THE LEADER IN REMOTE PATIENT MONITORING (RPM), TELEHEALTH AND VIRTUAL CARE, TRANSFORMING AND ENABLING ACCESS TO CARE

amc health
ADVANCED MONITORED CAREGIVING

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A ROBUST AND FLEXIBLE VIRTUAL CARE AND REMOTE PATIENT MONITORING PLATFORM

AMC Health provides virtual care management and remote patient monitoring (RPM) solutions leveraging an FDA Class II-cleared platform, AI/machine learning and advanced analytics.

AMC Health is device and condition agnostic allowing for tailored solutions to manage co-morbidities and poly-chronic patients.

AMC Health's holistic, whole-person care approach features enhanced care coordination and telecare management solutions (TCM) serving all populations including Medicare, Medicaid, Commercial and Pediatrics.

MYCARE VIRTUAL® APP

- Member/patient-facing application
- Measure and track vitals
- Simple and interactive surveys drive engagement, and adherence and help identify risks and SDoH
- Enable 1:1 communication with clinicans via secure text and video
- Educational content to improve health literacy and promote self-management

CARECONSOLE®

Clinician-facing application designed for clinicians by clinicians, our CareConsole® platform is an FDA Class II Approved Clinical Decision Support (CDS), Software as a Medical Device (SaMD)

245k+
MEMBERS NATIONWIDE

50
PROVIDING CARE IN ALL 50 STATES

20+
TWENTY YEARS OF LEADERSHIP IN RPM AND VIRTUAL CARE

5
PEER-REVIEWED & PUBLISHED STUDIES

200+
BLUETOOTH-ENABLED DEVICES

CONDITIONS MONITORED BY RPM AND TELEHEALTH

CHRONIC CONDITIONS

Heart Failure
Diabetes
- Controlled
- Uncontrolled

Pre-Diabetes
Hypertension
- Controlled
- Uncontrolled

Hypotension
COPD
Asthma
Coronary Artery Disease (CAD)
Chronic Kidney Disease (CKD)
End Stage Renal Disease (ESRD)
Cancer
HIV
Cirrhosis

TRANSITIONAL CONDITIONS

Post-Discharge
Hospital at Home
Care Transitions
ER Episodes
Re-Admission Prevention
Wound Management
COVID-19
- Disease treatment
- Screening/quarantine

Long COVID-19
Infectious Disease
Infectious Illness
Low ADL Monitoring Program
Pain Management
Sleep Apnea

ACUTE/SPECIALTY CONDITIONS

Women's Health/ Maternity
- At-Risk Maternity
- NICU
- Postpartum Wellness

Pediatric
- Asthma
- Child wellness

Mental/Behavioral Health
- Anxiety
- Depression
- Bipolar Disorder
- Dementia
- PTSD
- Substance Abuse Disorder
- Tobacco Cessation

WELLNESS/MAINTENANCE

Wellness
Nutrition/Diet
Weight Management
Medication Adherence
Medication Reconciliation & Optimization
Therapeutic Monitoring
Health Education
Social Determinants of Health (SDOH)
Multiple Sclerosis
PERS

IMPROVE COST AND CLINICAL OUTCOMES, OPTIMIZE MEMBER AND PROVIDER EXPERIENCE

AMC Health's purpose is to strengthen the connection between payers, physicians, patients, and caregivers by expanding care where people live.

Combining our biometric measurements, advanced analytics and predetermined clinical processes, payers have near real-time actionable data to support their members and providers.

A high-powered analytics platform, coupled with clinical processes and in-home monitoring devices produces a longitudinal record of a person's experience.

Payers and providers can leverage this longitudinal view to inform and deploy these enhanced care management tactics that lower the cost of healthcare, reduce unnecessary healthcare encounters, and improve overall outcomes.

AMC Health provides telecare management and full virtual clinical resources certified in all 50 states.

EASE OF USE

For convenience, all AMC Health devices are wireless and easy to use on a daily basis, regardless of patient age and location.

ADVANCED DATA ANALYTICS

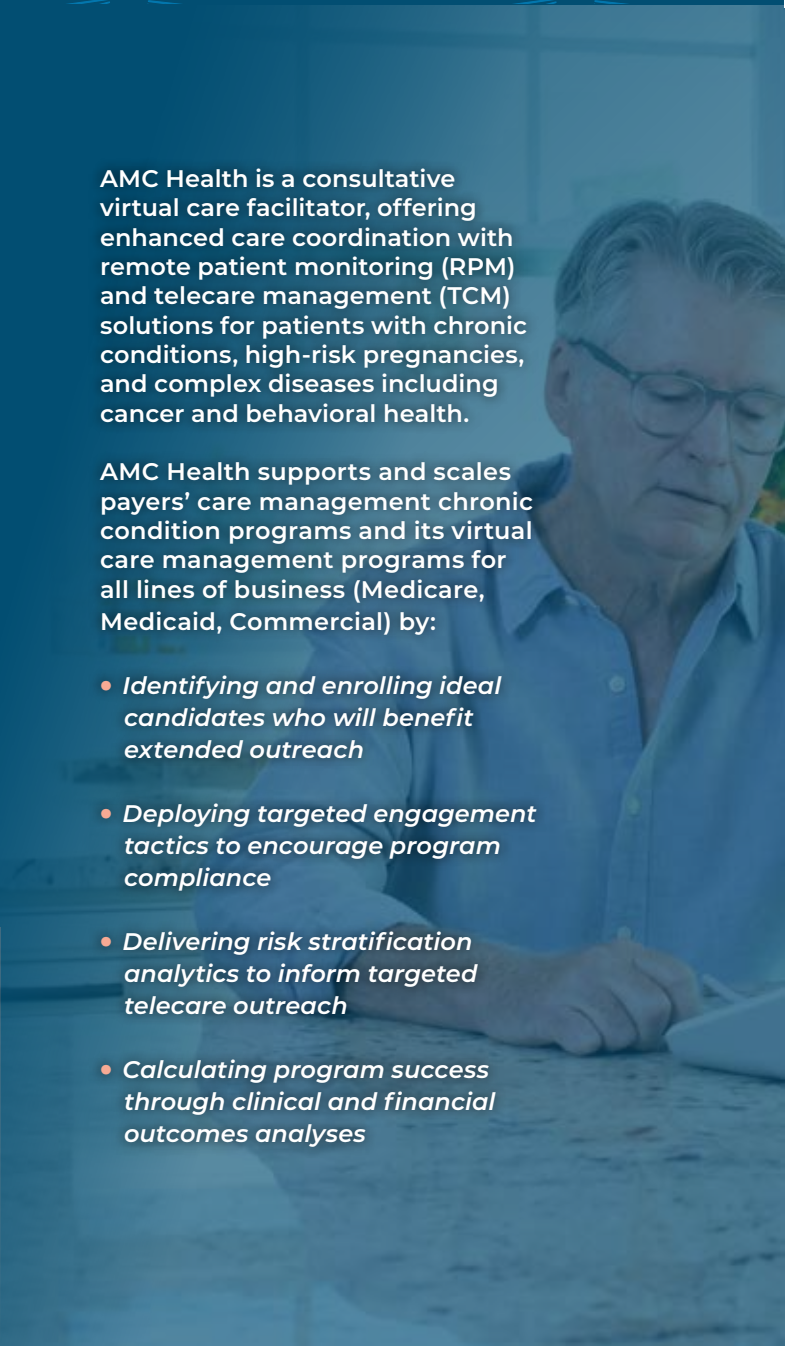
Real-time patient data is easily accessible through our Care Console® platform and our app.

BETTER PATIENT CARE

Deliver better care for your members, while improving their access to care and empowering them to manage their own health.

CLINICAL STAFFING

AMC Health's CareConsole® is configured with alert fatigue in mind, helping your care team to prioritize higher risk members, and action lists efficiently.



AMC Health is a consultative virtual care facilitator, offering enhanced care coordination with remote patient monitoring (RPM) and telecare management (TCM) solutions for patients with chronic conditions, high-risk pregnancies, and complex diseases including cancer and behavioral health.

AMC Health supports and scales payers' care management chronic condition programs and its virtual care management programs for all lines of business (Medicare, Medicaid, Commercial) by:

- *Identifying and enrolling ideal candidates who will benefit extended outreach*
- *Deploying targeted engagement tactics to encourage program compliance*
- *Delivering risk stratification analytics to inform targeted telecare outreach*
- *Calculating program success through clinical and financial outcomes analyses*

8 KEY ADVANTAGES OF REMOTE PATIENT MONITORING (RPM) AND TELEHEALTH

1 Improve Quality Outcomes: HEDIS, Medicare STARS, CAHPS	**2** Lower Readmissions / Avoidable Hospitalizations / ED
3 Promote Member Education and Med Adherence	**4** Identify Social Determinants of Health (SDoH)
5 Enhance Care Management	**6** Increase Access to Care
7 Improve Member and Provider Satisfaction	**8** Engage Members in Self-Care

PROVIDERS

AMC Health's Virtual Care, Telehealth and Remote Patient Monitoring (RPM) Solutions are designed to engage your patients, deliver the best care, increase revenue, identify gaps in Social Determinants of Health and improve access to care.

Ninety percent of the nation's $3.3 trillion in annual health care costs are from people with chronic and multiple chronic health conditions.

AMC Health's services enhance your clinical workflows, and optimizes your revenue through the use of the new CPT codes.

These CPT codes can be found in the back of this booklet.

EASE OF USE

For convenience, all AMC Health devices are wireless and easy to use on a daily basis, regardless of patient age and location.

ADVANCED DATA ANALYTICS

Real-time patient data is easily accessible through our Care Console platform and our app.

BETTER PATIENT CARE

Deliver better care for your members, while improving their access to care and empowering them to manage their own health.

INCREASED REVENUE

Take advantage of the new Medicare CPT codes designed for telehealth and RPM and also achieve shared savings targets.

8 KEY ADVANTAGES OF REMOTE PATIENT MONITORING (RPM) AND TELEHEALTH

1. Increased Health and Safety of Patients/Members
2. Identification of Gaps in Social Determinants of Health
3. Data to Identify Risk Factors (Clinical and Non-Clinical)
4. Reduce Readmissions
5. Improve Outcomes
6. Control Costs
7. Increase Patient/Member Satisfaction
8. Enhance Coordinated Care

EMPLOYERS

AMC Health's Employer market improves the health and wellness of employees. AMC Health measures the success of your health and wellness programs to improve employee health and ensure they are receiving optimal care in the appropriate setting.

AMC Health was founded to strengthen the connection between physicians, patients and caregivers, and expand care delivery beyond the walls of hospitals and clinics.

AMC Health's comprehensive virtual care services deliver an analytics platform, clinical oversight, patient-generated metrics, and produces actionable analytics to help treat patients efficiently and effectively with in-home monitoring devices.

EASE OF USE

For convenience, all AMC Health devices are wireless and easy to use on a daily basis, regardless of patient age and location.

ADVANCED DATA ANALYTICS

Real-time patient data is easily accessible through our Care Console® platform and our app.

BETTER PATIENT CARE

Deliver better care for your members, while improving their access to care and empowering them to manage their own health.

INCREASED PRODUCTIVITY

Reduce employee leave time due to illness and hospitalization.

AMC HEALTH'S PROGRAM GOALS INCLUDE:

- Reduce costly and potentially unnecessary inpatient encounters, complications, emergency department visits, readmissions and improve medication adherence.
- Improve patient/member safety, clinical outcomes, treatment plans.
- Provide relevant educational content on program conditions and promote healthy lifestyle choices.

AMC HEALTH'S DIFFERENTIATORS

We bring health information together from diverse data sources, FDA-approved equipment, and technology, recommending the optimal combination of technologies and devices to achieve program objectives.

– Our analytics platform is one of the few in the industry recognized for having the FDA class-II approval (Software as a Medical Device).

– AMC Health leads the industry with over 20 years of RPM and virtual care program and clinical insights, based on our extensive predictive analytics, based on tens of millions of data points collected over time.

– The result is our platform that identifies at-risk patients in near real time

– Using multiple years of claims data, we analyze populations to identify optimal candidates that will benefit from program participation.

– AMC Health analyzes the performance of program participants in real-time, and offers clinical and program recommendations to maximize program effectiveness and ROI.

– Bi-directional integration with client EHR and claims platforms

GOVERNMENT

AMC Health proudly serves the Veterans Administration's (VA) National Remote Patient Monitoring (RPM) program, the largest RPM program in the world.

AMC Health's Virtual Care, Telehealth, and RPM solutions are designed to engage our Veterans, deliver the best patient care, and provide better access to care.

Since 2020, AMC Health has partnered with health technology innovators Cognosante to deliver the best in Telehealth solutions for those who have served.

This RPM program and AMC Health's comprehensive virtual care services deliver an analytics platform, clinical oversight, patient generated metrics, and produces actionable analytics to help treat Veterans efficiently and effectively within the comfort of their homes.

EASE OF USE

For convenience, all AMC Health devices are wireless and easy to use on a daily basis, regardless of patient age and location.

ADVANCED DATA ANALYTICS

Real-time patient data is easily accessible through our Care Console® platform and our app.

BETTER VETERAN CARE

Better care for our Veterans, while improving their access to care and empowering them to manage their own health.

CONTINUUM OF CARE

Veteran keep devices post graduation to maintain healthy behaviors and promote self-management

GOVERNMENT

WHY CHOOSE AMC HEALTH AS YOUR PARTNER IN RPM?

20 years as the leader in RPM

Broadest offering of virtual care solutions and devices

FDA Class II Cleared SaMD

Full end-to-end logistics support

Advanced data analytics

Broadest corpus of peer reviewed studies

Clinical expertise for patient interventions and telecare management

Alert handling to decrease care manager alert fatigue

Real-time monitoring and alerting

Availability of specialized solutions

Survey templates enable your or our clinical staff to manage, triage, track, report alerts and provide better care for patients

Improved patient engagement

Our Results are Proven, Trusted and Guaranteed

3.3x
return on investment

REDUCED MEDICAL COST FOR HEART FAILURE PATIENTS

Complex Care Management Results:

- 23% relative reduction in all-cause readmissions of 23%
- $216 pmpm (ROI=3.3) average relative cost savings – sustained over 24 months
- 2x - doubling the number of HF patients that could be managed by same FTEs

as reviewed by Population Health Management for Geisinger

22%
reduction in all-cause readmission

REDUCED HOSPITAL RE-ADMISSIONS

Post-Discharge Program Results:

- 22% reduction (ROI=>6:1) in all-cause readmit rate relative to controls
- Patients participating in our Post-Discharge Program saw a reduced risk of at least one readmission relative to controls for intent-to-treat cohort.

as reviewed by Medical Care for Geisinger

We provide the largest corpus of peer-reviewed studies in the industry.

1.8pts improvement for HbA1c

IMPROVED CARE OF PATIENTS WITH DIABETES

Diabetes Program Results:

- 1.8 points improvement across-the-board on average for HbA1c within 6 months, and 3.3 points for those who completed the program to goal
- 71% of hypertensive subset within BP targets within 6 months

as reviewed by JOURNAL of MANAGED CARE MEDICINE for NYC HEALTH+ HOSPITALS

11/9 mmHg

IMPROVED CARE OF PATIENTS WITH HYPERTENSION

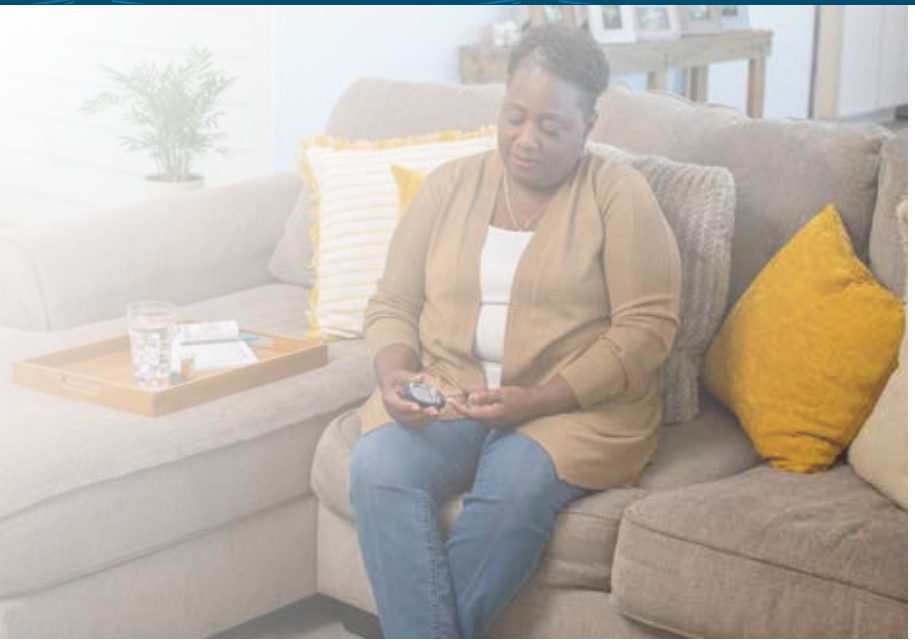
Hypertensive BP Management Results:

- 11/9 mmHg improvement over controls
- 72% with sustained control at 18 months
- Faster elimination of false positives

as reviewed by JAMA The Journal of the American Medical Association for HealthPartners

Additional studies available and/or pending upon request.

CASE STUDY 1



MEET MARY, AGE 55

Mary was enrolled with AMC Health and received the Bluetooth Blood Pressure, Glucose Meter Device, and Modem. Using our secured web and data enabled portal, Mary and her clinical team received daily alerts about her compliance and progress. Within the first three months, Mary has:

CONDITIONS

Type II Diabetes
Hypertension
Depression

EXPERIENCE (BEFORE AMC)

Hospitalized 3x for preventable skin lesions

Elevated A1c of 10

OUTCOMES (WITH AMC)

Reduced A1c to 7.7

65% **reduced risk** of microvascular complications

29% **reduced risk** of heart attacks

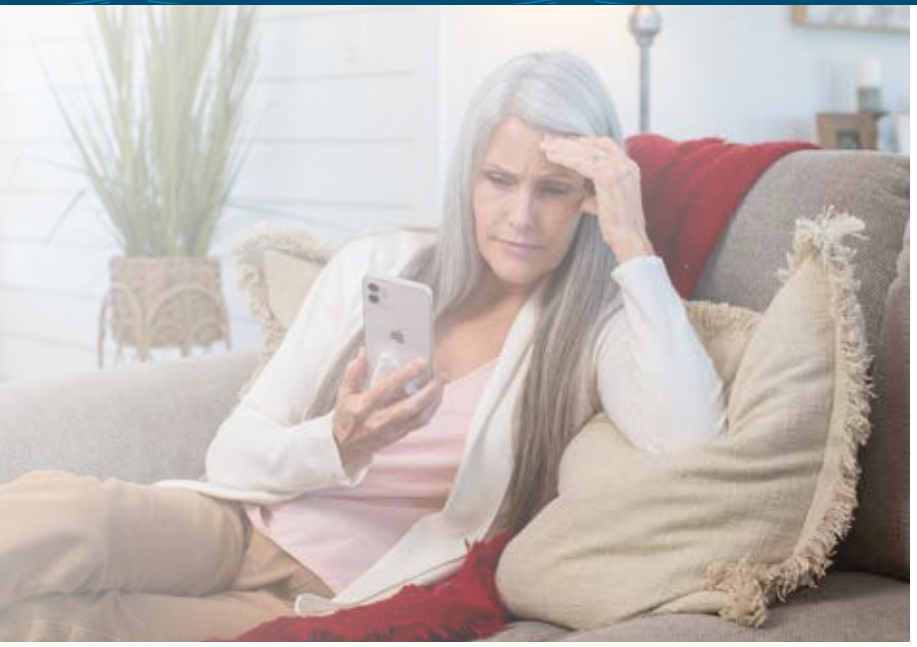
25% **reduced risk** of stroke

Improved Disease Literacy & Lesion Healing

No complications

All case studies are real member outcomes.
Member name has been changed for privacy.

CASE STUDY 2



MEET ALICE, AGE 42

Alice was enrolled with AMC Health and received a Bluetooth enabled Tablet, enabling real-time Patient/Doctor engagement in the comfort of her own home. She now lives with more confidence and great peace of mind. In the past 6-months, Alice has:

CONDITIONS

Ovarian Cancer
Depression

EXPERIENCE (BEFORE AMC)

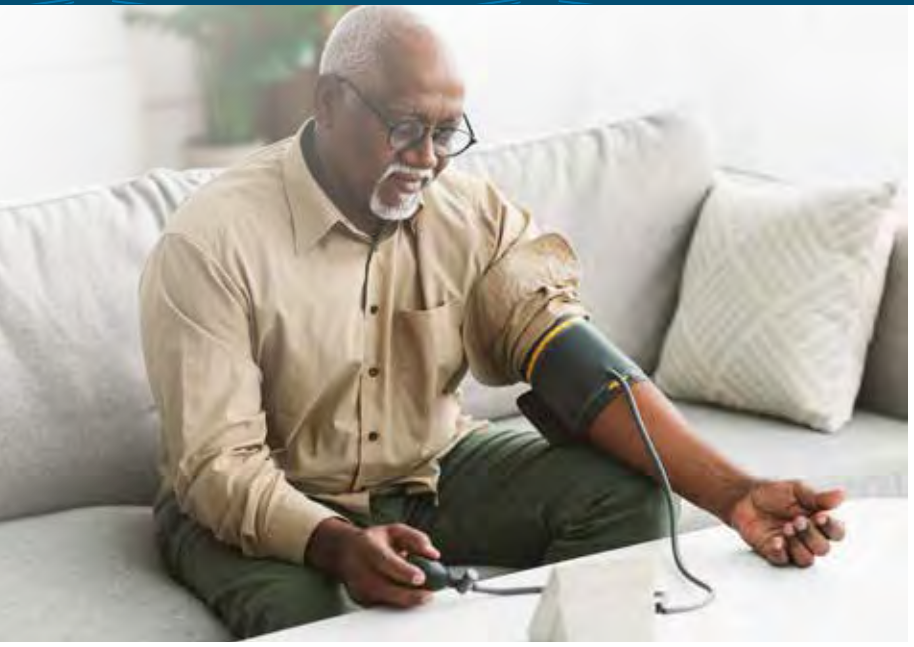
Repeat hospital admissions
Repeated ER encounters for Depression

OUTCOMES (WITH AMC)

With an AMC Health Tablet, Alice has experienced:

ZERO missed treatments
ZERO ER encounters
ZERO Re-Admissions

CASE STUDY 3



MEET JOSEPH, AGE 60

Joseph was enrolled with AMC Health and with our flexible solutions, he remained connected with his clinical team. Joseph reached his goals, including:

CONDITIONS

Myocardial Infraction
CAD
Hypertension
Depression

EXPERIENCE (BEFORE AMC)

Hospitalized for Hypotension from Rx Confusion

OUTCOMES (WITH AMC)

Rx Reconciled
Target BP (126/82, Pulse 72)
No ER or Readmissions

(40 Days Post Discharge)

CASE STUDY 4

HEART FAILURE PATIENT

Study based on 1,719 patients with Heart Failure (Stage II or higher)
with biometric monitoring for an average of 11 months

For the entire telehealth enrolled population (high + moderate risk), the average reduction in admits/k ($p<.05$) was 82 fewer than the controls, **for an average ROI of 2.7:1**, with the highest average ROI among those on program the longest

For the subset of 635 high-risk participants, the average difference in admits/k was 69 ($p<0.05$) compared to the controls, **for an average ROI of 4.6:1**

CLINICAL BENEFITS OF REMOTE PATIENT MONITORING (RPM)

72%
Sustained hypertension control at 18 months

81%
Sustained improvement in glycemic control

29%
Average reduced risk of heart attacks

51%
Average reduced risk of stroke

65%
Average reduced risk of microvascular complications

33%
Reduction in hospitalizations*

*teleheath.va.gov

50%
Reduced probability of 30-day readmissions

1.8pts
Average reduction in A1c over 30 days

15mm Hg
Average reduction in systolic pressure

3.3 to 1
Average return on investment

41%
Reduction in COVID-19 Inpatient/ ED Claims

31%
Reduction in readmissions against control

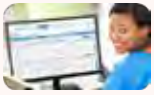
END TO END RPM SERVICES

Outreach
Identify candidates optimal for RPM program participation

Engagement
Clinical support, participant enrollment, evaluation and SDoH gap identification

Logistics
Condition Specific, pre-configured devices delivered to participants and set up with AMC Health support

Resources
Educational Tools and Resources, Scheduling, and Medication Adherence



Monitoring
Daily clinical monitoring and alert management with actionable reporting

Graduation
Successful patient/member self-management

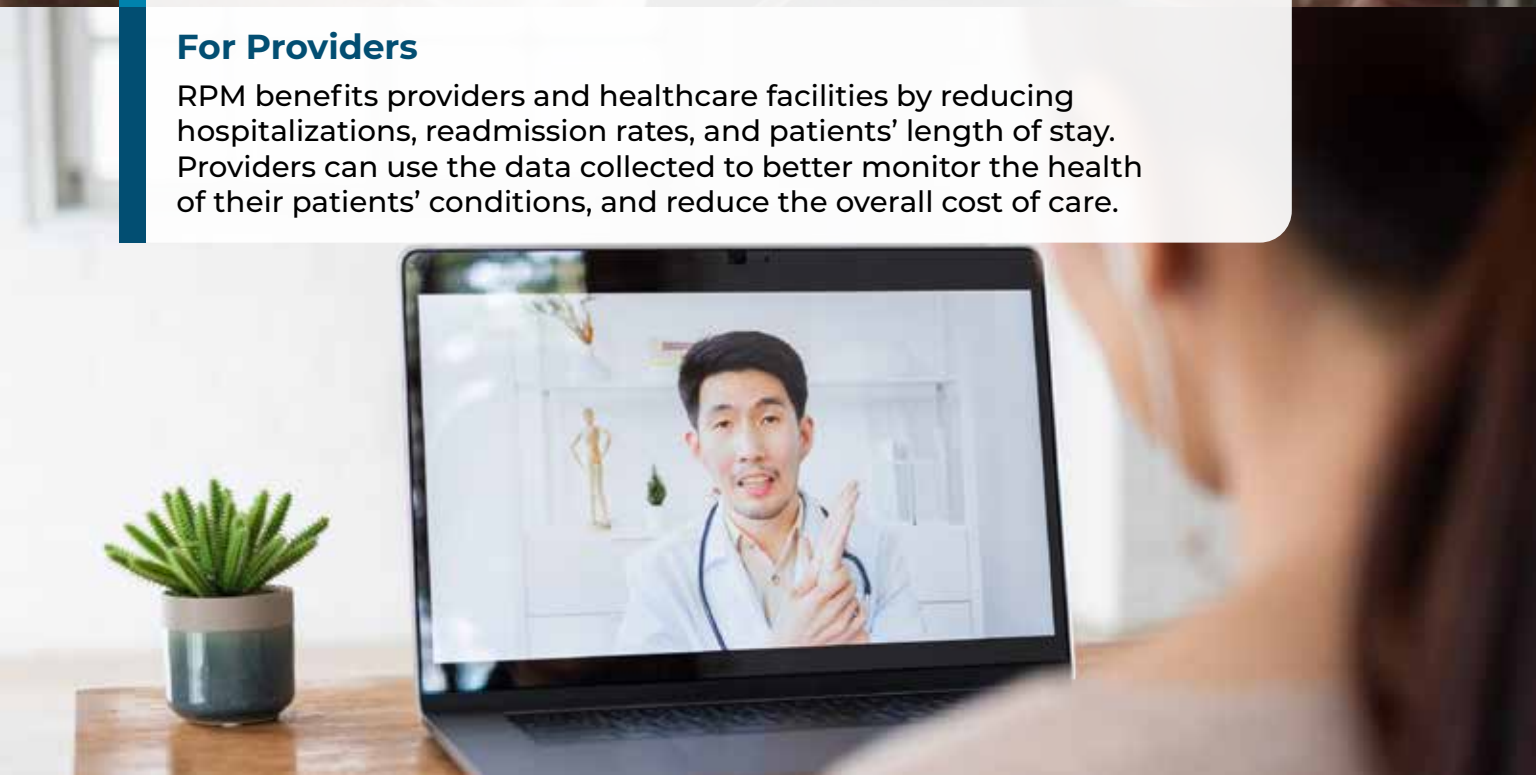
Benefits of Remote Patient Monitoring (RPM)

For Patients

RPM helps patients stay healthy with easy access to their physicians from the comfort of their homes. Patients also benefit from improved outcomes, access to their providers and reduced healthcare costs.

For Providers

RPM benefits providers and healthcare facilities by reducing hospitalizations, readmission rates, and patients' length of stay. Providers can use the data collected to better monitor the health of their patients' conditions, and reduce the overall cost of care.



PROVIDER CPT CODES

Ninety-nine percent of the nation's $3.3 trillion in annual health care costs are from people with chronic and multiple chronic health conditions. AMC Health helps you manage your patient's health better and realize more revenue.

	CPT Code	Offered Remotely	Time Per Month	Reimbursement*
REMOTE PATIENT MONITORING (RPM)	99453	Yes	Initial Setup	$19
	99454	Yes	Each 30 days	$50
	99457	Yes	Initial 20 minutes	$40
	99091	Yes	Each 30 minutes	$54
	99458	Yes	Each additional 20 minutes	$39
STANDARD CCM	99490	Yes	Initial 20 mins	$42
	99439	Yes	Each add'l 30 minutes	$38
COMPLEX CCM	99487	Yes	Initial 60 minutes	$92
	99489	Yes	Each add'l 30 minutes	$44
	99491	Yes	Each add'l 30 minutes	$87
CCM AT RHCS & FQHC	G0511	Yes	Replaces codes 99490 & 99487. Same eligibilty	$78
HCPCS	G0506	No	Comprehensive assessment	$62

**Reimbursement values reflect the CMS 2023 non-facility pay rate and are subject to change. Exact reimbursement amounts vary by geographic region.*

REMOTE PATIENT MONITORING (RPM) CODES

99453
PATIENT DEVICE SETUP

Service Initiation is billed under CPT 99453 (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment).

**$19 per instance*
One time setup and education

99454
EQUIPMENT/DEVICE MONITORING

Data Transmission is billed under CPT 99454 (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; each 30 days).

**$50 per patient/per month*

99457
INTERVENTIONS

Treatment Management Services – billed under CPT 99457 (Remote physiologic monitoring treatment management services, clinical staff/ physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month initial 20 minutes).

**$48 per patient/per month*

99091
DATA COLLECTION AND ANALYTICS

Data Analysis and Interpretation is billed under CPT 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).

**$54 per patient/per month*

99458
ADD'L INTERVENTIONS

Additional 20 mins of patient review and communications by physicians, QHCP's or clinical staff.

**$39 per patient/per month*

**CMS regionally adjusted*

STANDARD CCM CODES

99490
NON-COMPLEX CCM

Treatment of non-complex Chronic Care Management of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.

**$42*

99439
ADDITIONAL TIME INCREMENTS

Treatment of non-complex Chronic Care Management of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.

**$38*

COMPLEX CCM CODES

99437
CCM SERVICES PROVIDED PERSONALLY BY A PHYSICIAN OR OTHER QUALIFIED HEALTHCARE PROFESSIONAL

Required Element:

- Multiple (two or more) chronic conditions expected to last at least 12 months
- Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline

Each additional 30 minutes by a physician or other qualified healthcare professional, per calendar month.

**$62 per patient/per month*

99487
MODERATELY TO HIGHLY COMPLEX CCM

Treatment of moderately to highly complex Chronic Care Management covering the first 60 minutes of clinical staff time of QHP provider time.

**$92*

99489
ADDITIONAL TIME FOR MODERATELY TO HIGHLY COMPLEX CCM

Additional time for treatment of moderately to highly complex Chronic Care Management covering an additional 30 minutes of clinical staff time of QHP provider time in the same billing cycle as 99487.

**$44*

99491
CCM SERVICES PROVIDED PERSONALLY BY A PHYSICIAN OR OTHER QUALIFIED HEALTHCARE PROFESSIONAL

Required Element:

- Multiple (two or more) chronic conditions expected to last at least 12 months
- Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline

At least 30 minutes of physician or other qualified healthcare professional time, per calendar month

**$87 per patient/per month*

CCM AT RHCS & FQHC CODE

G0506

Comprehensive assessment of and care planning by the physician or other qualified health care practitioner for patients requiring CCM services (billed separately from monthly care management services).

(Add-on code, list separately in addition to primary service)

**$78*

HCPCS CODE

G0511

General care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month

(Add-on code, list separately in addition to primary service)

**$62*

	CPT Code	Offered Remotely	Time Per Month	Reimbursement*
COMPLEX PCM	99426	Yes	Initial 30 minutes	$61
	99427	Yes	Each add'l 30 mins	$47
STANDARD PCM	99424	No	First 30 minutes	$81
	99425	No	Each additional 30 minutes	$58
BHI AND PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT SERVICES	99484	Yes	Initial 20 minutes	*$47
	99492	Yes	Initial 70 minute visit	*$155
	99493	Yes	Each add'l 60 minutes	*$155
	99494	Yes	Each add'l 30 minutes	*$59

COMPLEX PCM CODES

99426
PRINCIPAL CARE MANAGEMENT SERVICES FOR A SINGLE HIGH-RISK DISEASE

Required Element:

- One complex chronic condition expected to last at least 3 months
- Patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- Disease-specific care plan requires development, monitoring, or revision
- Frequent adjustments in medication regimen required
- Management of the condition is unusually complex due to comorbidities
- Ongoing communication and care coordination between relevant practitioners furnishing care

First 30 minutes of clinical staff time directed by physician or other qualified healthcare professional, per calendar month

**$61*

99427
PRINCIPAL CARE MANAGEMENT SERVICES FOR A SINGLE HIGH-RISK DISEASE

Required Element:

One complex chronic condition expected to last at least 3 months

- Patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- Disease-specific care plan requires development, monitoring, or revision
- Frequent adjustments in medication regimen required
- Management of the condition is unusually complex due to comorbidities
- Ongoing communication and care coordination between relevant practitioners furnishing care

First 30 minutes of clinical staff time directed by physician or other qualified healthcare professional, per calendar month

**$47*

**CMS regionally adjusted*

99424
PRINCIPAL CARE MANAGEMENT SERVICES FOR A SINGLE HIGH-RISK DISEASE

Required Element:

- One complex chronic condition expected to last at least 3 months
- Patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- Disease-specific care plan requires development, monitoring, or revision
- Frequent adjustments in medication regimen required
- Management of the condition is unusually complex due to comorbidities
- Ongoing communication and care coordination between relevant practitioners furnishing care

First 30 minutes provided personally by a physician or other qualified healthcare professional, per calendar month.

**$81*

99425
PRINCIPAL CARE MANAGEMENT SERVICES FOR A SINGLE HIGH-RISK DISEASE

Required Element:

- One complex chronic condition expected to last at least 3 months
- Patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- Disease-specific care plan requires development, monitoring, or revision
- Frequent adjustments in medication regimen required
- Management of the condition is unusually complex due to comorbidities
- Ongoing communication and care coordination between relevant practitioners furnishing care

First 30 minutes provided personally by a physician or other qualified healthcare professional, per calendar month.

(To be listed separately in addition to code for primary procedure.)

**$58*

STANDARD PCM CODES

BEHAVIORAL HEALTH INTEGRATION (BHI) AND PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT SERVICES

99484
GENERAL BEHAVIORAL HEALTH INTEGRATION

This code covers BHI services that require at least 20 minutes of clinical staff time for models of care other than CoCM that may also include “core” service elements such as assessment and monitoring, care plan revision for patients whose outcome is not improving as desired or promoting a continuous relationship with a designated care team member. This code can be billed more than once a month.

**$47*

99492
COLLABORATIVE CARE MANAGEMENT SERVICES (COCM)

Initial psychiatric CoCM services treatment for the first 70 minutes in the first month.

**$155*

**CMS regionally adjusted*

99493
ADDDITIONAL COLLABORATIVE CARE MANAGEMENT SERVICES (COCM)

Additional psychiatric CoCM services treatment for the first 60 minutes in the subsequent month.

**$155*

99494
ADDITIONAL COLLABORATIVE CARE MANAGEMENT SERVICES (COCM)

If additional psychiatric CoCM services treatment is required, CPT 99494 covers additional 30-minute encounters in any calendar month.

**$59*

**Based on MAC*

SELF-MEASURED BLOOD PRESSURE CODES

99473
SELF-MEASURED BLOOD PRESSURE MONITORING (SMBP)

A one-time charge for when a physician practice staff member provides training, device setup and calibration of an SMBP device validated for clinical accuracy for patients when patients are instructed to monitor their BP at home.

**$12*

99474
NEW-TWO CONSECUTIVE SMBP READINGS

This CPT code is for the measurement of SMBP that includes two consecutive, separate, self-measured readings one minute apart, twice daily for 30-days. CPT code covers collection of data reported by the patient and/or caregiver to the physician or other qualified healthcare professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient.

**$15*

**CMS regionally adjusted*

TCM AND BEHAVIORAL HEALTH CODES

99495
TRANSITIONAL CARE MANAGEMENT SERVICES

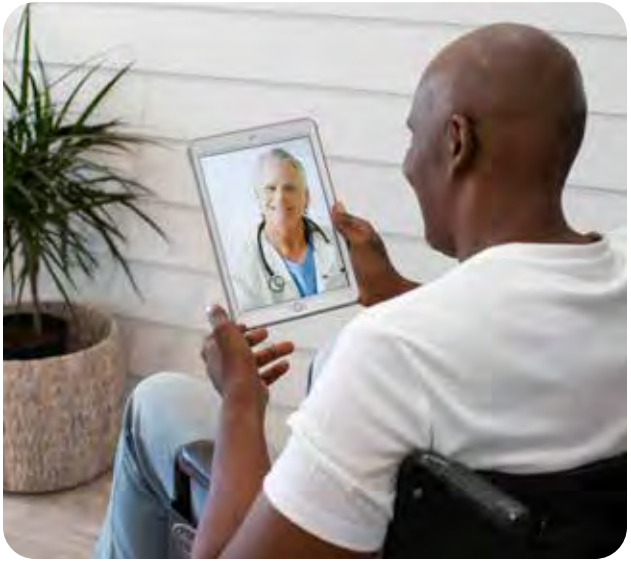
TCM services including interactive contact with the moderately complex patient within 2 days of discharge, with a face-to-face visit within 14 days of discharge.

**$208*

99496
TRANSITIONAL CARE MANAGEMENT SERVICES- HIGHLY COMPLEX PATIENTS

TCM services including interactive contact with the highly complex patient within 2 days of discharge, with a face-to-face visit within 7 days of discharge.

**$282*



OVERVIEW OF THE 2023 REMOTE THERAPEUTIC MONITORING (RTM) CODES

The 2023 Proposed Rule recognizes Remote Therapeutic Monitoring (RTM) as a novel digital healthcare solution that acts as a counterpart to the existing Remote Physiological Monitoring (RPM) system.

It introduces five new CPT codes for RTM that closely resemble the RPM codes established within the last few years. The most significant element to the inclusion of these codes is the extension of reimbursable digital healthcare applications to include non-physiologic data monitoring, such as respiratory system status, musculoskeletal system status, medication response, medication adherence, and pain levels.

WHAT IS RTM?

Remote Therapeutic Monitoring is the umbrella term for a set of five treatment management service codes:

- **98975** — RTM (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment
- **98976** — RTM (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
- **98977** — RTM (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
- **98980** — RTM treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes)
- **98981** — RTM treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)

The reimbursement amounts for the RTM codes are “at parity” with their RPM counterparts of 99454, 99457 & 99458.

HOW DOES RTM DIFFER FROM RPM?

While RTM is intended to supplement the existing Remote Physiological Monitoring CPT codes, there are vital differences between the two in the nature of data, method of data collection, and practitioners who are eligible to receive reimbursement for remote patient monitoring.

RTM allows for the observation and control of a broader range of health conditions when compared to RPM. RTM coding incorporates the reimbursement of services that are similar to RPM but do not qualify for Remote Patient Monitoring billing within the current CPT codes.

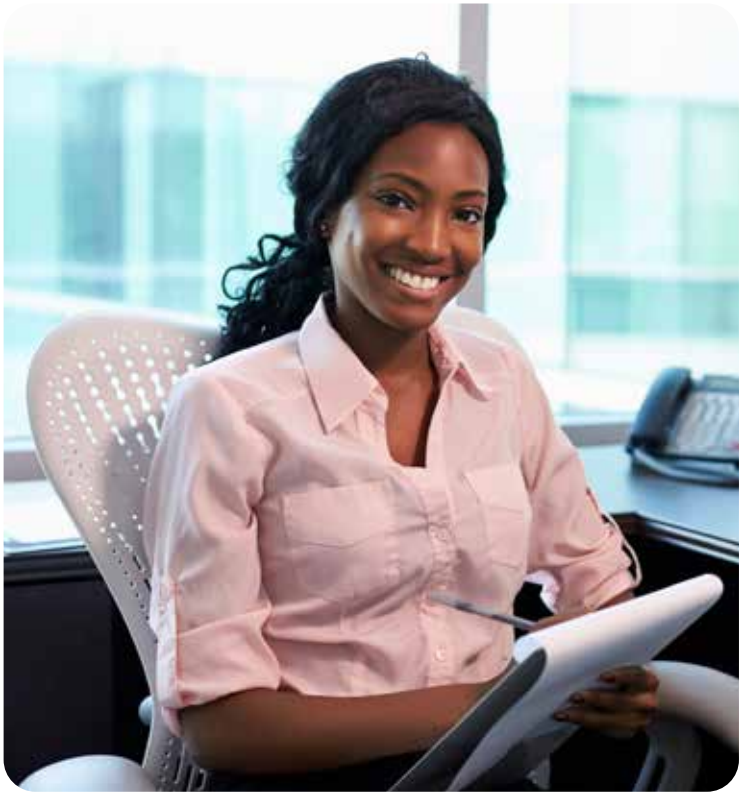
Both RTM and RPM entail the use of medical devices. A key difference is the inclusion of self-reported data within RTM codes. The RPM codes require FDA cleared medical devices to automatically store and forward physiological data, and physiological data only. Not video, not med adherence, and not self-reported symptom data. In contrast, RTM data can be self-reported, entered manually into a device, and digitally uploaded by the patients themselves.

RTM can cover the reporting of non-biometric, physiologic information like medication adherence and pain through an app or web-based platform classified as Software as a Medical Device (SaMD), which monitors metrics like pain levels and medication adherence, which is not captured and transmitted through existing hardware devices.

Another technical difference from the RPM codes is that the new RTM codes are classified as “General Medicine” codes, as opposed to the “Evaluation and Management (E/M)” service classification of RPM. On the plus side, this enables many more Qualified Health Care Professionals (QHCPs) to apply for reimbursement than previously possible under RPM. Under RPM, it is limited to nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM) and Physician assistants (PA). In contrast, the RTC codes can be billed by far broader list of professional types:

- Physicians
- Anesthesiology Assistants
- Certified Nurse Midwives
- Certified RN Anesthetists
- Certified Nurse Specialists
- Clinical Social Workers
- Nurse Practitioners
- Occupational Therapists (in private practice)
- Physician Assistants
- Psychologists
- Qualified Audiologists
- Speech-Language Pathologists (in private practice)
- Registered Dietitians or Licensed Nutrition Professionals

In fact, these types of ancillary service providers above are expected to comprise the main types of professionals submitting these new codes. For example, Home Health Agencies that provide PT, OT and Speech Therapy to stroke patients on an outpatient basis will be able to provide these services on a remote bases at the patient's home as a billable service. Similarly, RTs can now expense the data coming from inhaler monitoring technologies like Propeller and Adherium, and Cancer treatment programs can expense pain management monitoring activity with smart pillboxes.



LIMITATIONS

On the minus side, "General Medicine" clinical services cannot be performed by staff unassociated with the billing practice (under general supervision) per the "incident to" provisions. This means the billing practitioners themselves must provide the 20 minutes under RTC.

The codes limit the scope of transmissions to monitor the musculoskeletal and respiratory systems only. This effectively excludes provisions for data from the vascular, digestive, neurological, or endocrine systems. As of January 2022, stakeholders are optimistic CMS will include an expanded list of conditions in the future. For example, in early November 2021, the AMA announced revisions to the CPT codes for RTM to clarify coding of Cognitive Behavioral Therapy monitoring services

Medical technology of some fashion must be employed to bill for RTM, even if it's only software as a medical device (SaMD) as defined under the federal Food, Drug, and Cosmetics Act. This excludes non-SaMD solutions like wellness wearables such as Fitbit. AMC Health's CareConsole® is indeed an FDA Cleared SaMD application that qualifies, whereas those dashboards of many of our competitors are likely not.

Are RTM codes subject to the de minimis therapy payment adjustment standards?

The device codes (98976 & 98977) are not subject to it, but the education/set-up code 98975 is.

Can the patient manually self-input the data?

Yes. While RTM codes still require the device used to meet the FDA's definition of a medical device, self-reported RTM data via a smartphone app or online platform classified as Software as a Medical Device (SaMD) may qualify for reimbursement, according to CMS. This differs from RPM codes, which require the device to digitally (automatically) record and upload patient physiologic data (i.e., data cannot be patient self-recorded, self-reported, or entered manually into the device). See the embedded highlighted FDA link for examples.

What software qualifies as SaMD?

It's essentially software that acts as a medical device in that it treats, mitigates, prevents, cures, or diagnoses a medical condition. That means involving analytics that brings in data (whether through automated connections to hardware or whether it uses self-reported inputs from a patient) and doing something with data for the purpose of diagnostics, clinical decision support or treatment recommendation. SaMD can exist as a web portal, or it could be a mobile medical application.

Complex Care Management (Heart Failure)

*"Our partnership with AMC Health reduced all-cause readmissions by ~23% with an average $216 PPPM relative cost savings sustained over 24-months and an 3.3 ROI...plus, we were able to double the number of heart failure patients managed by same FTEs"**

*(Appeared in Population Health Management)

TCM Program (Diabetes Patient)

*"I was enrolled in AMC Health's diabetes management program 6-months ago and I'm excited to say my A1c has gone down by 1.3pts, and now at 7.2. I love knowing someone is helping me manage my diabetes, better. Thank you, AMC!"**

*(Quote from actual member in Diabetes program)

Care Management (Hypertension BP Program)

*"AMC Health helped us achieve 11/9 mmHg improvement over controls and reach 72% sustainable control at 18-months. Plus, eliminating false positives, better, for our Hypertensive BP management program."**

*(Appeared in JAMA – Journal American Medical Assoc)

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ADVANCED MONITORED CAREGIVING

The Top 10 Reasons Why AMC Health is the Leader in Remote Patient Monitoring

20

Twenty years delivering world-class Remote Patient Monitoring

Flexible RPM platform, device agnostic and integrates with your EMR

Healthwise Educational content to improve health literacy

FDA Class II cleared software as medical device

AI/machine learning and predictive analytics to identify candidates

5

Five peer-reviewed published studies

Integrated devices including CGM, Apple Health Kit, Propeller & bring your own glucometer

Full clinical nursing support services available in all 50 states

30+

Conditions monitored including post-acute, chronic, behavioral, wellness and specialty

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