PHYSICIAN PRACTICE SURVIVAL: THE VALUE OF VIRTUAL SERVICES

TEXAS MGMA ANNUAL CONFERENCE

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VIRTUAL SERVICES

- Principal Care Management
- Chronic Care Management
- Remote Patient Monitoring
- Telehealth
- Telephone Evaluation and Management Services

PRINCIPAL CARE MANAGEMENT SERVICES

PRINCIPAL CARE MANAGEMENT (PCM) SERVICES

- New Medicare initiative for 2020
- Similar to Chronic Care Management (CCM) services
- Directed towards the comprehensive care of a single high-risk or complex condition
- Non-face-to-face care
- Billable monthly

BENEFITS OF PCM SERVICES*

- For patients:
  - Quality of care improvements
  - Reductions in cost
- For providers (physicians and other qualified health care professionals):
  - Same as above, plus compensation for services now provided for free
  - MIPS cost and quality performance category performance improvements
- For payers and other organizations:
  - Cost reductions
    - Shared risk program performance improvement
      - E.g., Medicare Advantage, ACOs and other alternative payment models

*Extrapolated from published data for CCM

BASIC PCM REQUIREMENTS

- Medicare patients (Part B eligible)
- Provide 30 minutes of non-face-to-face management services
- Two codes
  - G2064: 30 minutes of care provided personally by the provider
  - G2065: 30 minutes of care provided personally by clinical staff members

MAXIMUM PCM COMPENSATION (PER PATIENT)

- G2064 (Provider only code)
  - Average non-facility compensation: $94/month
  - Up to $1,128/year
- G2065 (Clinical staff members)
  - Average non-facility compensation: $40
  - Up to $480/year
- Comment: The above represents situations where PCM services are needed monthly. A significant percentage of patients may not require 30 minutes of PCM services each month and some will require more than 30 minutes.

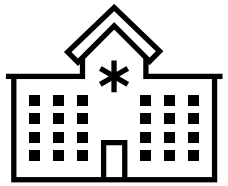
WHAT CONDITIONS QUALIFY FOR PCM?

One of more of the following:

- Conditions “typically” expected to last between 3 months and 1 year, or until the death of the patient
- Conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Qualifying conditions may have led to a recent hospitalization

ANTICIPATED "CIRCUMSTANCES"



- One or more of the following should be present:
  - Disease specific care management by a specialist is warranted
  - The condition requires the development or revision of a disease specific care plan*
  - The condition requires frequent adjustments to the medication regimen
  - The condition is unusually complex due to comorbidities
  - PCM services are triggered by an exacerbation of the patient's complex chronic condition, such as a recent hospitalization
  - The primary care practitioner and/*or the patient* decide that another clinician should provide relevant care management services for a high-risk or complex condition

*Required for all patients

GOAL OF THE TREATING "SPECIALIST"

- The goal of the specialist is to:
  - "Eventually return the patient to the care of the primary care practitioner once the condition has become more manageable"
- However, CMS clearly states that primary care providers can also provide PCM services
  - The goal of the primary care provider is to manage a condition that would benefit from supplemental non-face-to-face services.

PCM DEFINITIONS

STRAIGHT FROM THE HORSE'S MOUTH

DEFINITION OF PCM SERVICE CODE G2064 (CMS)

- Comprehensive care management services for a single high-risk disease
- At least 30 minutes of ***physician or other qualified health care professional*** ("provider") time per calendar month with one or more of the following elements:
  - One complex chronic condition lasting at least 3 months, which is the focus of the care plan
  - The condition is of sufficient severity to place the patient at risk of hospitalization, or was the cause of a recent hospitalization
  - The condition requires development or revision of disease specific care plan
  - The condition requires frequent adjustments in the medication regimen
  - The management of the condition is unusually complex due to comorbidities

DEFINITION OF PCM SERVICE CODE G2065 (CMS)

- Comprehensive care management services for a single high-risk disease
- At least 30 minutes of ***clinical staff time*** directed by a provider per calendar month with one of more of the following elements:
  - One complex chronic condition lasting at least 3 months, which is the focus of the care plan
  - The condition is of sufficient severity to place the patient at risk of hospitalization, or it has been the cause of a recent hospitalization
  - The condition requires development or revision of disease specific care plan
  - The condition requires frequent adjustments in the medication regimen
  - The management of the condition is unusually complex due to comorbidities

DEEPER DIVE INTO PCM REQUIREMENTS

"THE WEEDS"

PCM AND “INCIDENT TO”

- PCM services may be provided by clinical staff members “incident to” the provider’s license - under general supervision
- Clinical staff members must meet definition of clinical staff member
  - Definitions vary from state to state
  - Medical assistants, for example may or may not be consider clinical staff members, depending on the state

ACTIVITIES ELIGIBLE FOR PCM SERVICE MINUTES

- Telephone calls (portion spent on care)
- Correspondence
  - Secure email communications
  - Portal communications
  - Communications through health care “app”
- Discussions between staff members about patient care
- Managing and organizing patient information (labs, study results, etc.)
- Care plan updates
- Communications with other care and other service providers
  - Primary care/specialists/ED/hospital/community health/ED/SNF/assisted living/family members/home health, others

PATIENT CONSENT

- May be verbal or in writing
  - Must be documented in the medical record
- Consent only needs to be obtained once
- Patient needs to be informed that:
  - PCM services are available
  - Only one provider can bill per month for PCM services
  - PCM services can be stopped effective at the end of the service period (month)
  - Cost sharing applies (in most settings the copayment is covered by supplemental insurance)

INITIATING VISIT

- Required for new patients or those not seen in past year (face-to-face or telehealth visit)
- Visit must be an E/M service visit such as:
  - 99202-99215, Annual Wellness Visit (AWV), or Initial Preventative Physical Examination (IPPE).
  - All separately payable
- Time spent providing non-face-to-face care on the same day as an E/M service cannot be counted towards PCM service time
  - May be difficult to track…

CERTIFIED EHR USAGE REQUIREMENTS

- Provider must be using a certified EHR (2015 edition requirements)
  - “Core Patient Information” must be recorded in EHR:
    - Demographics
    - Problem list
    - Medications
    - Allergies
- No current requirements tied to Promoting Interoperability performance

24/7 ACCESS

- Patients/care givers need continuous access to PCM provider practice
- Cross-over arrangements allowed (e.g., when one practice covers for another)
  - Should be a contractual agreement between practices
- Access to a call center alone does not meet this requirement

DESIGNATED CARE TEAM MEMBER AND "ENHANCED" COMMUNICATIONS

- Designated Care Team Member
  - An individual should be identified as the designated care team member for PCM services
  - Not limited to providers
  - Patient should be informed when designated care team member is changed
- Enhanced Communication Opportunities
  - Practice needs to offer asynchronous non-face-to-face methods other than telephone
  - Examples include secure email, portal communications, health care apps

DISEASE SPECIFIC CARE MANAGEMENT

- Systematic needs assessment
  - Medical and psychosocial
    - Only as applicable to the condition
- Ensure receipt of preventive services
  - Only as applicable to the condition
- Medication reconciliation, management and oversight of self-management
  - Only as applicable to the condition
- Ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented in the patient's medical record

DISEASE SPECIFIC ELECTRONIC CARE PLAN

- Must be revised or monitored as needed
- Plan is available in a timely manner as needed
  - Within and outside the practice (can include fax)
- Copy of care plan is given or made available to the patient or caregiver.
  - Format not specified by CMS (e.g., paper copy, available on patient portal, sent via fax, sent via secure email, etc.)
- Time spent updating the care plan may be counted towards PCM service time

PCM CARE PLAN "TYPICAL" REQUIREMENTS

- For all patients: demographics, problem list, medications, medication allergies, condition being managed
- Only applicable to condition being managed:
  - Expected outcome and prognosis
  - Measurable treatment goals
  - Symptom management
  - Planned interventions and identification of the individuals responsible for each intervention
  - Medication management
  - Community/social services ordered
  - A description of how services of agencies and specialists outside the practice are directed/coordinated
- Scheduled for periodic review and, when applicable, revision of the care plan

MANAGEMENT OF CARE TRANSITIONS/REFERRALS

- Only transitions/referrals applicable to the condition being managed
- Examples including when the condition is affected by:
  - Discharges
  - Emergency department visits
  - Follow-up
  - Referrals
- Support transitions/referrals by creating and exchanging a summary of care document
  - Format for exchange not prescribed by CMS (e.g., paper, electronic, fax)
- Note: Transitional Care Management Services can be billed concurrently

HOME-AND COMMUNITY-BASED CARE COORDINATION

- Coordinate with all home-and community-based clinical service providers
  - Only applicable to condition being managed
  - Communications should include discussion of psychosocial needs and functional deficits
  - Coordination and discussions should be documented

DO ALL REQUIREMENTS NEED TO BE MET EACH MONTH?

- CMS:
  - “All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month.”

PCM CLINICAL EXAMPLES

WORKFLOWS AND MEETING REQUIREMENTS

PCM CLINICAL EXAMPLE: CROHN'S DISEASE

- Crohn's disease patient with recurrent exacerbations in GI practice
- Provider recommends PCM services to patient who enrolls
- Designated care team member assigned who speaks with patient
- Clinical staff creates care plan that is reviewed/approved by billing provider
- Clinical staff: weekly communications with the patient regarding the status of their condition
  - Symptom monitoring, weight tracking, medication adjustments, dietary counseling, follow-visit with nutritional professional, connects patient to a support group, etc.
- Staff members (including providers) document care provided and track minutes
  - Once the monthly 30-minute threshold is obtained submit code G2065 ($40.00)

PCM CLINICAL EXAMPLE: HEART FAILURE

- Male patient with heart failure recently discharged from hospital
- Symptomatic (shortness of breath)
- Lives alone
- Cardiologist has weekly communications with the patient and his care givers to “fine-tune” the patient’s care
  - The provider spends 8 minutes per week (on average) personally providing the care management services
    - Submits G2064 ($85-$95)

PCM EXAMPLE: MULTIPLE SCLEROSIS

- Recent exacerbation requiring stay in rehabilitation facility
- Transitioning to home
- Significant activity around connecting the patient to home services, physical therapy, and meal services
- Has other comorbid conditions complicating care (e.g., pressure ulcers)
- 30 minutes of clinical staff time spent providing management services
  - During the calendar month
- Report HCPCS code G2065 ($40)

CHRONIC CARE MANAGEMENT (CCM) VS. PCM

CHRONIC CARE MANAGEMENT OVERVIEW

- Medicare program active for 5 years
- Reimburses practices for care provided to patients with two or more chronic conditions
- Require the practice to manage all aspects of patient care
- Comprehensive care plan required
- Multiple reimbursement pathways

CHRONIC CARE MANAGEMENT BENEFITS

- Study* commissioned by CMS evaluated the CCM program
- Enrolled patients:
  - Hospitalized at lower rates than non-CCM patients
  - Used emergency department services less often
  - Reduced the cost of care by an average of $95 per month
  - Had significantly higher rates of advance care planning
  - Had more visits with their primary care physician
  - Utilized more home health care services

*Shurrer J, O'Malley A, Wilson C, McCall N, Jain N.. Evaluation of the diffusion and impact of the chronic care management (CCM) services: final report. Princeton, NJ: Mathematica Policy Research, 2017

CCM VS PCM: AVAILABLE CODES

- CCM has multiple codes:
  - Non-complex CCM services
    - 99490, G2058, 99491
  - Complex CCM services
    - 99487 and 99489
  - Extensive assessment and CCM care planning by provider during CCM initiating visit
    - G5059
- PCM has only two codes (at this time)
  - G2064 and G2065

CCM SERVICES REIMBURSEMENT MATRIX

*Average non-facility payment

HCPCS/ CPT® Code	Service Description	Monthly Medicare Payment (non-facility)
99490	Non-complex CCM services, 20-39 minutes by clinical staff	$42.23
G2058	Add-on code for 99490, additional 20 minutes (maximum of two per month)	$37.89
99490 and G2058	40-59 minutes of non-complex CCM time	$80.12
99490 and G2058 (2)	60 or more minutes of non-complex CCM time	$118.01
99491	CCM services personally performed by provider, 30 minutes or more	$85.90
99487	Complex CCM services, 60-89 minutes	$95.01
99489	Add-on code for 99487, additional 30 minutes of complex CCM services	$46.01
99487 and 99489	90 to 119 minutes of complex CCM services	$141.02
G0506	Provider extensive assessment and care planning during initiating visit	$38.85

PCM SERVICES REIMBURSEMENT MATRIX

* Average non-facility payment

HCPCS Code	Service Description	Monthly Medicare Payment*
G2064	PCM services, 30 or more minutes by provider	$95.00
G2065	PCM services, 30 or more minutes by clinical staff	$40.00

- CCM services started in 2015 with one code: 99490
- PCM services will likely be updated over time

PCM AND CCM PROVIDER ONLY SERVICES

- Require a minimum of 30 minutes of provider time
  - Reimbursement relatively high ($95) per month
  - May be applicable for:
    - Selected patients with management challenges
    - Situations where providers have additional bandwidth
    - Situations where providers are quarantined at home
- These services are underutilized
- Represent potentially new revenue streams (in the right setting)

CCM VS PCM: QUALIFYING CONDITION REQUIREMENTS

- CCM services require two or more *chronic* conditions
  - Conditions expected to last at least 12 months or until the death of the patient
  - Like PCM, the chronic conditions "place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline"
- PCM allows for conditions expected to last for as little as 3 months or until death
  - Conditions do not have to be chronic (technically)
- CMS did not provide examples of applicable conditions…

CCM VS. PCM: TOTAL VS. FOCUSED CARE

- CCM
  - Requires comprehensive management of ***all aspects*** of patient care
  - May be challenging for some specialty practices
    - Exceptions include settings where the specialist is providing primary care
- PCM
  - Requires comprehensive management of a single condition

CCM VS PCM: CARE PLAN

- CCM “comprehensive” care plan must be based on an assessment or reassessment of the patient’s physical, mental, cognitive, psychosocial, functional, and environmental status and needs
  - Not required for PCM unless applicable to PCM condition
- CCM plan must include an “inventory of resources” available to the patient
  - PCM plan resources limited to those applicable to condition

CCM VS PCM: MANAGEMENT OF CARE TRANSITIONS

- CCM
  - Must manage all transitions of care and referrals
    - Hospital admissions and discharges
    - SNF/Rehab hospital admissions and discharges
    - ED visits
    - Specialist evaluations
- PCM
  - Limited to management of transitions of care/referrals applicable to condition

CCM VS PCM: CLINICAL STAFF TIME REQUIREMENTS

- Both services offer reimbursement for supervised *clinical staff* time:
  - CCM:
    - Code 99490: 20 minutes or more of CCM services provided
    - Code G2058: additional 20 minutes of CCM services provided (submit with 99490)
    - Code 99487: 60 minutes of “complex” CCM services
    - Code 99489: Each addition 30 minutes of complex CCM management (submit with 99489)
  - PCM:
    - Code G2064: ***30 minutes*** or more of PCM services offered

CCM VS PCM: PROVIDER TIME REQUIREMENTS

- Both services offer reimbursement for services *personally provided by the provider*:
  - CCM:
    - Code 99491: 30 minutes or more of CCM services provided
  - PCM:
    - Code G2064: 30 minutes or more of PCM services offered

PCM: COMPATIBILITY WITH OTHER SERVICES

SERVICES THAT CAN BE PROVIDED CONCURRENTLY WITH PCM (AND CCM)

- Transitional Care Management (TCM) services
- Remote Patient Monitoring (RPM) Codes 99453 and 99457/99458
- Inherent E/M Complexity (GPC1X)
- CCM (if billed by a different clinician)

(Above list is not comprehensive)

SERVICES THAT CANNOT BE PROVIDED CONCURRENTLY WITH PCM (AND CCM)

- Remote Patient Monitoring (RPM) Code 99061
- Behavioral Health Integration Services
- CCM (if billed by the same clinician)
- Surgical global period
- Interprofessional consultation services (CPT codes 99446–99449, 99451, and 99452)
- Time spent providing E/M services during the same calendar day

(Above list is not comprehensive)

THE DIGITAL OFFICE

WHAT EVERY PRACTICE SHOULD CONSIDER

VIRTUAL SERVICES THAT SHOULD BE CONSIDERED BY EVERY PRACTICE

- CCM/PCM
- RPM
- Telehealth services (post-pandemic)
- Telephone services
- E-Visits
- E-Check-in Visits

REMOTE PHYSIOLOGIC (PATIENT) MONITORING SERVICES (RPM)

A BRIEF OVERVIEW

REMOTE PHYSIOLOGIC MONITORING SERVICES OVERVIEW

- **99453 and 99454: Remote monitoring of physiologic parameter(s)**
  - 99453: initial; set-up and patient education
  - 99454: daily recording(s) or programmed alert(s) transmission, each 30 days
- **99457 and 99458: Remote physiologic monitoring services by clinical staff members with interactive communication (e.g., data interpretation generated once device is set up)**
  - 99457: first 20 minutes per month
  - 99458: additional 20 minutes per month

REMOTE PHYSIOLOGIC MONITORING SERVICES OVERVIEW (2)

- 99091: Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient to provider, minimum of 30 minutes of time, each 30 days
  - Provider time only
- 99473 and 99474: Self-measured blood pressure using a device validated for clinical accuracy
  - 99473: Patient education, training and SMBP device calibration
  - Separate self-measurements of two readings one minute apart (minimum of 12 minutes)
- All RPM services require documented prior consent

REQUIREMENTS: RPM SET UP AND DATA COLLECTION SERVICES

- Descriptions:
  - 99453: Remote monitoring of physiologic parameters: device set-up and patient education
    - Can only be submitted once episode of care, (ends with attainment of targeted treatment goals)
  - 99454: Monthly supply of devices and components for remote monitoring: “ongoing supply, monitoring, maintenance, and support of device,” each 30 days
    - Includes cost of medical device

REQUIREMENTS: RPM SET UP AND DATA COLLECTION SERVICES (99453 AND 99454) (2)

- Additional requirements
  - Device used must be a medical device as defined by the FDA (e.g., off the shelf BP cuff or glucometer)
  - Physiologic parameters include weight, blood pressure, pulse oximetry, glucose levels, others
  - Device needs to automatically send physiologic data on at least 16 calendar days in a month
  - Services may be provided by “auxiliary” staff members (e.g., technicians in the patient’s home that do not meet the definition of clinical staff members)

REQUIREMENTS: RPM TREATMENT MANAGEMENT SERVICES

- 99457: Management of data generated by remote physiologic monitoring, 20-39 minutes
- 99458: Add-on code for above, each additional 20 minutes (starting at 40 minutes)
- Requirements:
  - Management services may be provided by clinical staff members
    - "Incident to" via general supervision by provider (new for 2020)
  - Must include a live interactive communication with a minimum of two-way audio (proposed for 2021) between the clinical staff member with the patient by phone or other application.
- The time spent providing this service on the same day as an E/M encounter counts towards the E/M encounter only

REQUIREMENTS: PROVIDER INTERPRETATION OF PHYSIOLOGIC DATA (CODE 99091)

- Description: Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient to provider, minimum of 30 minutes of time, each 30 days
- Data management services must be performed by provider personally
- Patient must have had a “face-to-face” encounter will billing provider within the past year
- Time spent involved with data accession, review and interpretation, modification of the care plan as necessary (including communication to patient or caregiver, and associated documentation) is counted
- Does not ***require*** interactive communication with patient/caregiver

99091: PROVIDER INTERPRETATION OF PHYSIOLOGIC DATA (2)

- Medical device requirement not specified in CPT code book (non-FDA approved medical devices may also qualify)
- Concurrent billing:
  - May be billed concurrently with CCM, TCM
  - May not be billed concurrently with remote physiologic monitoring services (99457)
- As per CPT Professional 2020, 99091 may ***not*** be billed concurrently with CCM service codes
- The time spent providing this service on the same day as an E/M encounter counts towards the E/M encounter only

REMOTE PHYSIOLOGIC MONITORING SERVICE REIMBURSEMENT MATRIX

HCPCS Code	Service Description	Medicare Non-Facilty Payment
99453	Remote physiologic monitoring using FDA approved device by clinical staff – set up	$22
99454	Remote physiologic monitoring using FDA approved device by clinical staff – monitoring for 16-30 days, ***includes cost of device***	$65
99457	Management of data generated by remote physiologic monitoring with interactive communication– first 20 minutes	$54
99458	Management of data generated by remote physiologic monitoring – add on code for 99457, additional 20 minutes	$22
99453, 99454, 99457 and 99458	Services performed together	$163
99091	Collection and interpretation of physiologic data by provider	$72

ADDITIONAL VIRTUAL SERVICES

DURING AND AFTER THE COVID-19 PUBLIC HEALTH EMERGENCY (PHE)

POST-PANDEMIC TELEHEALTH ENCOUNTERS

- Consider the role of telehealth in the future
- Proven value for certain conditions (e.g., mental health conditions, tracking skin ulcers, post-operative care, CHF management, etc.)
- Proven value for certain situations (e.g., inclement weather, long distance travel, patients that have difficulty with transportation, patient with child care needs, patients that cannot afford to take time from work, etc.)
- Younger patient may seek telehealth as an option for routine care
- Telehealth allows practices to extend their geographic footprint
  - But that works two ways…

TELEPHONE EVALUATION AND MANAGEMENT SERVICES

- Likely will not be extended post-pandemic, or its reimbursement will be reduced
  - Considered a telehealth service during PHE (modifier -95)
- As per CMS, this services is limited to when patients do not have access to technologies that support video
  - The rationale for not providing a telehealth visit (with video) should be documented
- Service should be initiated by patient (as per CPT)
- The service cannot:
  - Be related to an E/M service provided within the previous seven days or
  - Lead to an E/M service or procedure within the next 24 hours or "soonest available" appointment
  - Be reported during the post-operative period
- New or established patients (during the PHE)
  - Establish patients only (as per CPT Codebook)

Code	Required Amount of Medical Discussion Time	Equivalent Office CPT Code During PHE (By Payment)
99441	5-10 minutes	99212
99442	11-20 minutes	99213
99443	21 or more minutes	99214

Non-Physician codes 98966-98968 may be reported for audio-only services provided by PTs, OTs, speech-language pathologists, social workers and dieticians.

E-VISITS

- E-visit codes 99421-99423 may be submitted when:
  - An established patient initiates a service inquiry (*new patients authorized during PHE*)
  - A provider spends five or more minutes of cumulative time in a seven-day period providing remote evaluation and management services.
- Code depends on amount of time spent, summated over a 7-day period:
  - Duration 5-10 minutes: 99421 ($15.84)
  - Duration 11-20 minutes: 99422 ($31.62)
  - Duration 21 or more minutes: 99423 ($51.12)
- The initiating communication from the patient must occur via a HIPAA-compliant secure platform such as a patient portals, e-mail, or other digital applications.
  - It cannot be through a phone call.
- The HHS OIG has stated it will exercise enforcement discretion for e-visit copayments during the public health emergency.
- Cannot be submitted if the patient receives an E/M service within seven days, or the patient-initiated inquiry stems from an E/M service provided in the past seven days and is for the same problem.

E-VISIT CODES (2)

- If an overlapping E/M visit occurs the time and or complexity can be used toward the E/M visit code level determination.
- Document the amount of time spent during each patient interaction and the topics discussed.
- Clinicians may use the time spent reviewing the initial inquiry, records review, ordering tests, writing prescriptions, developing a management plan and in follow-up communication with the patient through online portal communications, telephone calls, e-mail, or other forms of communication.
- E-visit codes G2061-G2063 may be submitted when:
  - Clinicians that do not have evaluation and management services in their scope of practice provide these services (same requirements as for the above
  - Duration five to 10 minutes: G2061 (Non-facility reimbursement: $12.53)
  - Duration 11 to 20 minutes: G2062 (Non-facility reimbursement: $22.10)
  - Duration 21 or more minutes: G2063 (Non-facility reimbursement: $34)

VIRTUAL CHECK-IN SERVICES (CODES G2010 AND G2012)

- G2010: “Store and forward” ($12.27)
  - Used when patients send recorded images or video for evaluation by provider
  - Must include interpretation and follow-up with patient within 24 hours
- G2012: Brief virtual (e.g., telephone) communication with patients ($14.80)
  - Must be at least 5 minutes in duration
  - Documentation of communication and time spent required
- For both services:
  - Established patients only (***new patients may receive these services during the PHE***)
  - Limited to providers
  - Cannot be billed if service:
    - Originated from a related E/M service within the past seven days
    - The service leads to an E/M service or procedure within 24 hours or the “soonest available appointment.”
  - Must be initiated by the patient.

ADDITIONAL CONSIDERATIONS

VIRTUAL SERVICES AND PATIENT EXPECTATIONS

- RPM is experiencing rapid growth.
  - Quote from Stanford physician: *“Being able to have multiple data points on them, literally every day, to manage patients with chronic diseases is way more effective than a patient going to see a doctor once every six months…”*
- Multiple studies have reported cost of care reductions associated with RPM and related home monitoring services
- Private payers, including Medicare Advantage Organizations, are launching pilot studies

PATIENT RETENTION AND VIRTUAL SERVICES

- Patients and their caregivers will begin to expect offices to be “fully digital”
- Patients have the option of being seen by providers that are at greater distances due to telehealth
- Having a fully enabled digital office may also help with provider recruitment and retention

PCM AND CCM CHALLENGES

- 20% Copayment
  - Not applicable to most patients
  - May be eliminated for CCM in 2021 (proposed bill)
- Staff availability to provide management services
  - Internal model (slow ramp up or staff supplementation)
  - External model (call center)
- Tracking time spent managing patients (across multiple staff members)
- Patient acceptance

PCM/CCM IMPLEMENTATION

- Assess patient population and number eligible for PCM or CCM services
- Determine ROI
  - Staffing needs and time
  - Consider outsourcing (care center model)
- Become familiar with requirements
- Determine software needs (e.g., EHR capable or not capable?)
- Determine reimbursement workflows
- Educate staff
- Monitor for usage and compliance

QUESTIONS?

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