobihealthnews.com

**https://pubmed.ncbi.nlm.nih.gov

Answers to FAQs

Some common questions about chronic care management billing and qualifications.

What is required to enroll patients in CCM?

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.

What insurance plans cover CCM?

Currently, traditional Medicare and most Medicare Advantage plans are reimbursed for providing CCM services. We continue to see this expand, and expect commercial payers to follow, as well.

Are there times when I cannot bill for CCM?

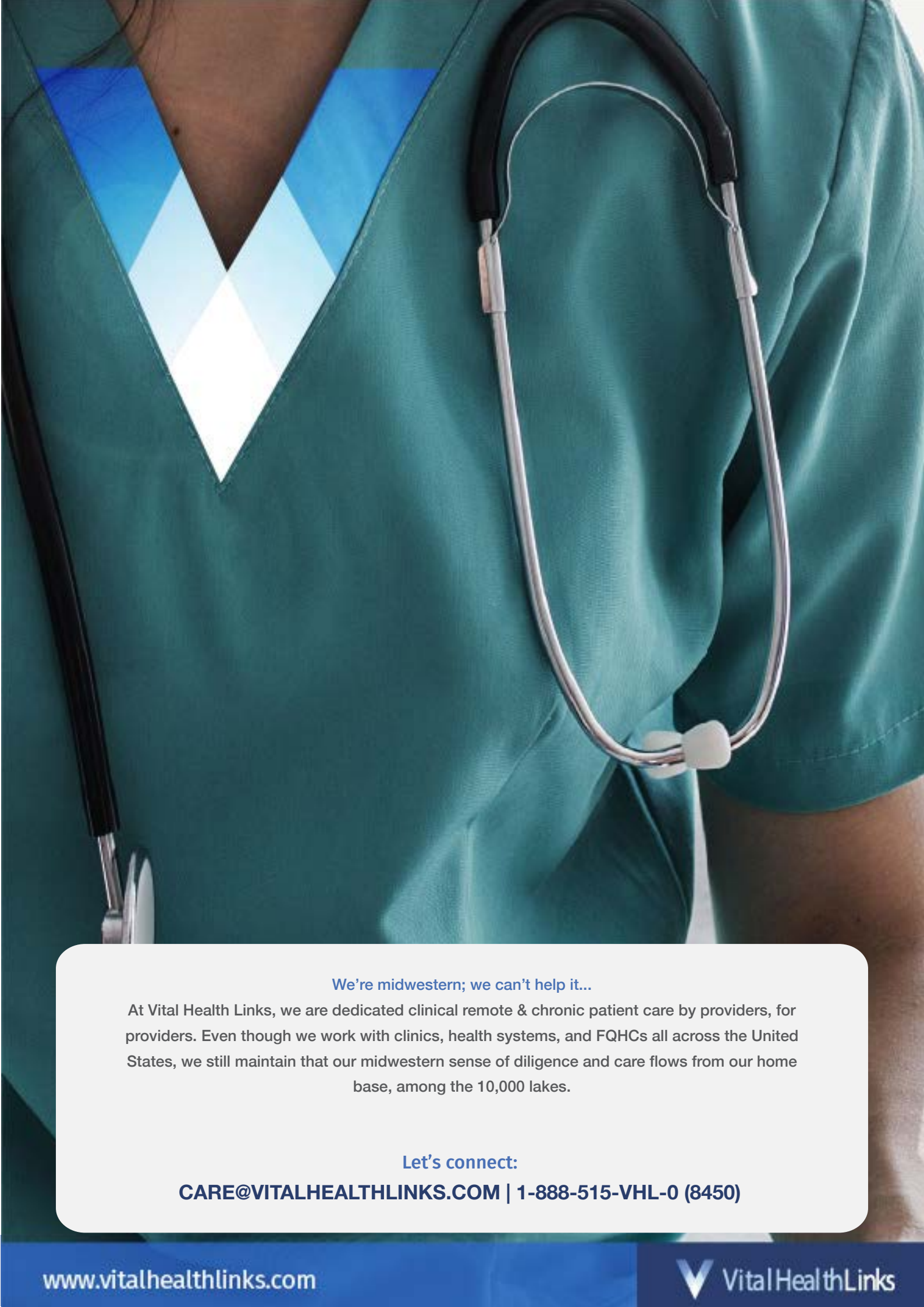
Yes. Specific care settings do not allow CCM billing because the resources required to provide care management services to patients in facility settings significantly overlap with facility staff's care management activities that are included in the associated facility payment. This includes nursing homes and skilled nursing facilities, and when the patient is an inpatient in the hospital. Other restrictions include when the patient is receiving hospice or has end-stage renal disease services. Transitional care management can be billed with 99490, as long as the service date does not overlap.

Is there a patient co-pay involved?

Yes, the 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 there are rumors that the co-pay might not be required soon.

Some vendors told me that sending videos to patients counts toward non-face-to-face time. Is that true?

No. Videos pushed to patients are NOT compliant, and do not count toward the 20+ non-face-to-face meeting minutes. The only time that counts is time spent by clinical staff or the biller.
Per CMS, "CPT 99490 is not counting or paying for time by the patient doing anything; it is only time by clinical staff (or the biller themselves) doing qualifying activities within one of the scope of the service elements."



We're midwestern; we can't help it...

At Vital Health Links, we are dedicated clinical remote & chronic patient care by providers, for providers. Even though we work with clinics, health systems, and FQHCs all across the United States, we still maintain that our midwestern sense of diligence and care flows from our home base, among the 10,000 lakes.

Let's connect:

CARE@VITALHEALTHLINKS.COM | 1-888-515-VHL-0 (8450)