CCM & RPM Billing, Qualifications and Codes

Prepared for clinical administrators, doctors and other healthcare professionals, in the interest of healthcare without boundaries.

Dear Colleagues,

Integrated Chronic Care Management works. It helps mitigate the systemic drain caused by chronic illness treatment, which is 3.5 times more expensive to treat than other conditions and accounts for 90% of U.S. healthcare costs. This, according to the American Heart Association. Moreover, it works so well that reimbursements for non-face-to-face CCM have steadily increased and broadened since the introduction of CPT 99490 in 2015.

As you know, in 2020, the need for virtual health exploded. Results included the massive patient and physician adoption of platforms like Remote Patient Monitoring and telehealth—even among some of the slowest populations to change. Despite initial protests, virtual health platforms proved so efficient and safe they became an accepted, if not necessary, tool to provide quality care.

For the first time, the platforms that make the delivery of CCM and RPM most valuable are considered business-as-usual. Moreover, the paths of least resistance favor providing quality care to more patients and receiving more reimbursements— while compromising nothing.

In this guide, you will find the critical elements to provide more profitable, personalized care that complements and enhances your existing model and standards of healthcare.

Welcome to your practice without boundaries.

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About Vital Health Links

- Providing CCM since 2016 (Inception of non-face-to-face reimbursement)
- Clinical focused Care Coordinator program is led and overseen by physicians
- Care Coordinator methodology enhances revenue growth through CCM & RPM reimbursements
- Founder/CEO Saurin Patel holds an MBA from Indiana University Kelley Business School
- Coordinated care platforms integrate with practice workflows and care standards
- CCM and RPM platforms are turn-key and require virtually no up-front investment such as in personnel, technology, or additional infrastructure

CCM/RPM Billing & Qualifications

With the expansion of the CCM program, including Remote Patient Monitoring, CMS now offers more opportunities to help patients achieve optimum health while putting physicians and practices in the best possible position to receive reimbursement for their care coordination efforts. The following describes CCM program fees and details.

CPT Code	Description	Requirements	Reimbursements
99453	Initial setup: of remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate	Patient education on use of equipment.	$19 *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 healthca e professional, qualified by education, training, licensu e/regulation (when applicable)	Requiured minimum of 30 minutes of time, each 30 days	$57
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with dailyb recording(s) or programmed alert(s) transmission	Every 30 days	$63
99457	Remote physiologic monitoring treatment management services by clinical staff/physician/other qualified healthca e professional	20 minutes or more time in a calendar month Interactive communication with the patient or a caregiver during the month	$51
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;	$41

CPT Code	Description	Requirements	Reimbursements
99490	Chronic care management services, directed by a physician or other qualified healthca e professional	• 20 minutes or more time in a 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 risk of death acute exacerbation/ decompensation, or functional decline; • Compreensive care plan established, implemented, revised, or monitored.	$42
99457	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission	Every 30 days	$63
99458	Remote physiologic monitoring treatment management services by a clinical staff/physician/other qualified health care professional.	Each additional 20 minutes of clinical staff time directed by a physician or other qualified healthca e professional, per calendar month	$63

NOTE: INFORMATION IN THIS PUBLICATION APPLIES ONLY TO THE MEDICARE FEE FOR-SERVICE PROGRAM/ MEDICARE

REQUIREMENTS AND PAYMENT FOR RHCS AND FQHCS

CCM, GENERAL BHI, PSYCHIATRIC COCM

Requirements	CCM	General BHI	Psychiatric CoCM
Initiating Visit	An E/M, AWV, or IPPE visit occurring no more than one-year priorto commencing care coordination services. Furnished by a primary care physician,NP, PA, or CNM. Separately billable RHC/FQHC visit.	Same Same Same	Same Same Same
Beneficiar Consent	Obtained during or after initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff. Written or verbal, documented in the medical record. Includes information: • On the availability of carcoordination services and applicable cost-sharing; • That only one practitioner can furnish and be paid for care coordination services during a calendar month; • That the patient has right to stop care coordination services at any time (effective at the end of the calendar month); and • That the patient has given permission to consult with relevant specialists.	Same Same Same	Same Same Same
Billing Requirements	At least 20 minutes of care coordination services per calendar month that is: • Furnished under the direction of the RHC or FQHC primary care physician, NP, PA, or CNM; and • Furnished by an RHC or FQHC practitioner, or by clinical personnel under general supervision.	Same	At least 70 minutes in the first calenda month, and at least 60 minutes in subsequent calendar months of psychiatric CoCM services that is: • Furnished under the direction of the RHC or FQHC primary care practitioner. • Furnished by an RHC or FQHC practitioner or behavioral health care manager under generalsupervision.

Requirements	CCM	General BHI	Psychiatric CoCM
Patient Eligibility	Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.	Any behavioral health or psychiatric condition being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services	Same As General BHI
Requirement Service Elements	Includes: • Structured recording of patient health information using Certified EH Technology and includes demographics, problems, medications, and medication allergies that inform the careplan, care coordination, and ongoing clinical care; 2 of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed; • Care plan information made available electronically (including fax) in a timely manner withinand outside the RHC or FQHC as appropriate and a copy of the plan resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;	Includes: • Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;...	Includes: • Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;...

Requirements	CCM	General BHI	Psychiatric CoCM
Requirement Service Elements (Cont'd)	• Care plan information made available electronically (including fax) in a timely manner withinand outside the RHC or FQHC as appropriate and a copy of the plan of care given to the patient and/or caregiver; • Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers; • Coordination with home- and community-based clinical service providers, and documentation of communication to and fromhomeand community-based providers regarding the patient's psychosocial needs and functional deficits in th patient's medical record; and • Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.		...relationship with the rest of the care team; and Psychiatric Consultant: • Participate in regular reviews of the clinical status of patients receiving CoCM services; • Advise the RHC or FQHC practitioner regarding diagnosis, options for resolving issues with beneficiar adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who a e not progressing; managing any negative interactions between beneficiaries behavioral health and medical treatments; and • Facilitate referral for direct provision of psychiatric care when clinically indicated

Where we go from here

CCM, RPM, and other extended patient care services help practices generate revenue beyond what CPT codes provide. When done correctly, remote patient care provides contextual engagement with patients, collects important between-visit data, and can help spot potential concerns early.

"It is critical to the success of achieving the "Triple Aim" of providing better care, lower costs, and improved health."

This relationship-based, proactive approach to care helps encourage preventive care making your patients' next visit more encouraging than the last.

Additionally, with the industry's latest reimbursement models, there is tremendous value in how CCM & RPM can improve patient satisfaction and health, leading to better quality and performance scores.

CCM and RPM are two significant pieces of coordinated care. However, there are still others, including Annual Wellness Visits and Transitional Care Management.

Additionally, having success with MACRA (MIPS or Advanced APM path) and CPC+ are part of a larger goal—the proactive management of chronic conditions before they become a more significant threat to patient and population health and its additional costly impact on the U.S. economy.

It is a complete care coordination strategy that Medicare has been advancing year after year. It is critical to achieving the "Triple Aim" of providing better care, lower costs, and improved health.

10,000 baby boomers will turn 65 every day for the next 8 years, a growing patient base that is prone to developing multiple chronic conditions.

Know your CCM/RPM options before you have to. Speak with one of our physicians:
1-888-515-8450 | care@vitalhealthlinks.com

Hello! We are Vital Health Links, a doctor-led provider of dedicated coordinated care. We partner with practices across the country, but credit out midwestern diligence and care to our home-base, among the shores of 10,000 lakes, in Minnesota. In other words, we are friendly and would love to connect with you.

To say 'hello'

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