CCM *vs.* RPM

Chronic Care Management and Remote Patient Monitoring

WHITE PAPER

A comprehensive guide detailing the differences between Chronic Care Management (CCM) and Remote Patient Monitoring (RPM)

accuhealth.

www.accuhealth.tech

Healthcare providers all over the nation are improving patient outcomes and reducing patient care load using Accuhealth's concierge level Chronic Care Management program. Our 24/7/365 clinical monitoring team is always available to speak to your patients and provide an intimate healthcare companion to build better habits and improve overall health and wellness.

BENEFITS INCLUDE:

- Improved Patient Outcomes
- Reduced Cognitive Overload for Providers
- Increased Medication Adherence & Appointment Reminders
- Improved Financial Viability

(Using CPT Codes 99490 - first 20min of time, 99439 - add on code for up to two additional units of 20min of interactive time, 99490 reimburses $64.02 and we invoice $25, 99439 reimburses $48.45 per unit - we invoice $20 per unit, max 2 units. As an example, 100 patients on CCM nets your clinic $9500/month (this is an average and most localities reimburse higher)

BREAKING DOWN CCM AND RPM

Services are generally non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more) chronic conditions expected to last at least 12 months.

REMOTE PATIENT MONITORING (RPM)

Services are generally the collection and analysis of patient physiologic data from one location and securely transmitted electronically to providers in a different location, that is used to develop and manage a treatment plan related to chronic and/or acute health illnesses or conditions. Physiological data can include vital signs like blood pressure, blood sugar, weight, SpO2 and/or heart rate information.

Your CCM program can be enhanced dramatically with Accuhealth Remote Patient Monitoring. If you are not already aware, you are able to bill for CCM and RPM concurrently because CCM patients qualify for RPM. Remote patient monitoring reduces avoidable ER visits. In 2022 alone, Accuhealth RPM resulted in over 7,000 avoidable hospital visits. Visit our website for updated numbers.

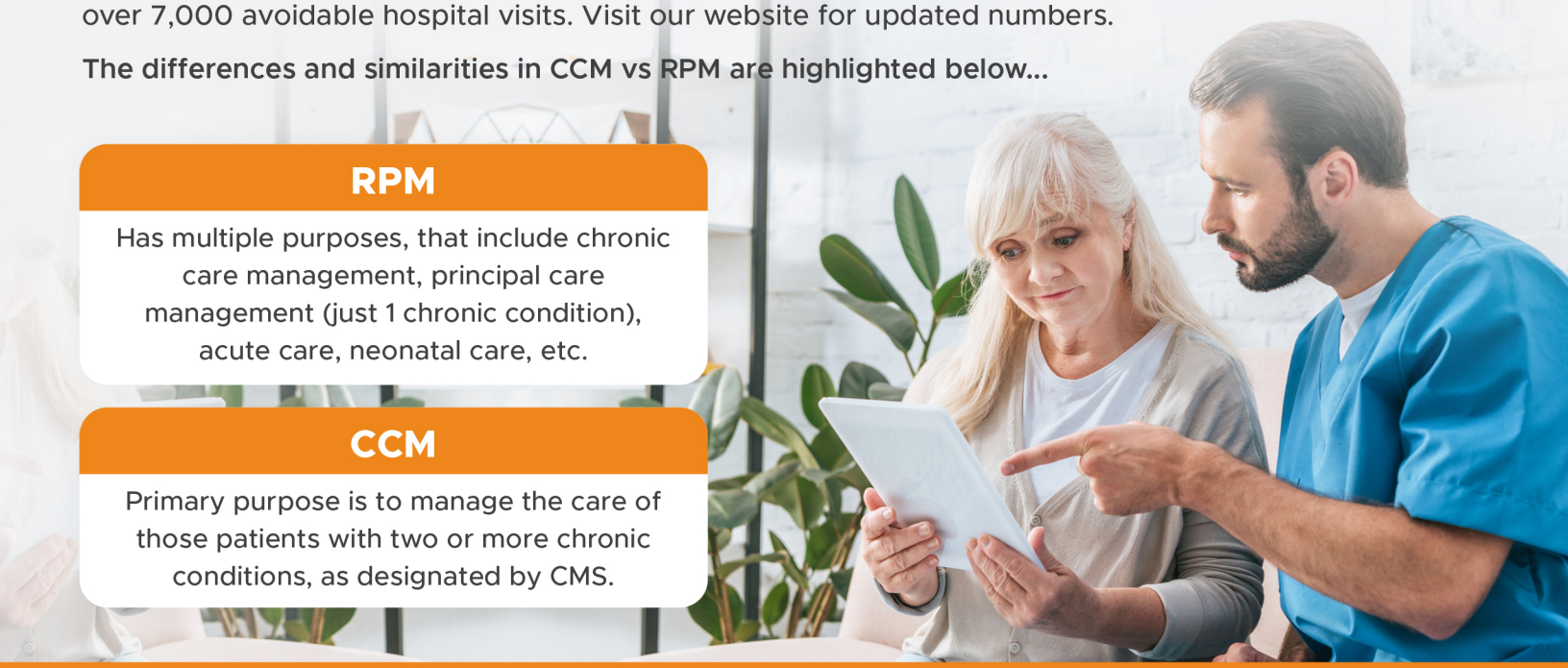
The differences and similarities in CCM vs RPM are highlighted below...

RPM

Has multiple purposes, that include chronic care management, principal care management (just 1 chronic condition), acute care, neonatal care, etc.

CCM

Primary purpose is to manage the care of those patients with two or more chronic conditions, as designated by CMS.



REQUIREMENTS FOR ACCUHEALTH CLINICAL MONITORING TEAM

RPM

1. Initial set-up and patient education on use of equipment.

2. Device(s) supply with daily recording(s) or programmed alert(s) transmission, 16 or more unique daily readings are required in a 30-day period for reimbursement.

3. Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month. Up to 2 additional units of 20 minutes are currently acceptable.

CCM

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

CARE ACTIVITIES

RPM

- Interpretation of the received data and interaction with patient on their treatment plan.
- Real-time clinical intervention for abnormal patient readings.
- Ongoing health coaching.
- Patient empowerment with physiological data.
- Device onboarding and patient education.
- Patient adherence reminders.
- Rewarding patient behavior and healthy wellness habits.
- 24/7/365 clinical access for patients, extending continuity of care.
- Medication adherence.

CCM

Comprehensive care plan must be established. It must then be implemented, revised, or monitored on a monthly basis.

Can involve the following:

- Systematic assessment of the patient's medical, functional, and psycho-social needs.
- System-based approaches to ensure timely receipt of all recommended preventive care services.
- Medication reconciliation with review of adherence and potential interactions.
- Oversight of patient self-management of medications.
- Coordinating care with home- and community-based clinical service providers.

EXPECTED MONTHLY REIMBURSEMENT

RPM

- **99453 -** One time patient setup onto RPM $19.
- **99454 -** Device supply and recordings; every 30 day code $50.
- **99457 -** 20-39 min., First 20 min of RPM clinical time (reviewing readings, phone calls...); calendar month code $49.
- **99458 -** Each additional 20 min of RPM clinical time, max 2 units; calendar month code $40.

CCM

- **99490 -** first 20 minutes, approximate reimbursement $63.
- **99439 -** any additional 30 minutes, approximate reimbursement $47 (capped at two units)

COMPLEXITY OF CASES

RPM

Does not have separate codes for medium to high complexity cases.

CCM

Has separate codes for medium to high complexity cases.

POSSIBILITY OF INCREMENTS

RPM	CCM
In increments of 20 minutes.	In increments of 20 minutes, however if 60 minutes will be required a month, the clinic is encouraged to bill a complex care code that starts at 60 minutes monthly.

REQUIREMENTS

RPM	CCM
Collection and interpretation of physiologic data 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) requiring a minimum of 30 minutes of time, each 30 days.	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month.

24/7 ACCESS TO CARE

RPM	CCM
Yes	N/A

SIMILARITIES

INITIATION

For new patients or patients not seen within 1 year prior to the commencement of RPM/CCM, Medicare requires initiation of services during a face-to-face visit with the billing practitioner. Has to be initiated by an Annual Wellness Visit, Initial Preventive Physical Exam, etc.

STAFF INVOLVED

Physicians, Qualified Health Professionals, Clinical Staff.

BILLING CYCLE

Monthly.

SUPERVISION

General Supervision.

PATIENT CONSENT

Required.

LOCATION OF PATIENT

Anywhere outside of the hospital. Does not have to be in an originating site, as it's typically the case with telehealth services.

COST SHARING

Copays and deductibles may apply.

What to look for in a CCM and/or RPM vendor?

- ✓ Well-documented capabilities to accurately track and record time spent with the patient
- ✓ Vendor should be able to auto-generate billing reports for both CCM and/or RPM
- ✓ RPM vendor should have a 24/7 Clinical Operations Center, whereas a CCM vendor would typically not have this in place
- ✓ Bilingual clinical staff
- ✓ Unlimited Telemedicine access for all patients and providers
- ✓ True EHR integration

Importance of EHR Integration

Any RPM or CCM vendor should have the ability to integrate fully with any clinic's existing EHR and serve as a natural extension of the clinic's existing process and procedures. This means documented evidence of the monthly service resides directly in the electronic health record of the patient.

Patient Engagement

Patient Engagement is paramount.

WATCH OUT! When selecting a vendor for either service, you should ask yourself: what is their patient engagement plan? And how can they objectively improve patient health and wellness over time?

Easy to use and accurate/reliable hardware

CCM vendors don't supply medical devices for remote monitoring, so should not be considered to be your RPM provider. When selecting an RPM vendor, you should choose one with plug-and-play cellular-connected devices that the vendor will ship directly to the patients, as well as educate the patient on how to take an accurate reading from home.

REMOTE PATIENT MONITORING BENEFITS

IMPROVED HEALTH OUTCOMES

The proof is in Accuhealth's data

OUR CLINICS' AVERAGE BLOOD GLUCOSE IMPROVEMENT OVER TIME
15 mg/dL

AVERAGE SYSTOLIC BLOOD PRESSURE IMPROVEMENT OVER TIME WAS
10 mmHg

AVERAGE DIASTOLIC BLOOD PRESSURE IMPROVEMENT OVER TIME WAS:
8 mmHg

AVERAGE RESTING HEART RATE IMPROVEMENT OVER TIME WAS:
3 bpm

AVERAGE WEIGHT LOSS IMPROVEMENT OVER TIME WAS:
16 lbs

ADDED PATIENT BENEFITS:

- ✓ Enhanced patient engagement and satisfaction
- ✓ Reduction in hospitalizations
- ✓ 24/7 clinical monitoring means more connected care
- ✓ Measurable patient data provides more touchpoints
- ✓ Reduction in overall cost of care
- ✓ Increased medication adherence

75% ADHERENCE RATE

20% MEDICATION ADHERENCE INCREASE

\+ IMPROVED PATIENT RETENTION

\+ IMPROVED CONTINUUM OF CARE