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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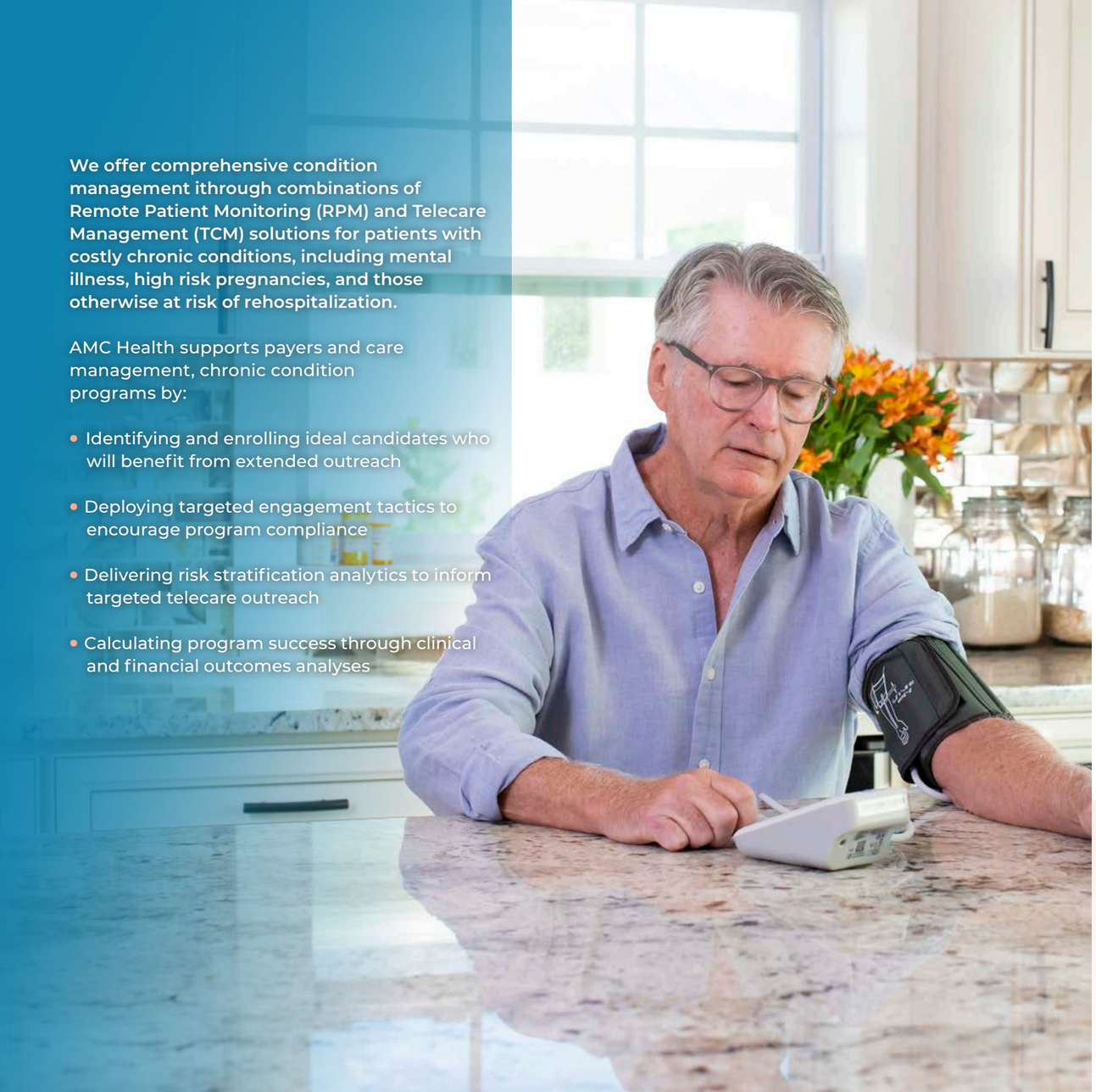
AMC Health provides end-to-end Virtual Care including Telehealth and Remote Patient Monitoring (RPM) solutions. We build actionable, real-time communication bridges between patients and their care teams to provide access to care for everyone living with chronic conditions and to enable and empower them to live healthier, more independent lives in the comfort of their own homes.



We offer comprehensive condition management ithrough combinations of Remote Patient Monitoring (RPM) and Telecare Management (TCM) solutions for patients with costly chronic conditions, including mental illness, high risk pregnancies, and those otherwise at risk of rehospitalization.

AMC Health supports payers and care management, chronic condition programs by:

- Identifying and enrolling ideal candidates who will benefit from 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

PAYERS

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

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

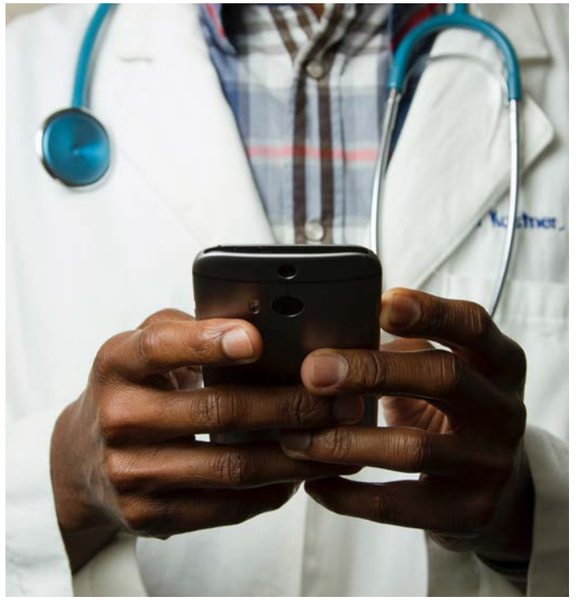
PROVIDERS

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.



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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.

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 18 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

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.

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.

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

Our 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.

CUSTOMIZED SOLUTION DESIGNED FOR VETERANS

Customized Chronic, Acute, Behavioral and Mental Health Conditions

- Bipolar Disorder
- Chronic Kidney Disease
- Cirrhosis
- Congestive Heart Failure
- COPD
- Coronary Artery Disease
- COVID-19
- Dementia
- Depression
- Prediabetes
- Diabetes
- HIV
- Hypertension/Hypotension
- Infectious Disease Quarantine
- Infectious Illness
- LAMP (Low ADL Monitoring Program)
- Multiple Sclerosis
- Pain Management
- Palliative Care
- Psychotic Disorder
- PTSD
- Sleep Apnea
- Sleep Maintenance
- Stable and Able
- Substance Use Disorder
- Tobacco Cessation
- VA Weight Management

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

CLINICAL BENEFITS OF REMOTE PATIENT MONITORING (RPM)

72% Sustained hypertension control at 18 months

81% Sustained improvement in glycemic control

50% Reduced probability of 30-day readmissions

1.8pts Average reduction in A1c over 30 days

29% Average reduced risk of heart attacks

51% Average reduced risk of stroke

15mm Hg Average reduction in systolic pressure

3.3 to 1 Average return on investment

65% Average reduced risk of microvascular complications

28% Reduction in hospitalizations

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

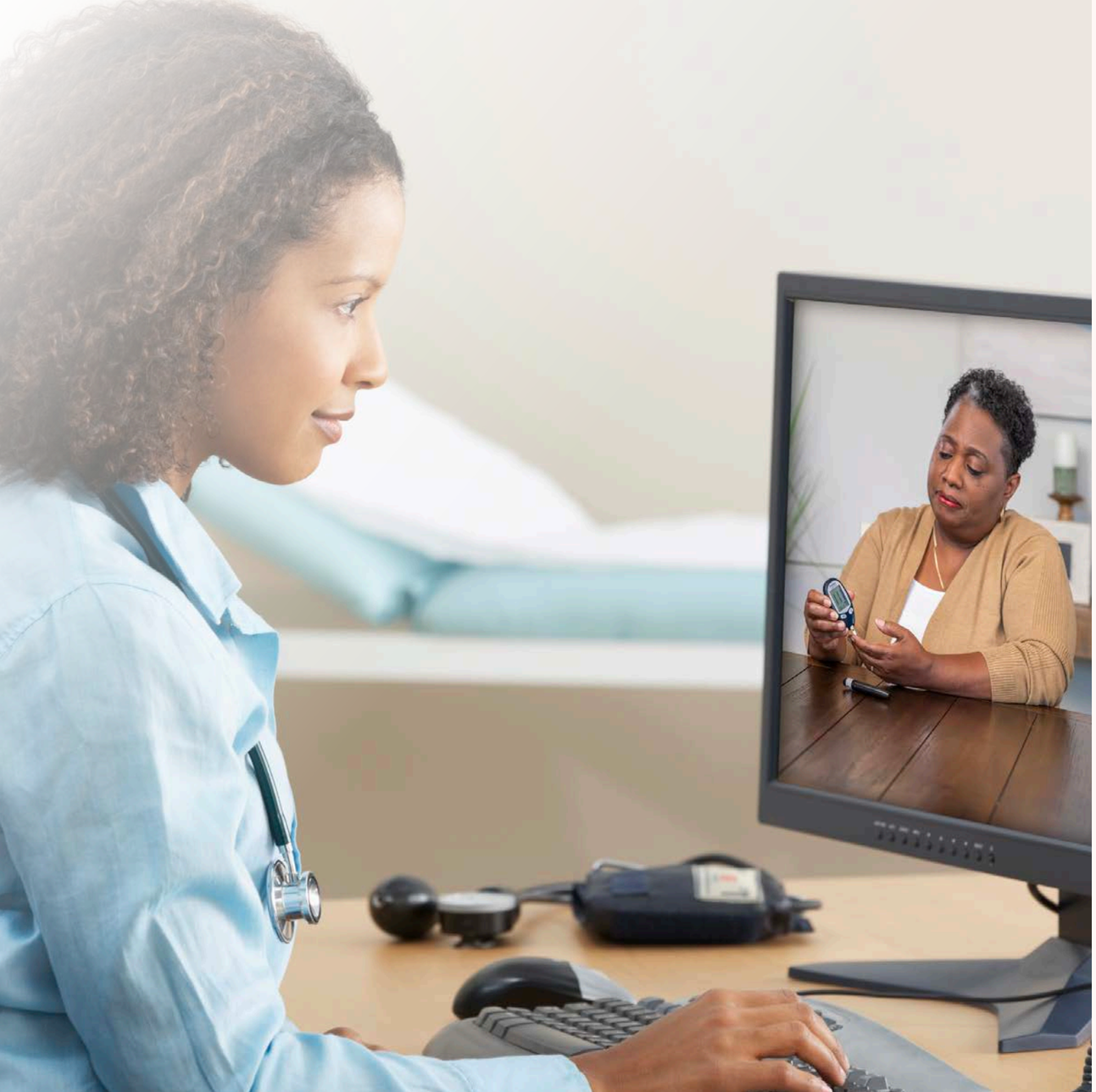
Engagement
Clinical support, participant enrollment, evaluation and SDoH gap identification

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



WHY CHOOSE AMC HEALTH AS YOUR PARTNER IN RPM?

20 years as the leader in RPM

Broadest offering of virtual care solutions and devices

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

Heart Failure | Diabetes

Cancer

Hypertension/Hypotension
CAD + CKD

Preventable ED
and Hospitalization Reduction

Asthma & COPD

HIV

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Conditions Monitored by RPM and Telehealth

Mental Health, Depression
and Generalized Anxiety Disorder

Medication Reconciliation

At-Risk Maternity |
Post-NICU Monitoring

Wound
Management

Wellness | Health Education

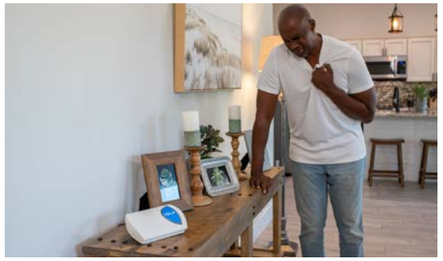
Post-Discharge
Readmission Prevention

HEART FAILURE

Heart failure is (HF) is a chronic and life-threatening condition that impacts more than 6 million people in the U.S and is a substantial burden on health care systems worldwide, contributing to high rates of hospitalizations, readmissions, and outpatient visits. It affects at least 26 million people worldwide, creating a global need for heart failure-related remote patient monitoring (RPM).

When a HF patient doesn't have a sound plan for consistent heart monitoring, they are at increased risk of their condition steadily worsening. In the worst-case scenarios, congestive heart failure leads to severe organ damage and death.

RPM empowers patients to improve self-management of their health and become an active participant in their health. RPM provides a more holistic view of a patient's health over time, increases the visibility of a patient's adherence to a treatment, and enables timely intervention before a costly episode of care.



FEATURES

- *Earlier identification of decompensation*
- *Better adherence to lifestyle changes and medication*
- *Early interventions (such as diuretic dosage changes) that reduce the need for hospitalization*
- *Reduced Hospitalization*
- *Improved health literacy*
- *Monitoring adaptive to your lifestyle (home, work, or travel)*
- *Vital signs monitoring*
- *Medication effectiveness*
- *Documented progress reports*
- *Personal triggers in real time which allows for sustainable lifestyle changes*
- *Condition specific questions*
- *Focused educational content*

3.3 to 1
Average return on investment

23%
Reduction in hospital readmissions

HYPERTENSION

Hypertension, also referred to as high blood pressure, can lead to severe complications and increases the risk of heart failure (HF), heart disease, stroke, and death. Hypertension is a contributing factor to heart disease. Implementing a RPM program with home telecare services and devices aligned to the participant's treatment plan can contribute to healthier lives, reduced healthcare costs, improved outcomes.

FEATURES:

- *Monitoring adaptive to your lifestyle (home, work, or travel)*
- *Vital signs monitoring*
- *Medication effectiveness*
- *Documented progress reports*
- *Personal triggers in real time which allows for sustainable lifestyle changes*
- *Condition specific questions*
- *Focused educational content*

72%
Sustained hypertension control at 18 months

15 mm Hg
Average reduction in systolic pressure

29%
Average reduced risk of heart attacks

25%
Average reduced risk of stroke

DIABETES

Diabetes is a condition that impairs the body's ability to produce and process blood glucose or blood sugar. Approximately 30M people, or 30% of the U.S. population at least 18 years old, have diagnosed and undiagnosed diabetes.

Diabetes can lead to a buildup of sugars in the blood, which can increase the risk of dangerous complications, including stroke, heart disease, kidney disease, liver disease and arrhythmias.

RPM empowers patients to improve self-management of their health and become an active participant in their health.

Clinicians can improve their relationships, and improve the experience of, their patients by using the data sent to them via RPM to develop a personalized care plan and to engage in joint decision making to help improve outcomes.

FEATURES:

- *Diet & Lifestyle Modification*
- *Blood Glucose Monitoring*
- *Blood Pressure Monitoring*
- *Medication adherence and effectiveness*
- *Documented progress reports*
- *Personal triggers in real time which allows for sustainable lifestyle changes*
- *Condition specific questions*
- *Focused educational content*

1.8 pts
Average reduction in A1c over 30 days

71%
Hypertensive BP targets within 6 mo.

BEHAVIORAL HEALTH

AMC Health's AMCareAtHome App provides the latest in RPM that keeps your patients/ members connected with their clinical team.

Behavioral Health programs available:

Depression | Bi-polar
Post-traumatic stress syndrome
General Anxiety Disorder

FEATURES:

- *2-way messaging*
- *Daily Surveys - Assessment tools (such as the PRIME-MD depression screening instrument). For patients not at immediate risk of decompensation or high utilization, a telephonic IVR-only regime can be an extremely effective low-cost screening, monitoring and health literacy support solution.*
- *Behavioral Health assessments and reassessments*
- *Adherence Monitoring*

- *Biometric Metabolic monitoring for SGIs*
- *Televideo - HIPAA and HiTECH secure televideo*
- *Remote provision of psychosocial therapies*
- *Focused educational content - Educational material for condition awareness and self-management, including rich video educational media*
- *Addressing Social Determinants of Health*
- *Video visits & Spanish language support*
- *Smart phone or tablet*

AT-RISK OBSTETRICS

AMC Health's Remote Maternity Care Program provides a tailored service to safely monitor mom and baby using our proven and trusted mobile devices. We help identify, predict, and prevent health risks.

Customized & Comprehensive Solutions Enable:

- *Early detection of risks during pregnancy, delivery & postnatal care*
- *Continuous monitoring associated with pregnancy problems, coexistent illnesses and age*
- *Easy to use Bluetooth peripherals and Bring Your Own Devices (BYOD)*
- *Educational materials and resources for enrolled patients*

At Risk Conditions

- *Gestational Diabetes and/or Pregnancy Induced Hypertension (PIH)*
- *Preeclampsia*
- *Hyperemesis Gravidarum (HG)*
- *Monitoring Underweight Pregnant Women*
- *Post-Partum Issues*

Pregnancies Not Flagged as High-Risk:

- *Routine reminders*
- *Brief, weekly health education sessions on nutrition, risk factors, exercise, etc.*

Hypertension During Pregnancy and Gestational Diabetes

Identified with Pregnancy Induced Hypertension (PIH), Preeclampsia or related diagnoses on claims or from the electronic health record (EHR), validated by prescribed medication and/or lab results

- *BMI ≥ 30*
- *First-time mothers*
- *Family history of PIH or Preeclampsia*
- *Women younger than 20 or older than 40*
- *Women carrying multiple fetuses*
- *Those with documented chronic hypertension or kidney disease before pregnancy*

POST-NICU

AMC Health provides Remote Patient Monitoring (RPM) solutions for newborns requiring extra support.

FEATURES:

- *Daily Vitals – Weight, Intake/Feeding*
- *Communication – Text Messages, Video-Connect, Educational Material & Surveys*
- *Health Trends – Tracks health trends over 7, 14-30 days*

ASTHMA

Asthma affects 6.1 Million children under age 18 and is **the leading chronic pediatric disease**. The US experiences $3 billion in losses due to missed work and school days, $29 billion due to asthma-related mortality, and $50.3 billion in medical costs on an annual basis.

The AMC Health RPM program utilizing the Propeller device makes managing asthma easier than ever before by tracking inhaler use and alerting to over- or under-use of controller and rescue medication. When combined with televideo, remote monitoring can foster better inhaler technique and rule it out as a factor in poor control. Propeller helps you and your members/patients understand what may be causing their symptoms, so they can live a more active life.

Our Asthma RPM program works alongside existing treatment plans to help patients/members:

- *Gain real insights into triggers*
- *Reduce the hassle of managing asthma*
- *Improve quality of life*
- *Share important information with member/patient and care team*

Asthma Outcomes

An asthma RPM program provides consistently higher levels of Medication Adherence leading to a reduced risk of asthma exacerbations. Patients with asthma expressed high levels of satisfaction with the RPM experience.

79% had fewer asthma attacks
50% more doses taken on schedule
50% more symptom-free days
57% fewer asthma related ED visits

Reduced Rescue Inhaler Usage

AMC Health's RPM program utilizing the Propeller device have demonstrated reductions in rescue inhaler use in a number of studies and populations. Reductions in rescue inhaler use can be associated with better asthma control, more days without symptoms and a better quality of life. In a clinical setting, mean daily rescue inhaler use was reduced by 84% over 12 months.

Reduced Healthcare Utilization

As users improve their medication adherence and asthma control, they may experience fewer hospitalizations and emergency department (ED) visits resulting in reduced healthcare costs.Over 12 months, ED visits were reduced by 53% and ED visits and hospitalizations were reduced by 57%.

COPD

Exacerbations of Chronic Obstructive Pulmonary Disease (COPD) represent a significant clinical problem, and are associated with decreased lung function, worsening quality of life and decreased physical activity levels, with even a single exacerbation having detrimental effects.

The AMC Health COPD RPM program utilizing the Propeller device makes managing COPD easier than ever before by tracking inhaler use and alerting to over- or under-use of controller and rescue medication. When combined with televideo, remote monitoring can foster better inhaler technique and rule it out as a factor in poor control. Propeller helps you and your members/patients understand what may be causing their symptoms, so they can live a more active life.

Our COPD RPM program works alongside existing treatment plans to help patients/members:

- *Gain real insights into triggers*
- *Reduce the hassle of managing asthma*
- *Improve quality of life*
- *Share important information with member/patient and care team*

Identification of COPD Patients at High Risk

Data from the platform may help identify patients at greater risk of a COPD exacerbation, allowing clinicians to intervene to prevent a hospitalization or ED visit.

Return on Investment

Research shows that uncontrolled asthma is expensive for patients, employers, payers and clinicians.

$1,349 per patient

12.7% Estimated annual excess direct costs associated with uncontrolled asthma

6.6 weeks Amount of work time lost compared with a person with controlled asthma

Outcomes for Patients with COPD (at 12 months of use)

Data from the platform may help identify patients at greater risk of a COPD exacerbation, allowing clinicians to intervene to prevent a hospitalization or ED visit.

Reduced Rescue Inhaler Usage

Reductions in rescue inhaler use may indicate more days without symptoms and a better quality of life.

Up to **2x** higher adherence
78% less rescue inhaler usage
35% reduction in COPD-related healthcare utilization
36% absolute improvement in rescue inhaler-free days
63% reduction in mean rescue inhaler puffs per day
73% reduction in nighttime rescue inhaler use

COVID-19 RPM INTEGRATION

AMC Health's virtual care, RPM and telehealth solutions are proven and customized to meet the needs of managing and monitoring patients in their own home, while enabling clinical teams to manage the unexpected surge of ED overflow and required premature patient discharges.

- *Fully scalable to meet short-term and long-term capacity needs*
- *At-home vital monitoring that enables hospitals to deploy required contingencies – with or without their homecare vendors*
- *Virtual care RPM (remote patient monitoring) that mitigates overtaxed resources*

What We Offer:

- *IVR survey ready for deployment and scalable across your entire population*
- *Immediately available and easily deployed private label IVR system capabilities*
- *Customized educational content*
- *Deploy AMC Health Clinical team support for alert response (optional)*
- *Proactive approach with tracking and reporting on calls deployed, answered, alerted*

How We Do It:

- *Processing of eligibility file in CareConsole; (standard HL7)*
- *Deploying educational IVR survey to every eligible member on file, 2 attempts per day for 2 days; or deploy across your entire population (repeatable upon request)*
- *Reporting on results including members who respond with "alert" type questions*
- *Optional service for AMC Health to triage alerts*

Member Support Tools:

- *COVID-19 Web Resources, Tools, Information and Links*
- *Teleconference Video: Conferencing to monitor, respond and track alerts*
- *COVID-19 Education: Print ready, customized, and sharable resources*

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Case Studies

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

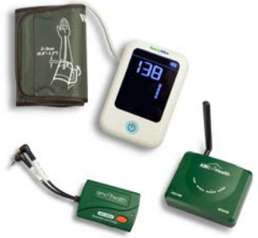
Type II Diabetes
Hypertension
Depression

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

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

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

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)

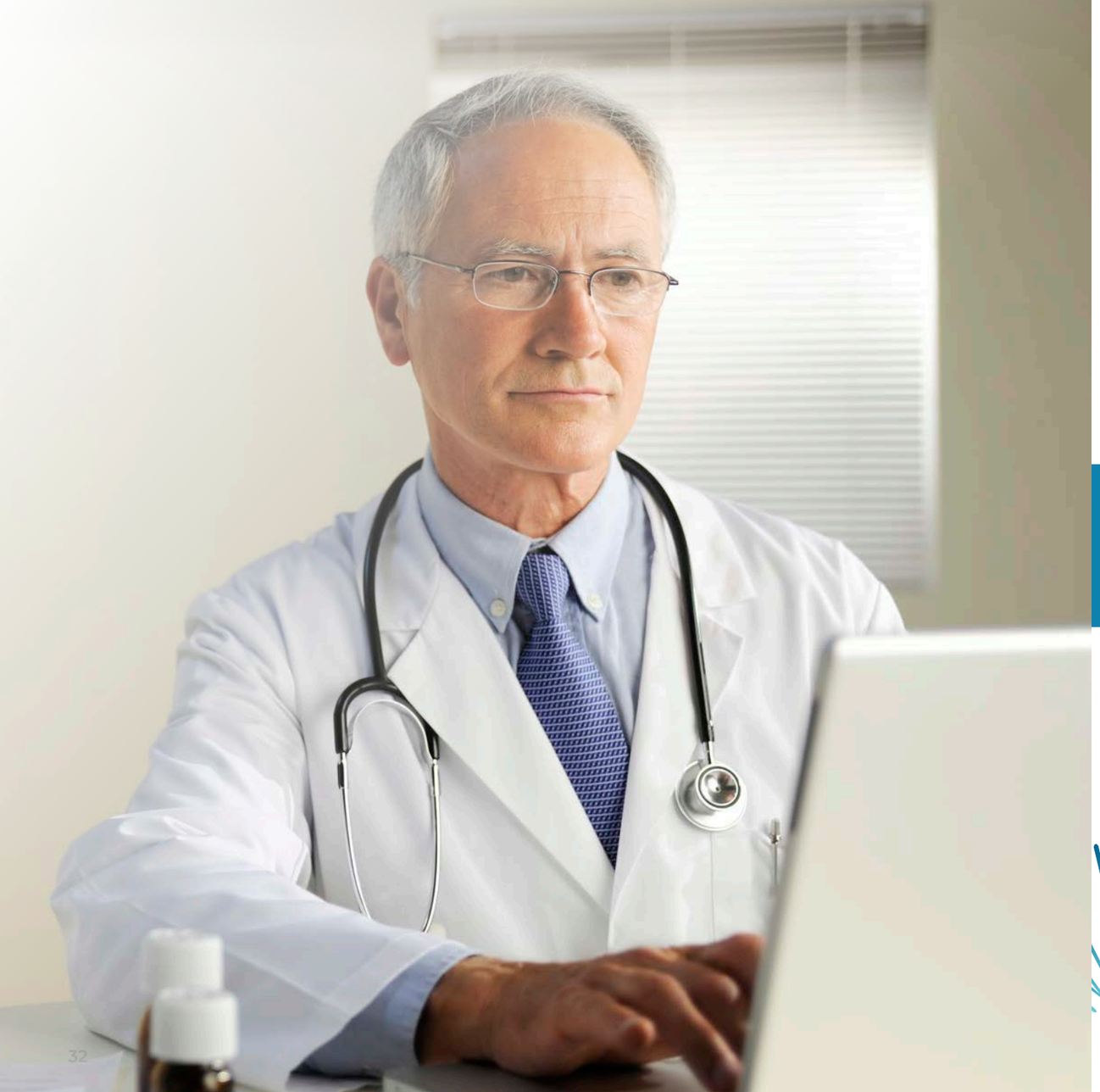
Case Study 4

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**



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CPT & RTM Codes

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 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).
**$19.19 per instance*
One time setup and education
(CMS regionally adjusted)

CPT CODE 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).

CHRONIC CARE RPM CODES

CPT CODE 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).
**$63.16 per patient/per month*
(CMS regionally adjusted)

CPT CODE 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).
**$50.94 per patient/per month*
(CMS regionally adjusted)

CPT CODE 99458
ADD'L INTERVENTIONS

Additional 20 mins of patient review and communications by physicians, QHCP's or clinical staff.
**$41.17 per patient/per month*
(CMS regionally adjusted)

CPT CODE 99458 - ADD'L INTERVENTIONS
Additional 20 mins of patient review and communications by physicians, QHCP's or clinical staff.
**$41.17 per patient/per month*
(CMS regionally adjusted)

CPT CODE 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.
**$41.17 (non-facility), $31.75 (facility-based)*
(CMS regionally adjusted)

CPT CODE 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.
**$37.94 (non-facility), $28.27 (facility-based)*
(CMS regionally adjusted)

CPT CODE 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.
**$91.77 (non-facility), $51.29 (facility-based)*
(CMS regionally adjusted)

CPT CODE 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.
**$43.97 (non-facility), $25.82 (facility-based)*
(CMS regionally adjusted)

SELF MEASURED BLOOD PRESSURE

CPT CODE 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.
**$11.51 (non-facility and facility-based)*
(CMS regionally adjusted)

CPT CODE 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.
**$15.00 (non-facility), $8.72 (facility-based)*
(CMS regionally adjusted)

TRANSITIONAL CARE MANAGEMENT AND BEHAVIORAL HEALTH CODES

CPT CODE 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.
**$207.96 (non-facility), $145.16 (facility-based)*
(CMS regionally adjusted)

CPT CODE 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.
**$281.59 (non-facility), $197.49 (facility-based)*
(CMS regionally adjusted)

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

CPT CODE 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.
**$46.76 (non-facility), $30.71 (facility-based)*
(CMS regionally adjusted)

CPT CODE 99492
COLLABORATIVE CARE MANAGEMENT SERVICES (COCM)

Initial psychiatric CoCM services treatment for the first 70 minutes in the first month.
**$154.23 (non-facility), $93.86 (facility-based)*
(CMS regionally adjusted)

CPT CODE 99493
ADDDITIONAL COLLABORATIVE CARE MANAGEMENT SERVICES (COCM)

Additional psychiatric CoCM services treatment for the first 60 minutes in the subsequent month.
**$154.23 (non-facility), $102.59 (facility-based)*
(CMS regionally adjusted)

CPT CODE 99494
ADDDITIONAL COLLABORATIVE CARE MANAGEMENT SERVICES (COCM)

If additional psychiatric CoCM services treatment is required, CPT 99494 covers additional 30-minute encounters in any calendar month.
**$58.97 (non-facility), $40.82 (facility-based)*
(CMS regionally adjusted)

**Based on MAC*

OVERVIEW OF THE 2022 REMOTE THERAPEUTIC MONITORING (RTM) CODES

The 2022 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.

FREQUENTLY ASKED QUESTIONS

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.

TESTIMONIALS

Geisinger

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)

HealthPartners

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)

OUR MISSION

AMC Health's mission is to create a world where personalized, life-changing healthcare services are provided to patients in their homes. Through our advanced analytics platform, these services reduce the access to care barriers, enhance patient care, and improve outcomes.

amc health

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