REAL REVENUE TODAY WITH POPULATION HEALTH

Brandy Hoell, MSN, RN, CCM
Chief Executive Officer & Partner
Trilogy Care Connect

Learning Objectives

- ❖ Attendee will have an understanding of expanded revenue opportunities in the ambulatory setting
- ❖ Attendee will be knowledgeable on the requirements for various population health revenue opportunities
- ❖ Attendee will understand ways to sustain and grow their ambulatory practice for population health
- ❖ Attendee will have the knowledge to evaluate the opportunities available in their clinical setting to promote a revenue opportunity that can be put into practice

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Real Revenue Today

- ❑ Population Health focused programs that bring real revenue today
    - ❑ Chronic Care Management
        - ❑ Monthly billable services
    - ❑ Transitional Care Management
        - ❑ Provider visits with increased reimbursement
    - ❑ Psychiatric Collaborative Care
        - ❑ Monthly billable services
    - ❑ Remote Patient Monitoring
        - ❑ Monthly billable services

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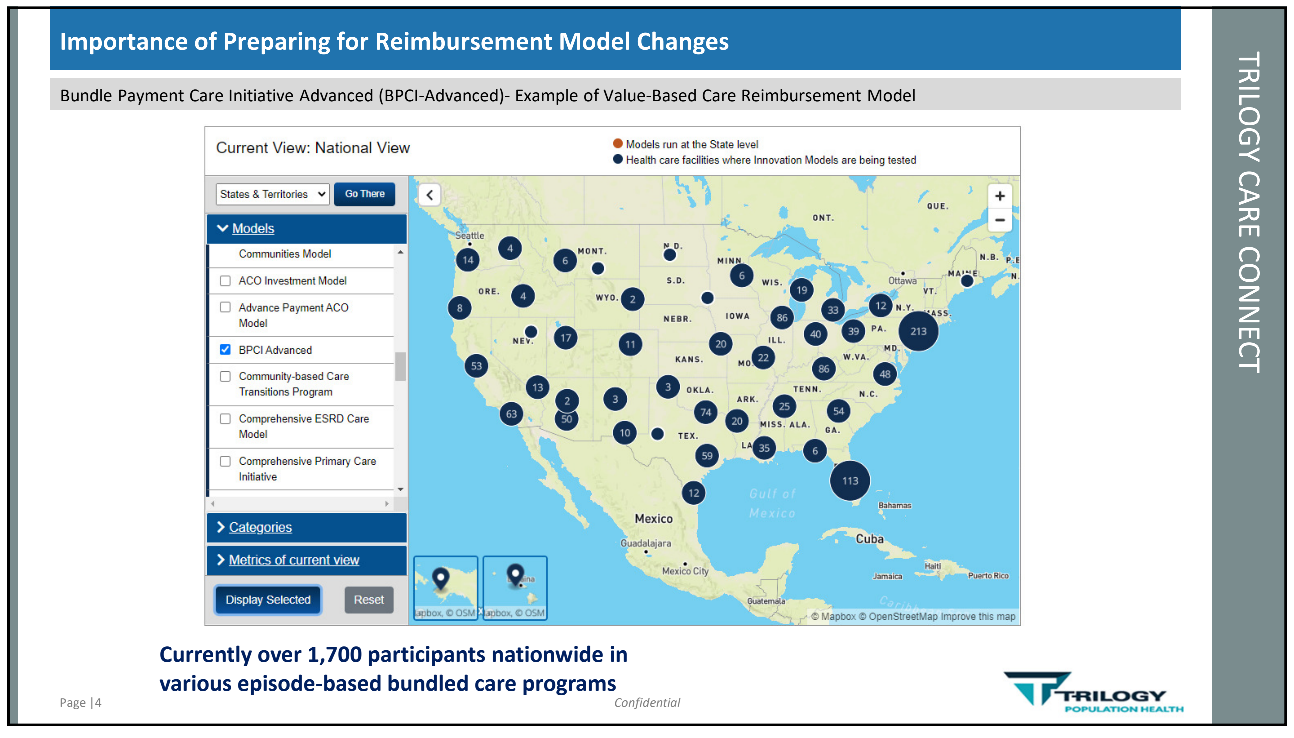

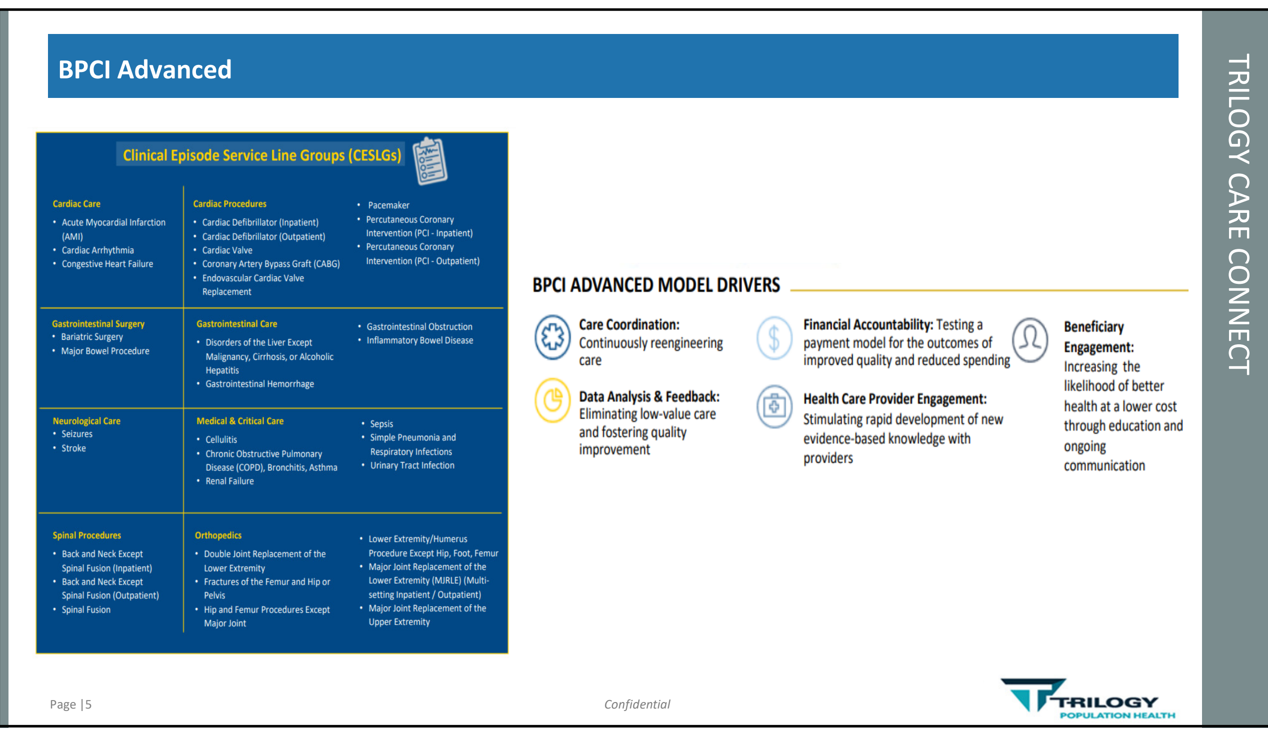

What Is Population Health?

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- National Institutes of Health defines population health as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group”
  - Take a look at your clinical practice and determine:
    - What population needs more focus?
      - Diagnosis specific
      - Social determinants of health (SDoH)
    - Are you receiving penalties related to quality outcomes?
      - VBP, HRRP, Payor specific penalties
    - Do you have a high ED utilization with specific patient groups?
      - Frequent utilizers of ED services rather than clinic visits
    - Do you have any value-based reimbursement models currently?
      - ACO, Bundled Payments, Risk-based contracts
    - Do you expect to enter any value-based reimbursement models in the future?
      - More payors are tying payments to outcomes

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State of Arkansas Access to Care Rankings

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Measure	Rating	Value	Rank
Clinical Care *	+	-0.586	43
Access to Care - Annual *	+	-0.681	43
Avoided Care Due to Cost	+	12.9%	44
Providers - Annual *	+	-0.940	47
Dental Care Providers	+	42.7	48
Mental Health Providers	+++	254.3	30
Primary Care Providers	+	216.1	44
Uninsured	++	9.1%	31
Preventive Clinical Services - Annual *	+	-0.611	41
Colorectal Cancer Screening	++	71.4%	35
Dental Visit	+	57.0%	50
Immunizations - Annual *	++	-0.420	38
Childhood Immunizations	++	73.6%	38
Flu Vaccination	+++	47.8%	22
HPV Vaccination	+	49.6%	44
Quality of Care - Annual *	++	-0.300	39
Dedicated Health Care Provider	++	76.3%	32
Preventable Hospitalizations	++	4,198	35

Source: America's Health Rankings 2021 Annual Report

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State of Arkansas Health Risk Rankings

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Measure	Rating	Value	Rank
Physical Health - Annual *	+	-1.082	46
Frequent Physical Distress	+	14.2%	48
High Health Status †	+	48.8%	46
Low Birthweight	++	9.2%	38
Low Birthweight Racial Disparity	+++	2.0	27
Multiple Chronic Conditions	+	13.8%	46
Arthritis †	+	29.5%	43
Asthma †	++++	9.1%	18
Cancer †	+	7.6%	44
Cardiovascular Diseases †	+	12.2%	48
Chronic Kidney Disease †	++	3.4%	38
Chronic Obstructive Pulmonary Disease †	+	9.0%	46
Diabetes †	+	13.2%	44
Risk Factors - Annual *	+	-1.130	41
High Blood Pressure †	+	41.0%	47
High Cholesterol †	+	37.4%	47
Obesity	+	36.4%	41

Source: America's Health Rankings 2021 Annual Report

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Arkansas Population Health Opportunity Takeaways

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- Arkansas Challenges
  - High prevalence of multiple chronic conditions (**Ranked 46th in the US**)
  - High prevalence of cigarette smoking (**Ranked 48th in the US**)
  - Low prevalence of physical exercise (**Ranked 44th in the US**)
  - High prevalence of depression (**Ranked 45th in US**)
  - High prevalence of frequent mental distress (**Ranked 50th in US**)

AMERICA'S HEALTH RANKINGS — **Arkansas** — 2021 ANNUAL REPORT

Flu Vaccination	Excessive Drinking
47.8% SINCE 2019, FLU VACCINATION* **INCREASED 14% FROM 42.1% TO 47.8%** *Percentage of adults	**16.1%** SINCE 2019, EXCESSIVE DRINKING* **INCREASED 8% FROM 14.9% TO 16.1%** *Percentage of adults
High Health Status	**Drug Deaths**
48.8% SINCE 2019, HIGH HEALTH STATUS* **INCREASED 18% FROM 41.4% TO 48.8%** *Percentage of adults	**13.2** SINCE 2019, DRUG DEATHS* **DECREASED 13% FROM 15.2 TO 13.2** *Deaths per 100,000 population

Source: America's Health Rankings 2021 Annual Report

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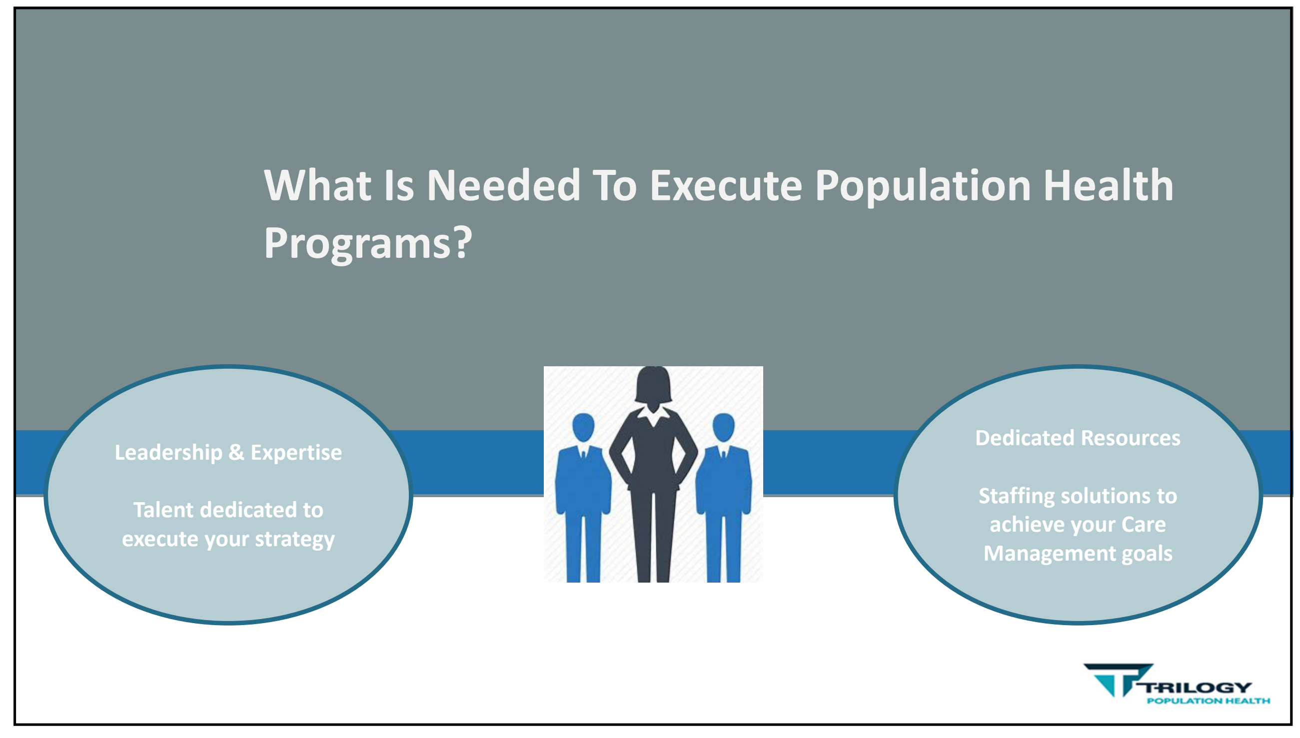

Leadership & Expertise to Execute Strategy

- Complete an assessment of organizational structure for population health alignment and readiness
- Determine the population and evaluate any risk stratification strategies
- Develop policies, procedures and job role design
- Evaluate any technology optimization or software to manage populations across the continuum of care

Dedicated Resources

- Interdisciplinary team assigned to your population - MUST be focused and a primary role
- Chronic Care Management
- Transitional Care Management
- Behavioral Health Integration Services
- Remote Patient Monitoring
- Condition Management
- Preventive Services
  - Care gaps
  - Annual wellness visits
  - Follow-up visits
  - Outreach campaigns

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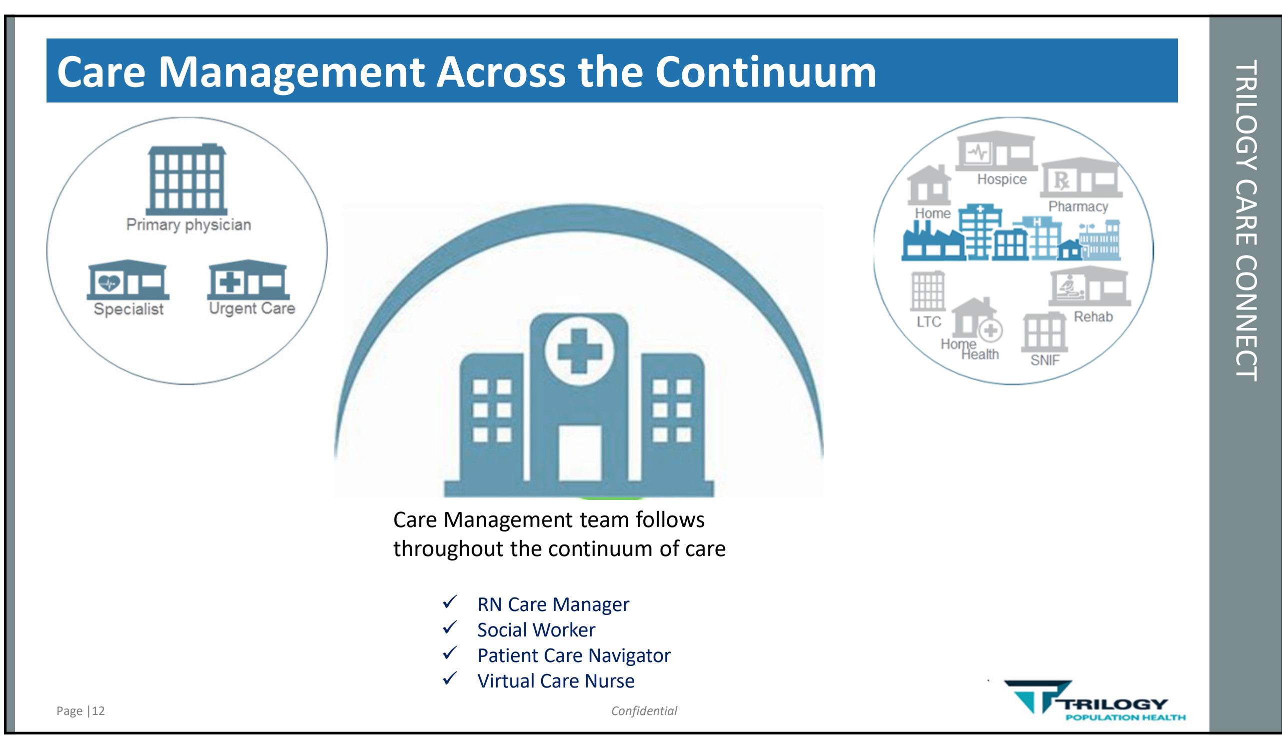
Care Management Across the Continuum



Care Management team follows throughout the continuum of care

- ✓ RN Care Manager
- ✓ Social Worker
- ✓ Patient Care Navigator
- ✓ Virtual Care Nurse

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Chronic Care Management (CCM) Services

Two-thirds of patients on Medicare have 2 or more chronic conditions

What is Chronic Care Management?

- CMS recognized the need for management of chronic conditions as a critical component of primary care services
  - In 2015 CMS began reimbursing for these services that are "incident to" a practitioner service
    - These services meet general supervision requirements and can be billed by practitioner when it is performed under his/her overall direction
  - Management of chronic conditions has been found to lead to better health outcomes and higher rates of patient satisfaction
  - Only one practitioner can be reimbursed each month for these services
  - CCM services can be reimbursed to a primary care provider or specialist
    - These services are billed by the practitioner and can be provided by clinical staff under the direction of the practitioner
    - Separate payment in addition to office visits
    - Billed based on time spent coordinating care and managing chronic conditions
    - Purpose is to provide support in between appointments and to help patients stay on track with their treatment plan for better health

How is Chronic Care Management Services Defined?

- Non-Face-to-Face Services provided to Medicare patients
  - Patients must have 1 or more chronic conditions that are expected to last at least 12 months and that place the patient at significant risk of death, acute exacerbation or functional decline
  - Billable services include:
    - Communication with the patient and/or caregiver
    - Coordination of care with other treating medical professionals
    - Medication management
    - Accessibility 24 hours per day to the clinical team
    - Care plan development and revision

Patient Eligibility for CCM Services (continued)

- Initiating Visit Required
  - Patients MUST have had a face-to-face visit with practitioner within the past 12 months prior to the start of CCM services
    - It is important to make sure patients have annual check-ups at a minimum
    - Case Managers coordinate office visits to promote routine primary care and follow-up
  - If a visit has not occurred in the past 12 months or for new patients:
    - CMS requires initiation of CCM services during a face-to-face visit
    - This is not part of CCM and is separately billable
    - Practitioners can bill G0506 during this visit as an add-on code for comprehensive assessment of and care planning for patients requiring chronic care management services (separately billable also from CCM services)

CCM Services Provider Billing

- Provider types that are able to bill for CCM Services:
  - Physicians
  - Physician Assistants
  - Clinical Nurse Specialists
  - Nurse Practitioners
  - Certified Nurse Midwives
  - Rural Health Clinics (RHCs)
  - Federally Qualified Health Clinics (FQHCs)
  - Hospitals
  - Critical Access Hospitals (CAHs)

Patient Eligibility for CCM Services (continued)

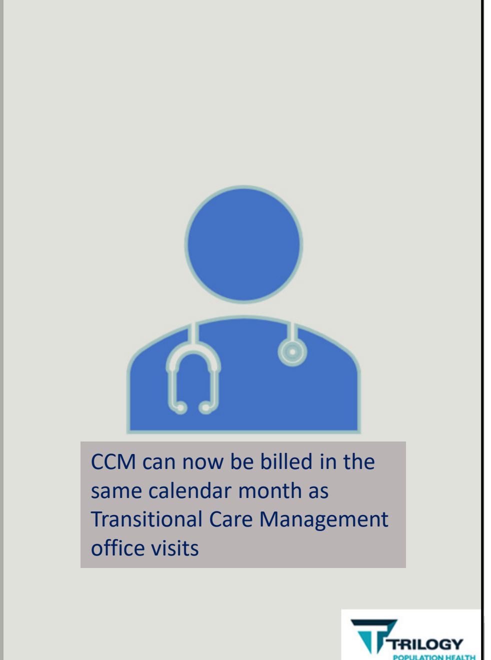
- Patient Consent is Required for CCM Services
  - Consent can be verbal or written - **MUST** be documented in the medical record
  - Consent must inform the following:
    - The availability of CCM services and applicable cost-sharing
    - That only one practitioner can furnish and be paid for CCM each calendar month
    - The right to stop CCM services at any time (effective at the end of a calendar month)

Although patient cost-sharing applies to the CCM service, most patients have supplemental insurance to help cover CCM cost sharing. Also CCM may help avoid the need for more costly services in the future by proactively managing patient health, rather than only treating severe or acute disease and illness.

Consent only needs to be obtained once PRIOR to starting CCM unless the patient changes practitioners that furnish CCM

Comprehensive & Transitional Care Management Services

- Systematic assessment completion
  - Physical, medical, functional and psychosocial needs
- Ensure timely receipt of all recommended preventive care services
  - Annual wellness exams, routine office visit needs, immunizations, lab/diagnostic routine services
- Medication reconciliation and management
  - Review of adherence and potential interactions
  - Oversight and promotion of self-management
- Coordinating care with community resources
  - Home and community-based care providers
  - Communication to and from community providers
- Manage care transitions between providers and settings
  - Referrals to providers, follow-up on ED visits and hospital discharge
- Exchange continuity of care documentation with providers
  - Share information with other providers involved in care



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Access to Care & Care Continuity Requirement

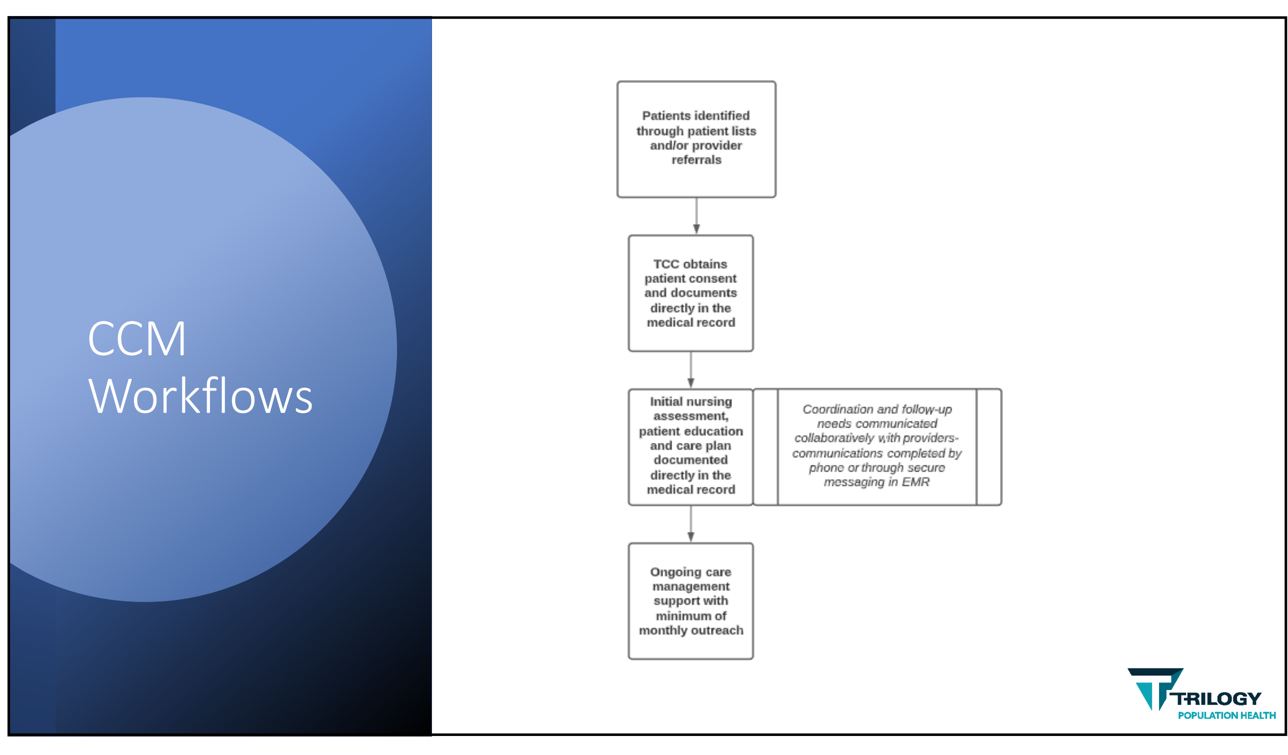
- Access 24/7 to practitioners or clinical staff is required
  - Provide patients with contact information to address any urgent needs regardless of day/time
  - Ensure continuity by scheduling routine appointments
  - Provide any enhanced opportunities for the patient to communicate electronically or telephonically with the practitioner
    - Telephone, secure messaging, internet, patient portal should be offered

CCM Services - Key Elements (Non-Complex and Complex CCM)

- Documentation
  - Record all interactions and time spent
    - Be specific in documentation
    - Document each individual contact and/or coordination service
  - Document the POC and list goals
    - Also document each POC initiation, update, monitoring or revision
  - Record demographics, problems, medications and allergies using EHR
  - Calculate total time for the calendar month to determine appropriate CPT for services provided

DOCUMENTATION IS KEY!!

- Examples of activities that are included in the time requirement:
  - Telephone communication
  - Review of medical records and test results
  - Self-management education and support
  - Coordination and exchange of health information with other providers
  - Can include any face-to-face time with patient or other health professionals
  - Sharing of health information including POC with patient or healthcare team
  - Managing care transitions - providing referrals and facilitating follow-up care
  - Coordinating with community providers


CCM
Workflows
Patients identified through patient lists and/or provider referrals
TCC obtains patient consent and documents directly in the medical record
Initial nursing assessment, patient education and care plan documented directly in the medical record
Coordination and follow-up needs communicated collaboratively with providers- communications completed by phone or through secure messaging in EMR
Ongoing care management support with minimum of monthly outreach
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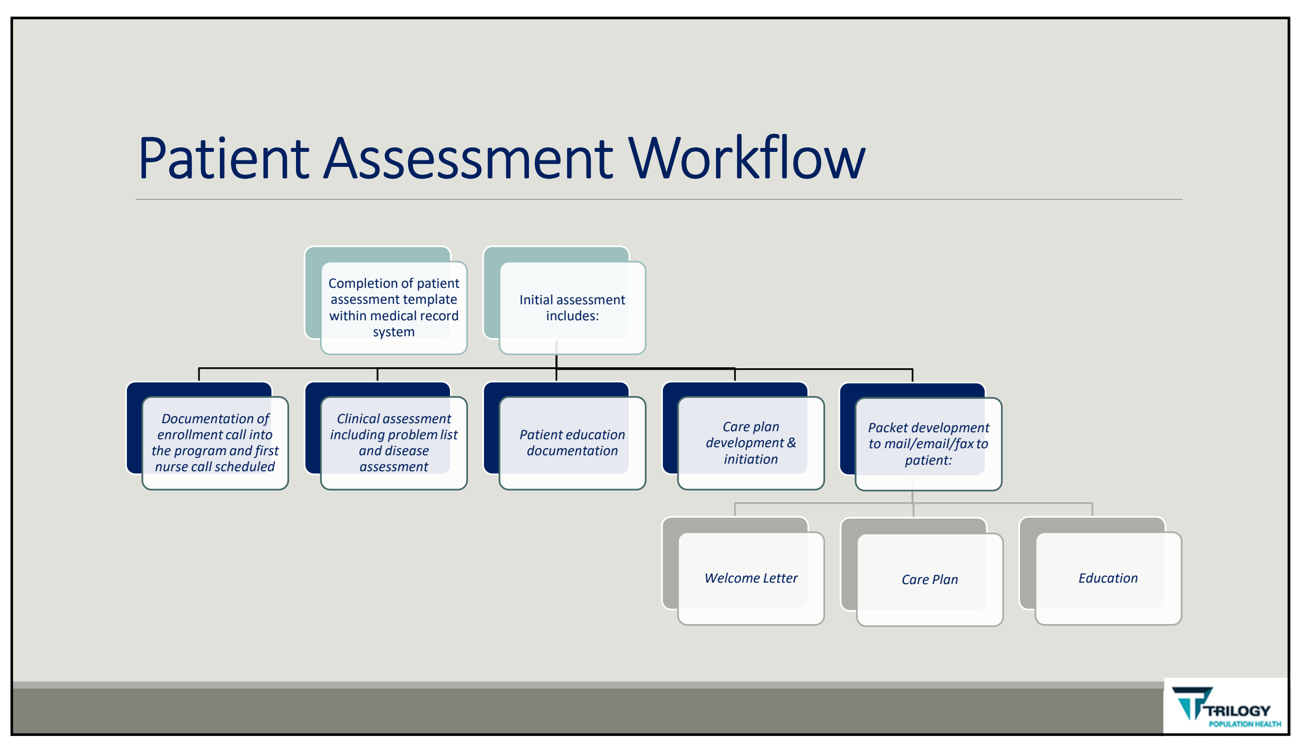
Patient Assessment Workflow
Completion of patient assessment template within medical record system
Initial assessment includes:
Documentation of enrollment call into the program and first nurse call scheduled
Clinical assessment including problem list and disease assessment
Patient education documentation
Care plan development & initiation
Packet development to mail/email/fax to patient:
Welcome Letter
Care Plan
Education
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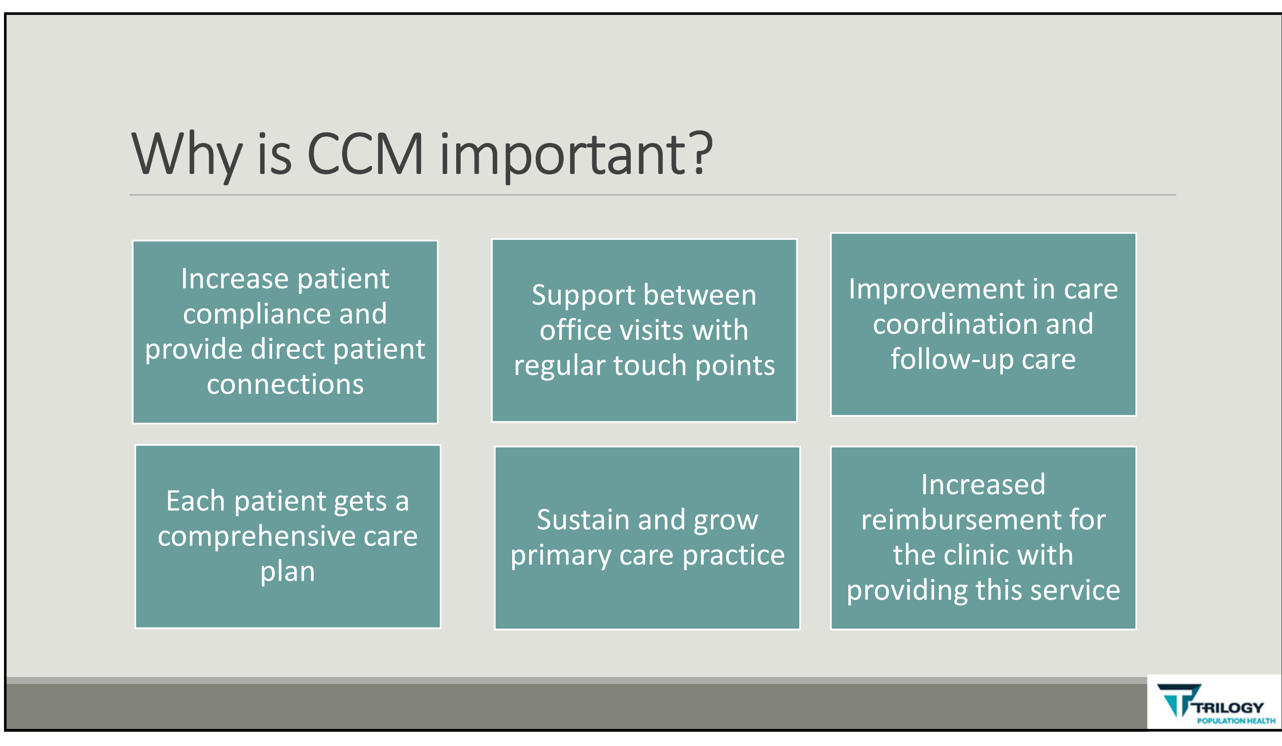
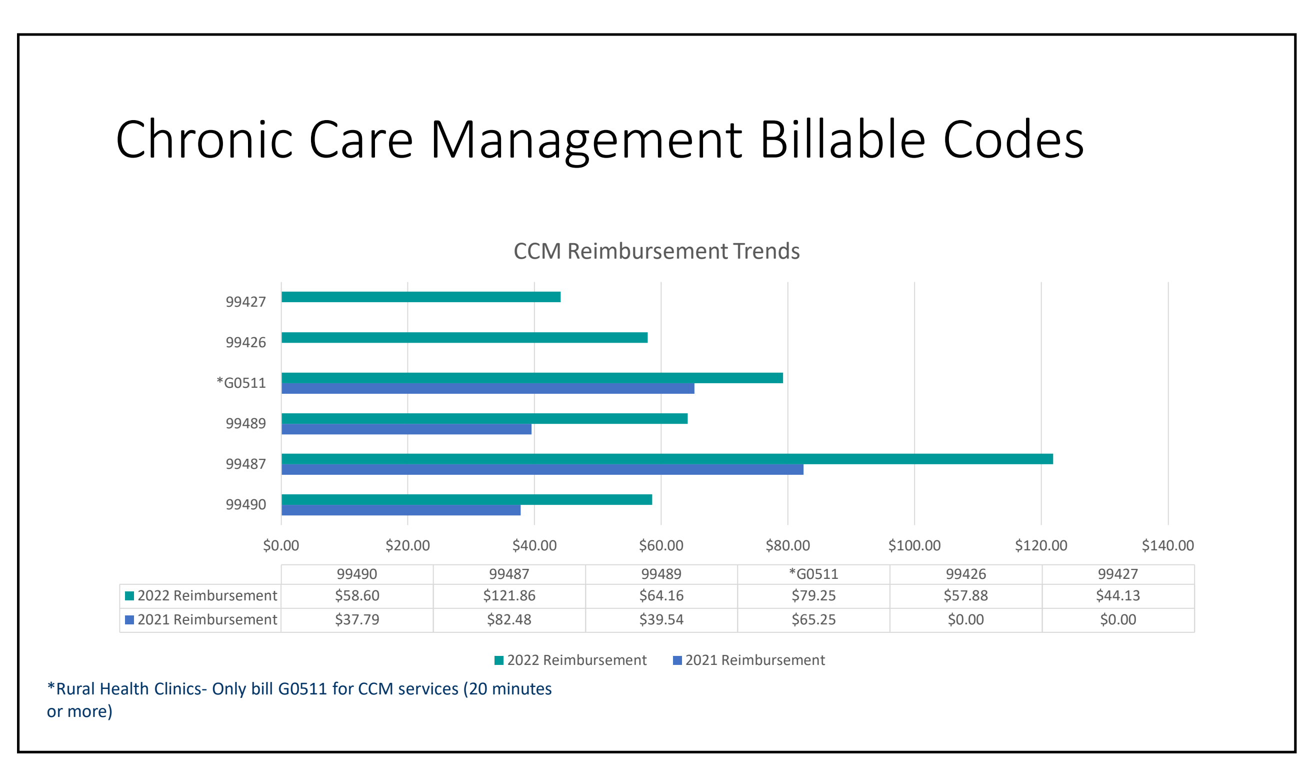
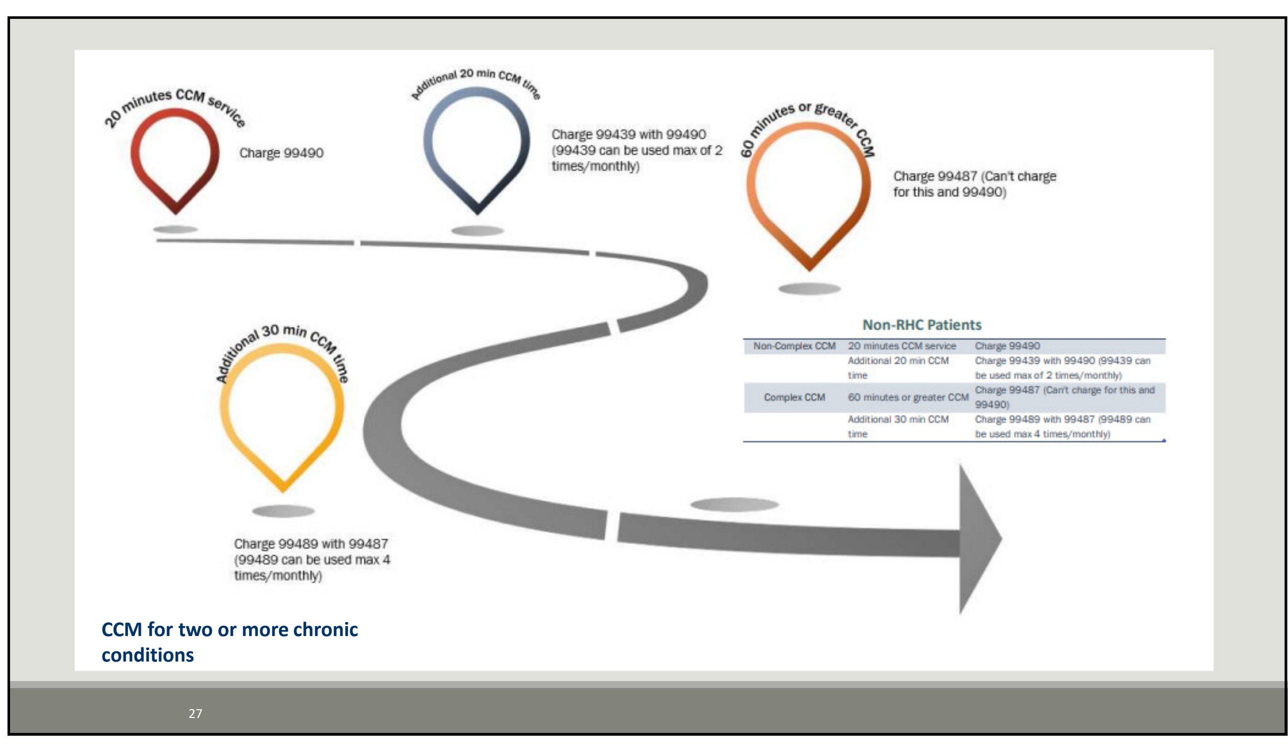
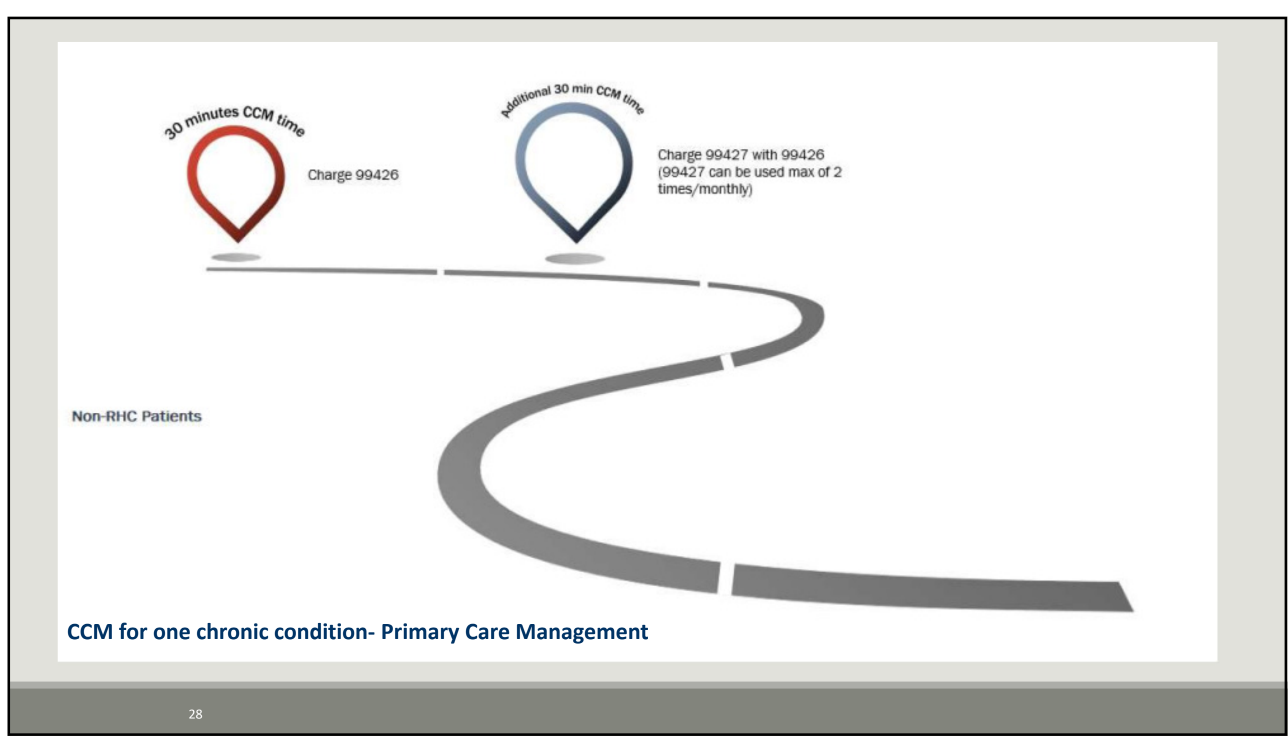


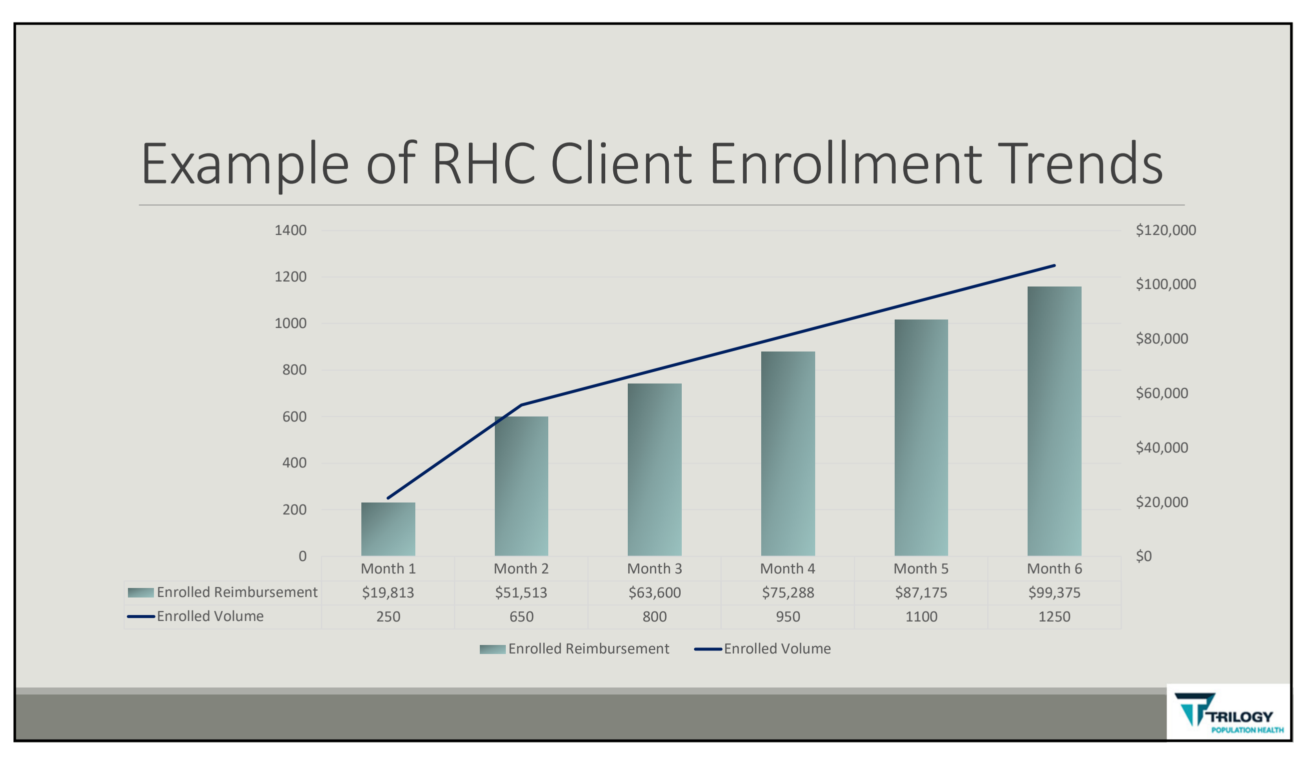


	99490	99487	99489	*G0511	99426	99427
2022 Reimbursement	$58.60	$121.86	$64.16	$79.25	$57.88	$44.13
2021 Reimbursement	$37.79	$82.48	$39.54	$65.25	$0.00	$0.00



Non-Complex CCM	20 minutes CCM service	Charge 99490
	Additional 20 min CCM time	Charge 99439 with 99490 (99439 can be used max of 2 times/monthly)
Complex CCM	60 minutes or greater CCM	Charge 99487 (Can't charge for this and 99490)
	Additional 30 min CCM time	Charge 99489 with 99487 (99489 can be used max 4 times/monthly)




Example of RHC Client Enrollment Trends
1400
1200
1000
800
600
400
200
0
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0
Month 1
Month 2
Month 3
Month 4
Month 5
Month 6
Enrolled Reimbursement
$19,813
$51,513
$63,600
$75,288
$87,175
$99,375
Enrolled Volume
250
650
800
950
1100
1250
Enrolled Reimbursement
Enrolled Volume
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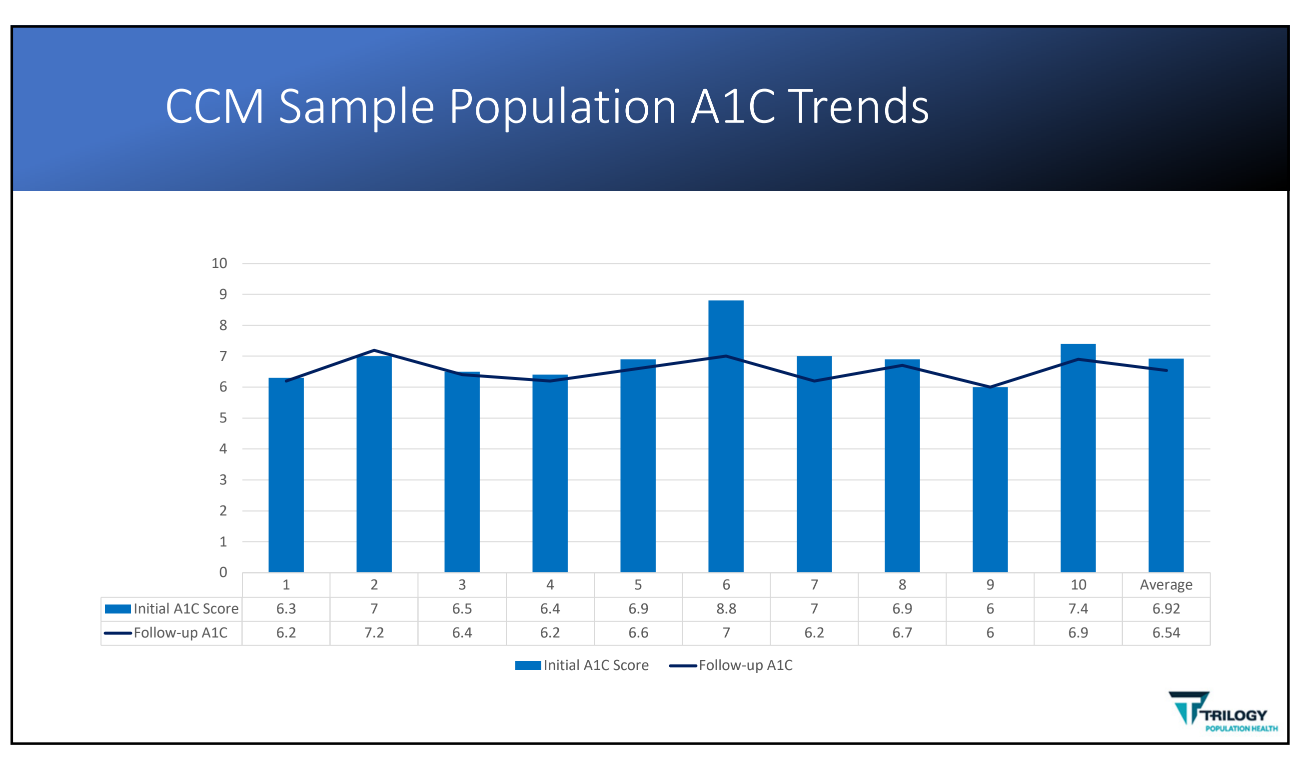
POPULATION HEALTH


CCM Sample Population A1C Trends
10
9
8
7
6
5
4
3
2
1
0
1
2
3
4
5
6
7
8
9
10
Average
Initial A1C Score
6.3
7
6.5
6.4
6.9
8.8
7
6.9
6
7.4
6.92
Follow-up A1C
6.2
7.2
6.4
6.2
6.6
7
6.2
6.7
6
6.9
6.54
Initial A1C Score
Follow-up A1C
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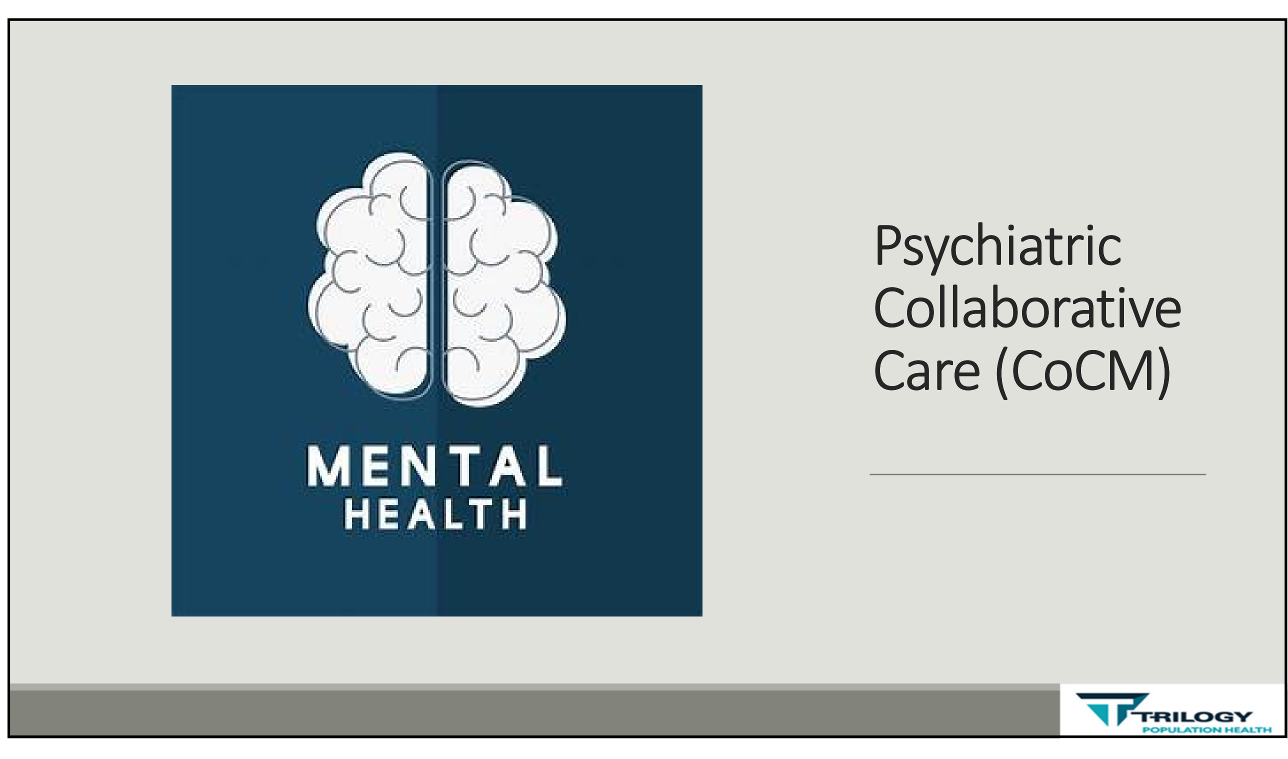
MENTAL
HEALTH
Psychiatric Collaborative Care (CoCM)
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POPULATION HEALTH

Collaborative Care with Behavioral Health
As few as 20% of patients started on antidepressant medications in usual primary care show substantial clinical improvements
Only 30-50% of patients have a full response to the first treatment plan
That means that 50-70% of patients need at least one change in treatment
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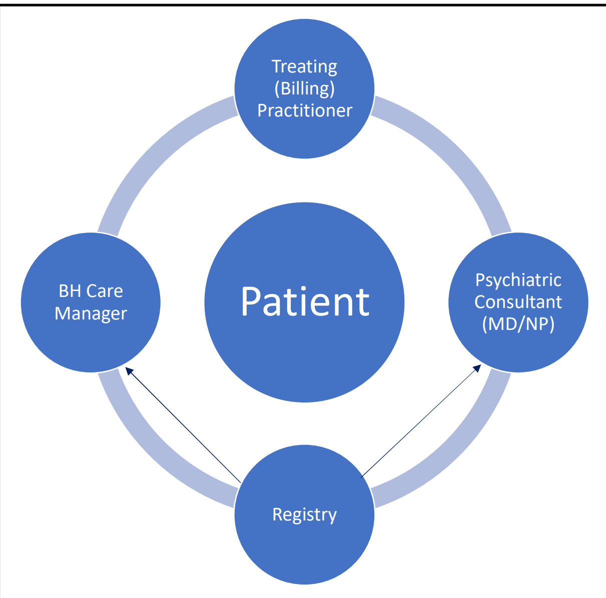


CPT codes 99492, 99493, and 99494 are used to bill for monthly services furnished using the Psychiatric Collaborative Care Model (CoCM), an approach to BHI shown to improve outcomes in multiple studies.

What is CoCM? This figure is a model of behavioral health integration that enhances "usual" primary care by adding two key services to the primary care team, particularly regarding patients whose conditions are not improving:

- Care management support for patients receiving behavioral health treatment
- Regular psychiatric inter-specialty consultation
- A team of three individuals provide CoCM: the Behavioral Health Care Manager, the Psychiatric Consultant and the Treating (Billing) Practitioner

Psychiatric Collaborative Care Services (CoCM)

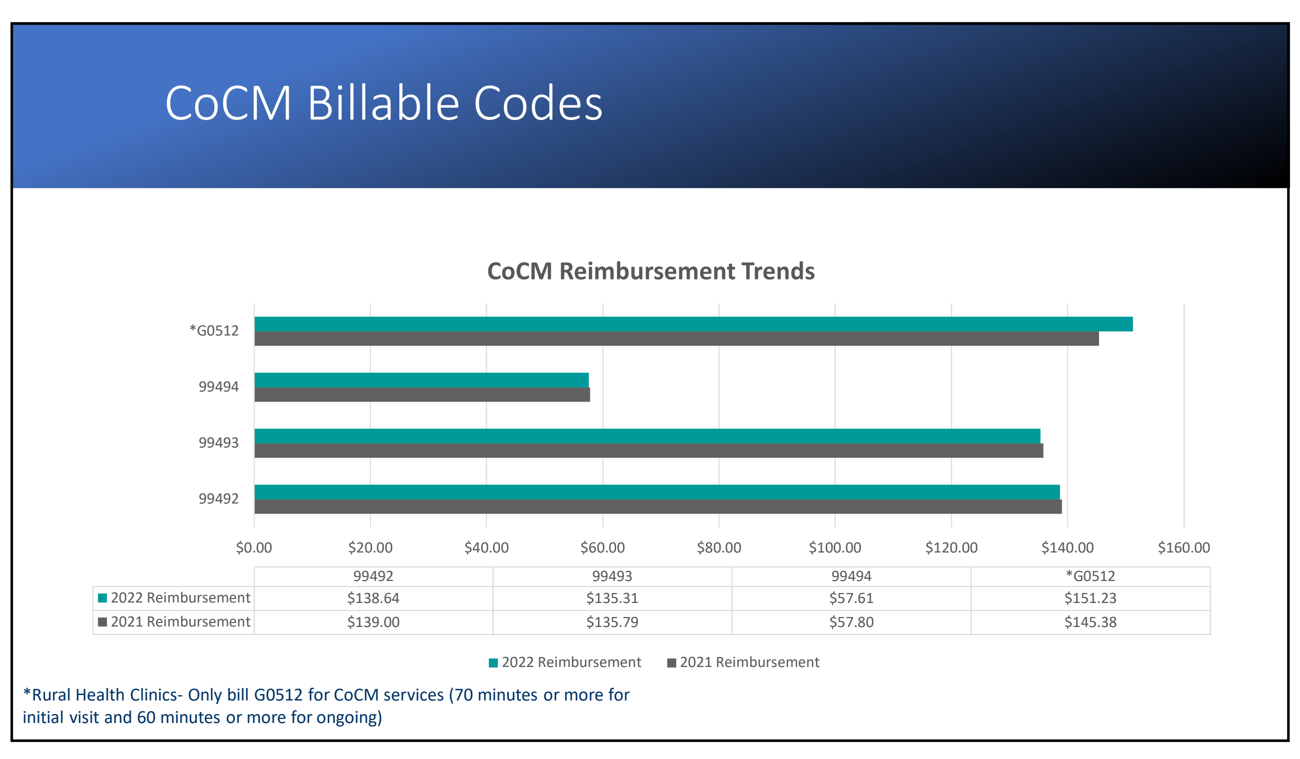
Service Components

- Initial assessment by the primary care team (billing practitioner and behavioral health care manager)
  - Initiating visit (if required, separately billed)
  - Administration of validated rating scale(s)
- Care planning by the primary care team, jointly with the beneficiary, with care plan revision for patients whose condition is not improving adequately. Treatment may include pharmacotherapy, psychotherapy, and/or other indicated treatments
- Behavioral health care manager performs proactive, systematic follow-up using validated rating scales and a registry

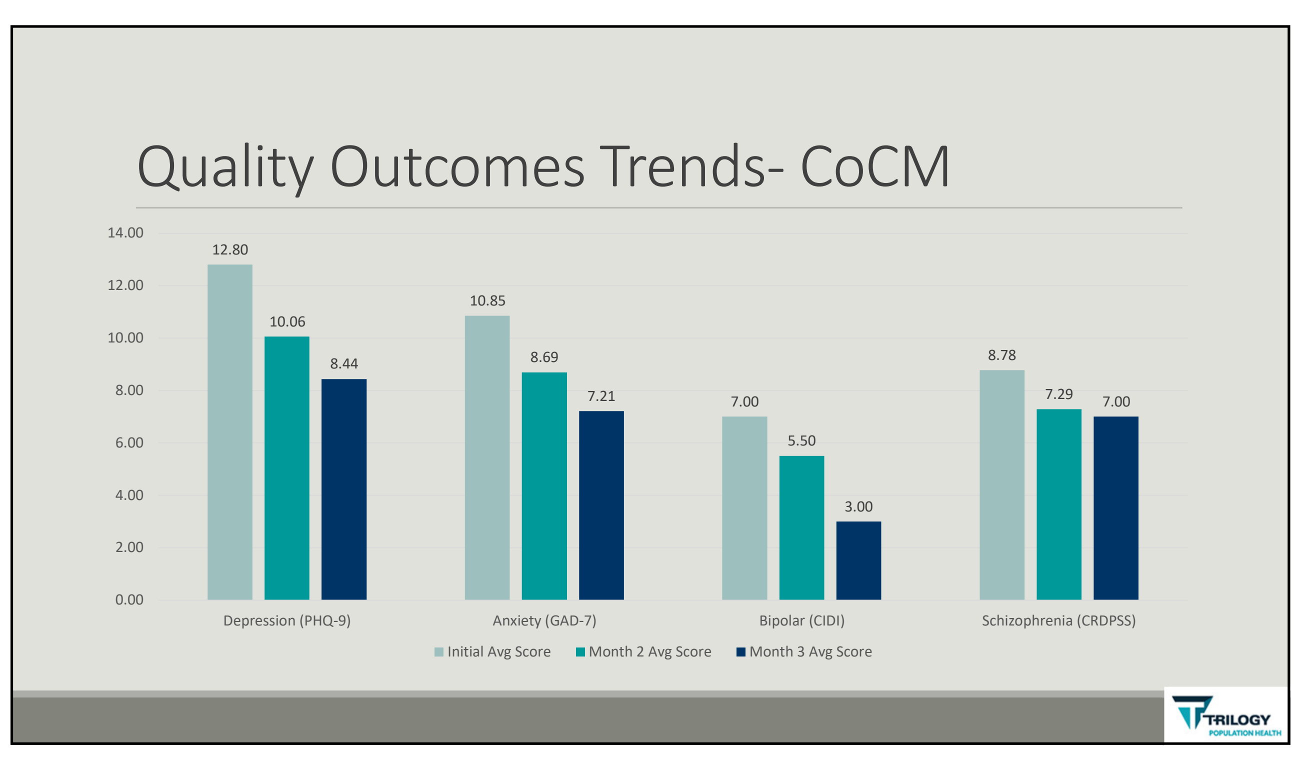
  - Assesses treatment adherence, tolerability, and clinical response using validated rating scales; may provide brief evidence-based psychosocial interventions such as behavioral activation or motivational interviewing
  - 70 minutes of behavioral health care manager time the first month
  - 60 minutes subsequent months
  - Add-on code for 30 additional minutes any month
- Regular case load review with psychiatric consultant:
  - The primary care team regularly (at least weekly) reviews the beneficiary's treatment plan and status with the psychiatric consultant
  - The primary care team maintains or adjusts treatment, including referral to behavioral health specialty care, as needed

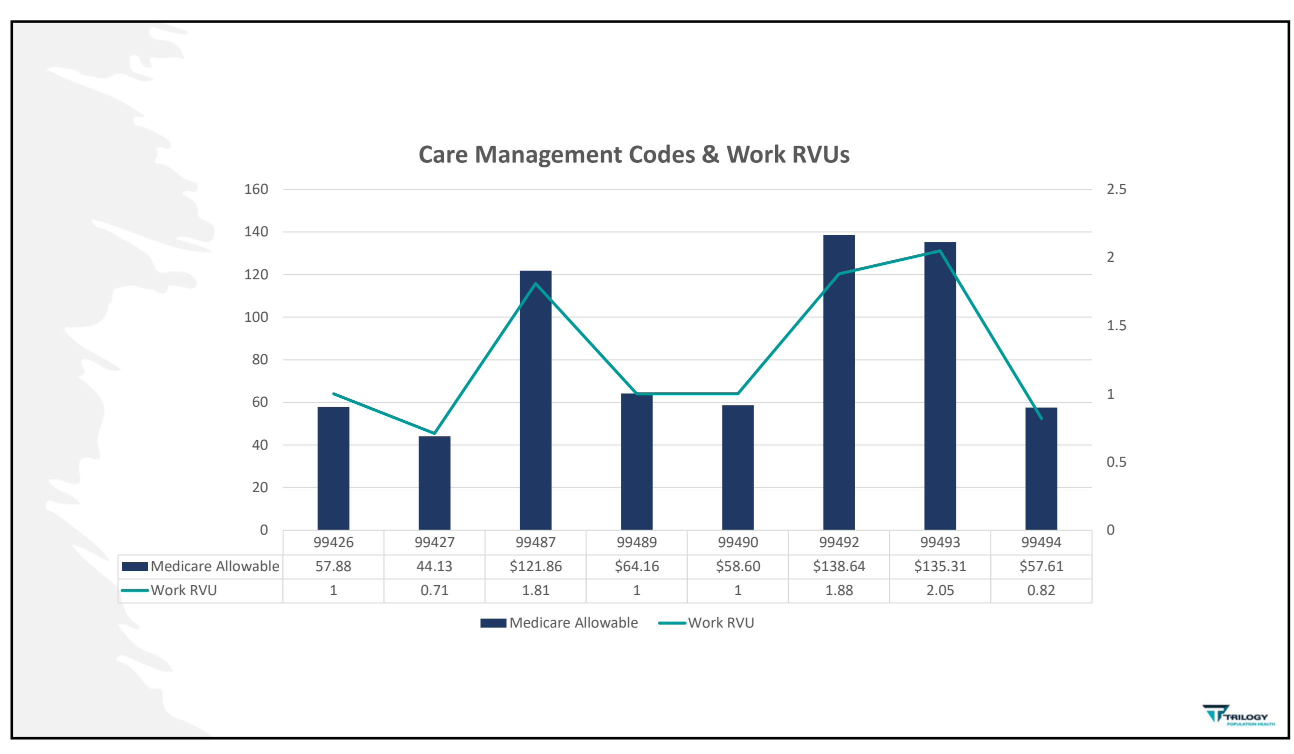
Psychiatric Collaborative Care Model Services (CoCM)

Service Requirements



	99492	99493	99494	*G0512
2022 Reimbursement	$138.64	$135.31	$57.61	$151.23
2021 Reimbursement	$139.00	$135.79	$57.80	$145.38





	99426	99427	99487	99489	99490	99492	99493	99494
Medicare Allowable	57.88	44.13	$121.86	$64.16	$58.60	$138.64	$135.31	$57.61
Work RVU	1	0.71	1.81	1	1	1.88	2.05	0.82

Transitional Care Management

What is Transitional Care Management?

- These are services during the transitional period following discharge from:
  - Inpatient
  - Observation
  - Skilled Nursing Facility
  - LTACH
  - Inpatient Psychiatric Hospital
  - Inpatient Rehab
  - Community Health Center
- The purpose of these services is to ensure appropriate hospital follow-up following discharge
  - These services cover a time period of 30 days starting the day of discharge
    - TCM services start on day of discharge and continues the next 29 days
- Patients must be discharged to one of the following community settings to qualify:
  - Home
  - Domiciliary
  - Rest Home
  - Assisted Living

Transitional Care Management

- **There are three components that MUST be completed within 30 days beginning the day of the actual discharge:**
  - Interactive Contact
  - Non-Face-to-Face Services
  - Face to Face Visit
- **The following providers can furnish TCM services:**
  - Physicians- any specialty
  - Non-physician practitioners (As legally authorized and qualified by scope of practice and state law)
    - Certified nurse midwives
    - Clinical Nurse Specialists
    - Nurse Practitioners
    - Physician Assistants

Non-Face-to-Face Services for Transitional Care

Services by Clinical Staff Under the Providers Direction	Services by Physician or Provider
• Communicate with agencies and/or community services • Provide education to the patient, family, caregiver to support self-management, independent living and ADLs • Assess and support treatment adherence and medication management • Medication reconciliation • Identify available community resources • Assist with accessing needed care and services	• Obtain and review discharge information • Review need for follow-up on pending tests and treatments • Interact with other healthcare professionals who will assume or reassume care of the patients system specific problems • Provide education to the patient, family and/or caregiver • Establish or re-establish referrals and arrange for needed community resources • Assist in scheduling required follow-up with community providers and services

TRANSITIONAL CARE MANAGEMENT SERVICES

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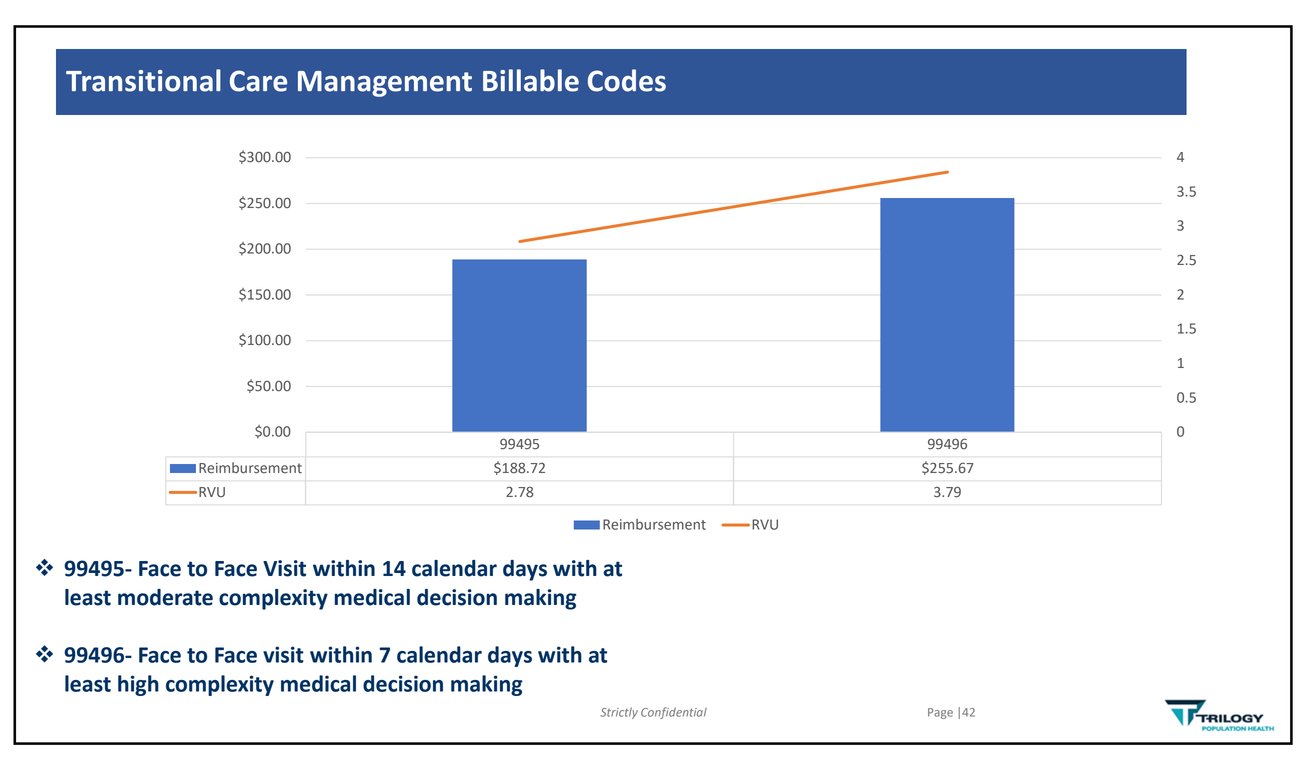
Transitional Care Management Billable Codes



	99495	99496
Reimbursement	$188.72	$255.67
RVU	2.78	3.79

- **99495- Face to Face Visit within 14 calendar days with at least moderate complexity medical decision making**
- **99496- Face to Face visit within 7 calendar days with at least high complexity medical decision making**

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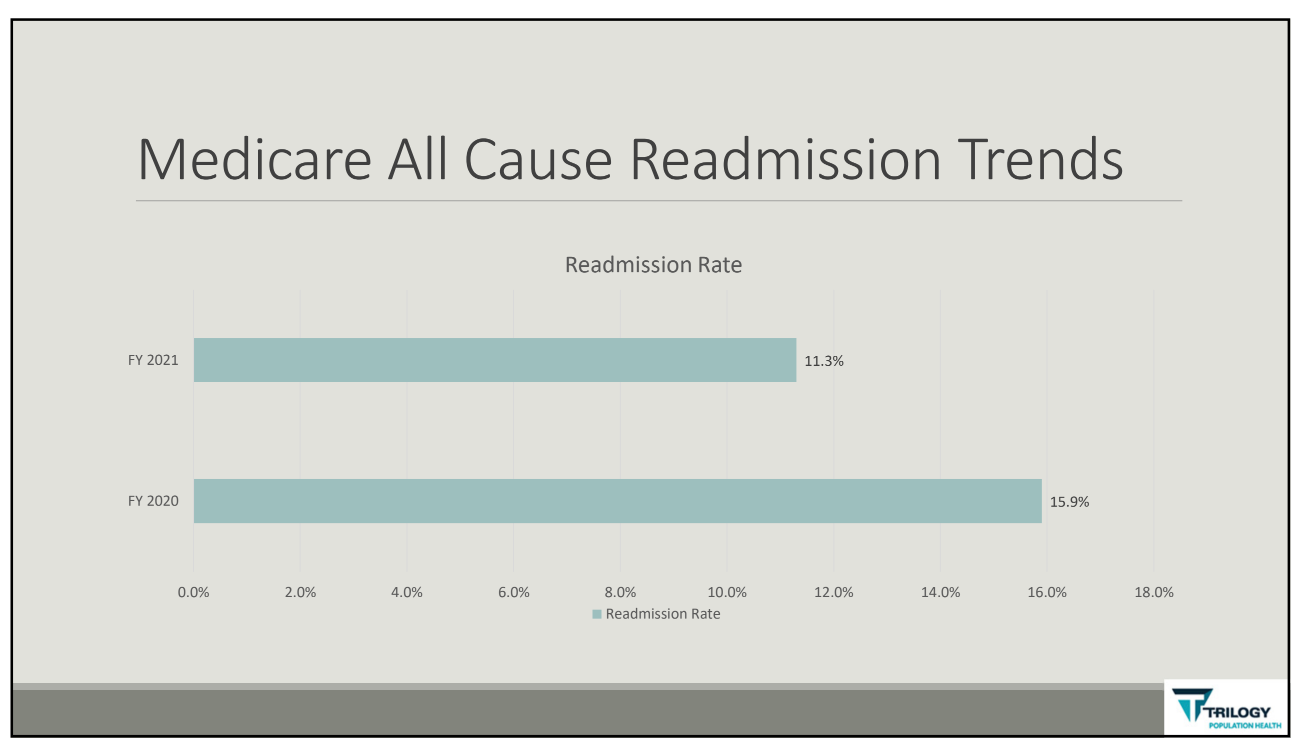

Medicare All Cause Readmission Trends
Readmission Rate
FY 2021
11.3%
FY 2020
15.9%
0.0%
2.0%
4.0%
6.0%
8.0%
10.0%
12.0%
14.0%
16.0%
18.0%
Readmission Rate
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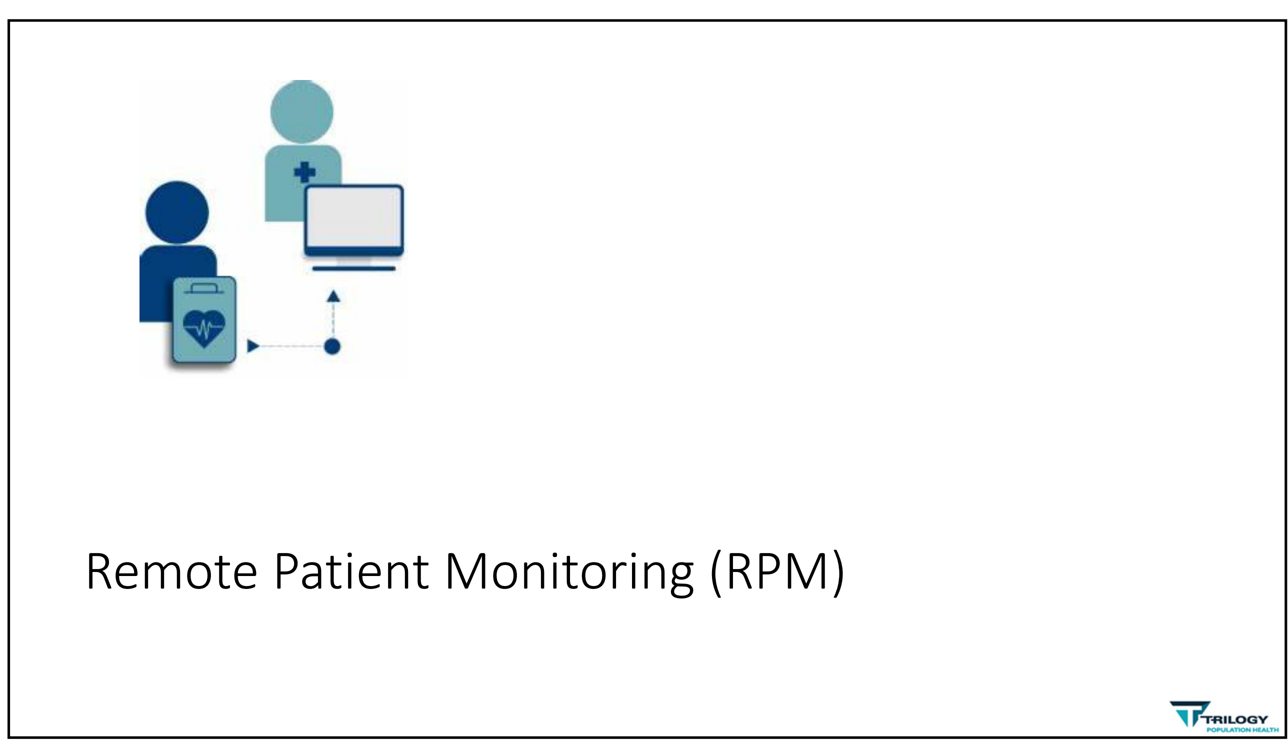
POPULATION HEALTH



Remote Patient Monitoring (RPM)
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POPULATION HEALTH

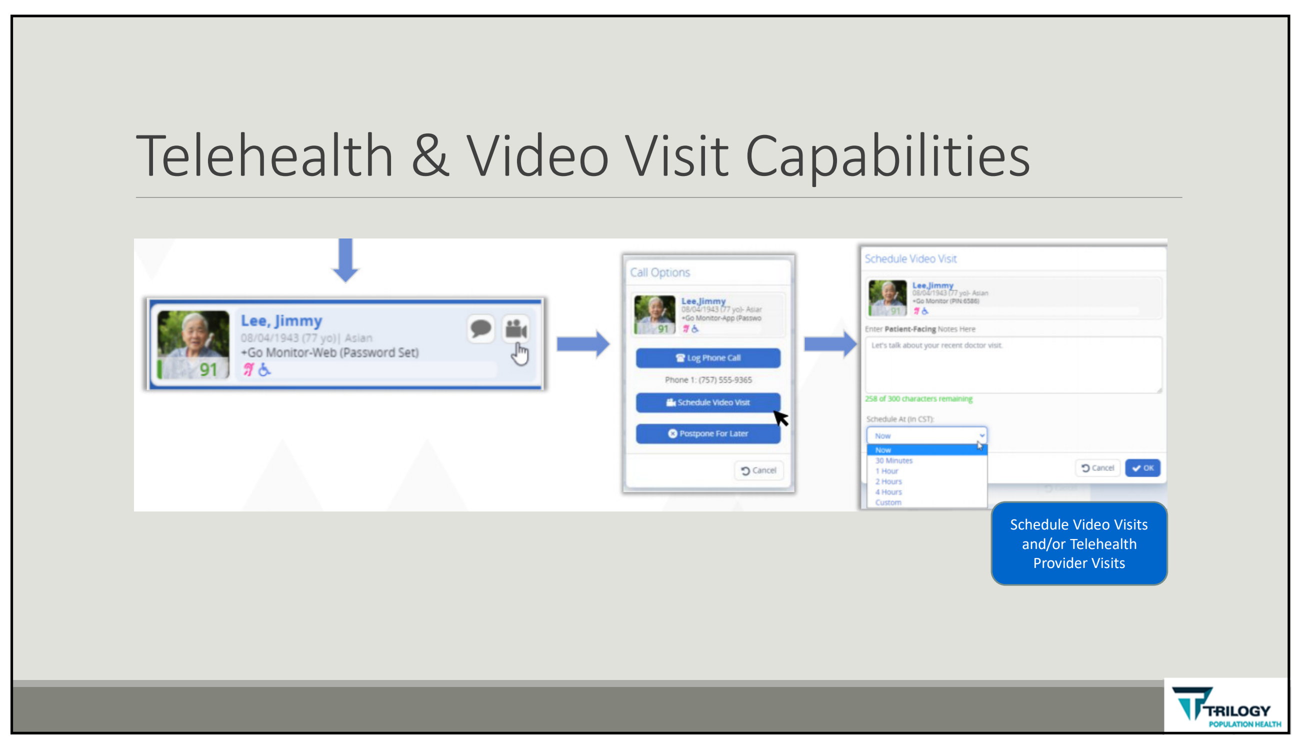
Requirements for RPM

- Patient Eligibility
  - Patients with chronic and acute conditions
  - Established patients
    - During PHE new patients are allowed
  - Patient consent
    - Required at the time RPM services are furnished
- Eligible Billing Providers
  - Providers that are eligible to furnish E&M services such as:
    - Physicians
    - Nurse Practitioners
    - Physician Assistants
  - Rural Health Clinics are not eligible for billing RPM

RPM Device Requirements

- The following are required to meet the billing requirements for monitoring services:
  - Satisfy the Food and Drug Administration's definition of a medical device defined by 201(h) of the Federal Food, Drug and Cosmetic Act
  - Automatic digital upload of patient physiologic data
    - Can not be patient reported
  - Considered reasonable and necessary for diagnosis and treatment of the patient illness or injury
    - Medical necessity
  - Be used to collect and transmit reliable and valid physiologic data
    - This allows the understanding of the patient's health status to develop and manage the plan of treatment
  - Examples of devices for RPM
    - Weights, blood pressure, heart rate, oxygen saturation, and blood glucose

Clinical RPM View
8 Items in 1 Page
Binnet, Brendan
Brown, Carter
Green, Jill
Kent, Martha
Liu, Anthony
TRILOGY
POPULATION HEALTH


Telehealth & Video Visit Capabilities
Lee, Jimmy
08/04/1943 (77 yo)| Asian
+Go Monitor-Web (Password Set)
Call Options
Log Phone Call
Phone 1: (757) 555-9365
Schedule Video Visit
Postpone For Later
Cancel
Schedule Video Visit
Enter Patient-Facing Notes Here
Let's talk about your recent doctor visit.
258 of 300 characters remaining
Schedule At (in CST):
Now
30 Minutes
1 Hour
2 Hours
4 Hours
Custom
Cancel
OK
Schedule Video Visits and/or Telehealth Provider Visits
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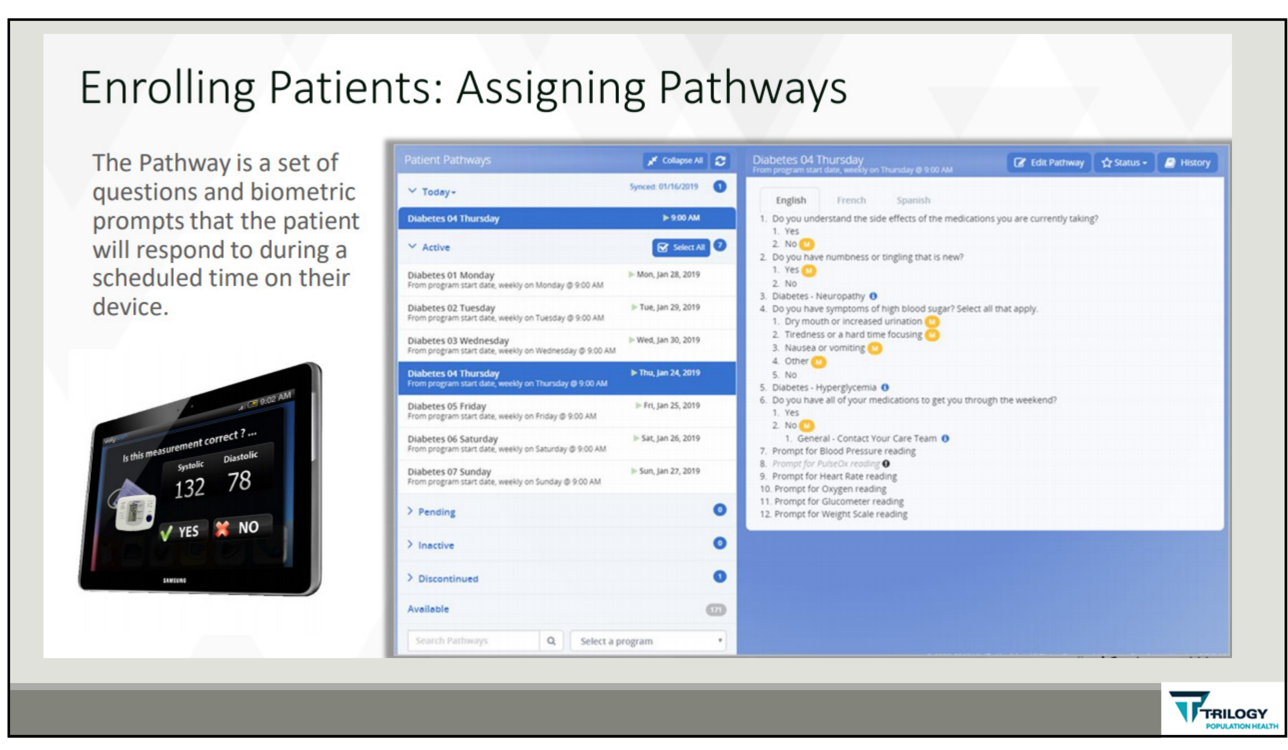
Enrolling Patients: Assigning Pathways
The Pathway is a set of questions and biometric prompts that the patient will respond to during a scheduled time on their device.
Is this measurement correct ? ...
Systolic
Diastolic
132
78
YES
NO
Patient Pathways
Diabetes 04 Thursday
Active
Diabetes 01 Monday
Diabetes 02 Tuesday
Diabetes 03 Wednesday
Diabetes 04 Thursday
Diabetes 05 Friday
Diabetes 06 Saturday
Diabetes 07 Sunday
Pending
Inactive
Discontinued
Available
English
French
Spanish
1. Do you understand the side effects of the medications you are currently taking?
2. Do you have numbness or tingling that is new?
3. Diabetes - Neuropathy
4. Do you have symptoms of high blood sugar? Select all that apply.
5. Diabetes - Hyperglycemia
6. Do you have all of your medications to get you through the weekend?
7. Prompt for Blood Pressure reading
8. Prompt for PulseOx reading
9. Prompt for Heart Rate reading
10. Prompt for Oxygen reading
11. Prompt for Glucometer reading
12. Prompt for Weight Scale reading
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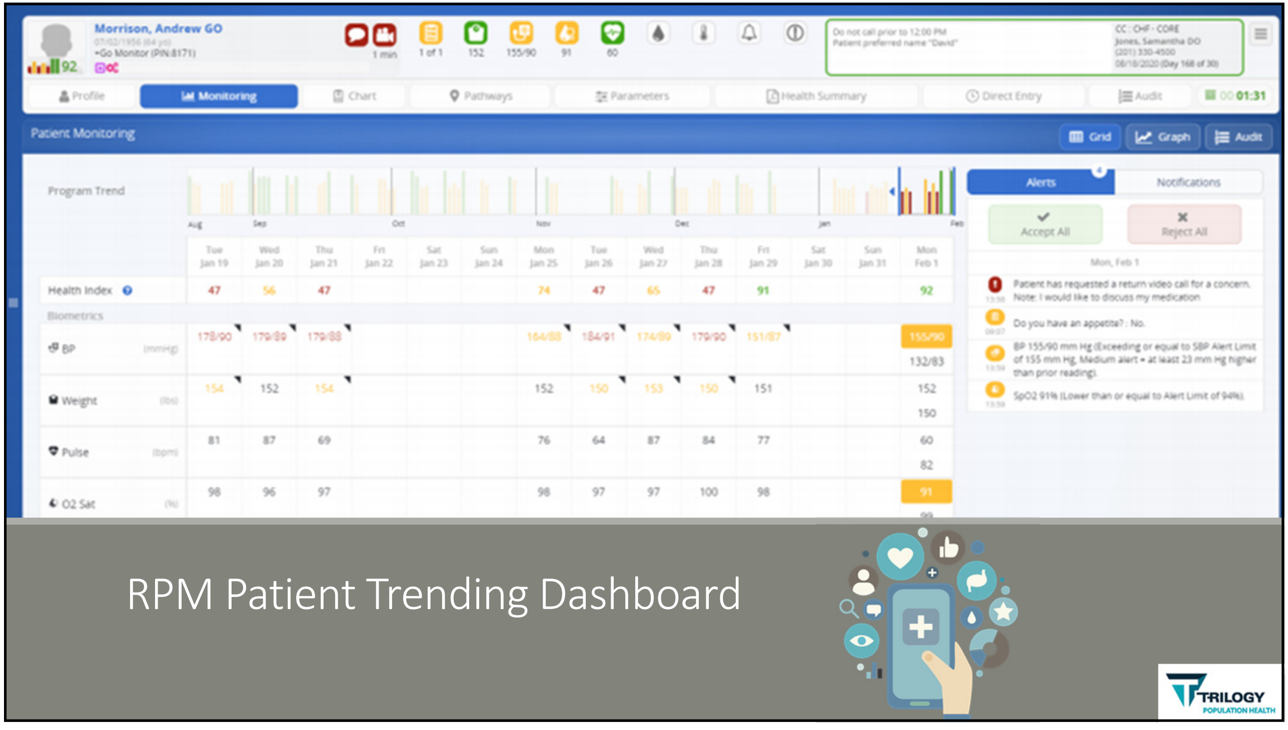
Morrison, Andrew GO
Profile
Monitoring
Chart
Pathways
Parameters
Health Summary
Direct Entry
Audit
Patient Monitoring
Grid
Graph
Audit
Program Trend
Health Index
Biometrics
BP
Weight
Pulse
O2 Sat
Alerts
Notifications
Accept All
Reject All
RPM Patient Trending Dashboard
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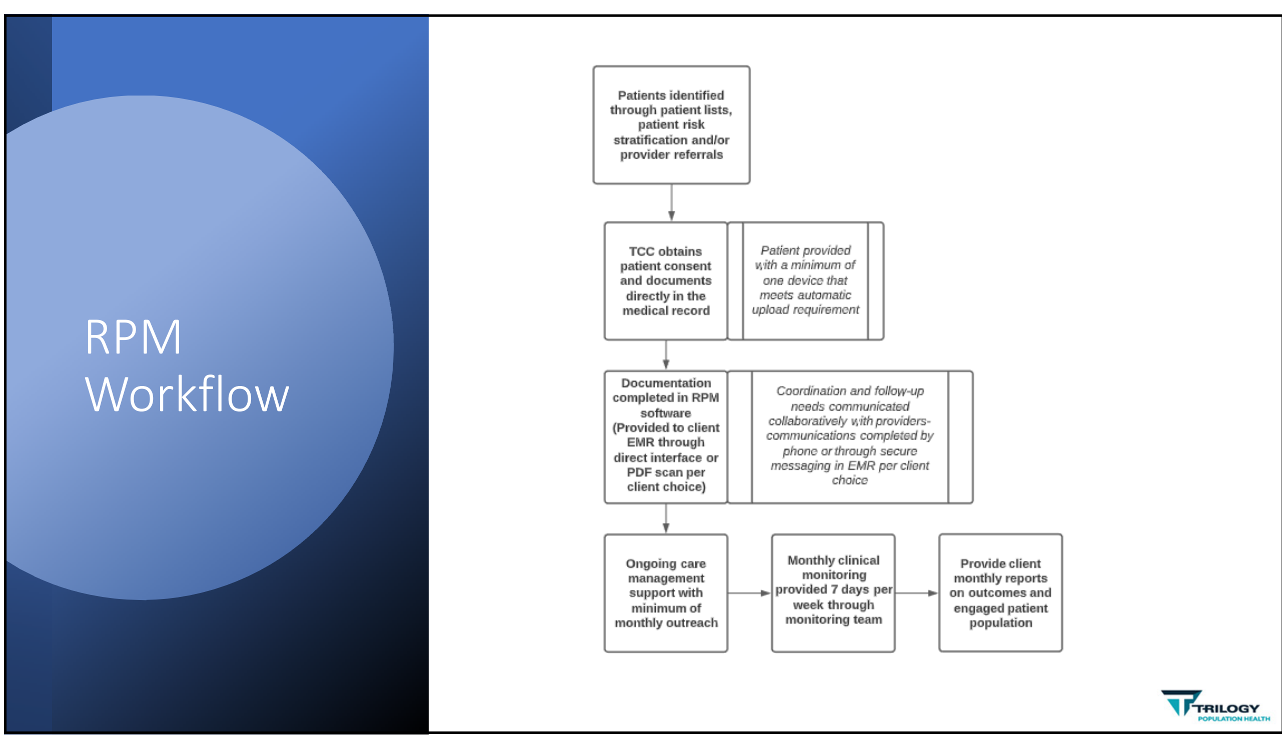
RPM
Workflow
Patients identified through patient lists, patient risk stratification and/or provider referrals
TCC obtains patient consent and documents directly in the medical record
Patient provided with a minimum of one device that meets automatic upload requirement
Documentation completed in RPM software (Provided to client EMR through direct interface or PDF scan per client choice)
Coordination and follow-up needs communicated collaboratively with providers- communications completed by phone or through secure messaging in EMR per client choice
Ongoing care management support with minimum of monthly outreach
Monthly clinical monitoring provided 7 days per week through monitoring team
Provide client monthly reports on outcomes and engaged patient population
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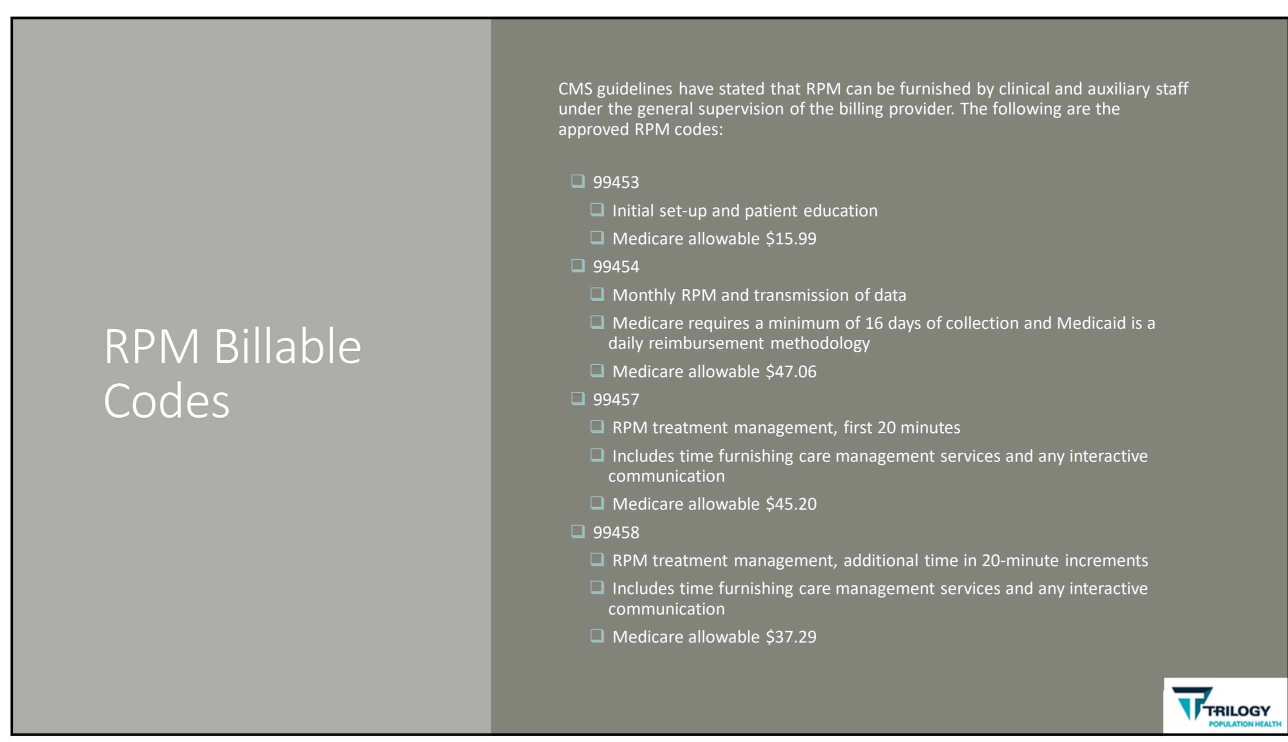
RPM Billable Codes
CMS guidelines have stated that RPM can be furnished by clinical and auxiliary staff under the general supervision of the billing provider. The following are the approved RPM codes:
99453
Initial set-up and patient education
Medicare allowable $15.99
99454
Monthly RPM and transmission of data
Medicare requires a minimum of 16 days of collection and Medicaid is a daily reimbursement methodology
Medicare allowable $47.06
99457
RPM treatment management, first 20 minutes
Includes time furnishing care management services and any interactive communication
Medicare allowable $45.20
99458
RPM treatment management, additional time in 20-minute increments
Includes time furnishing care management services and any interactive communication
Medicare allowable $37.29
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Additional Revenue Opportunities

Patients receiving RPM services also present additional Medicare revenue opportunities

- RPM communication with patient for Physician or Qualified Health Professional (MD, NP, PA)
  - CPT 99091
    - RPM communication with patient (30 min)
    - Time includes accessing, reviewing or interpreting the electronically transmitted patient-generated health data as well as communication with the patient.
    - Medicare allowable $52.41
  - CPT 99452
    - RPM communication monitor with PCP every 14 days
      - Time spent preparing for consultation referral and/or communicating with the consultant (16-30 minutes)
    - Medicare allowable $34.14
  - CPT 99451
    - Review RPM records with written report (5 minutes each 7 days)
    - Medicare allowable $33.82
  - CPT 99441-99443
    - Audio only or Audio/Video consult initiated by patient (5-10 min, 11-20 min, 21-30 min)
    - Medicare allowable $51.12, $83.37, $118.50

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Example of Shared Patient in RPM Model - Billing Considerations

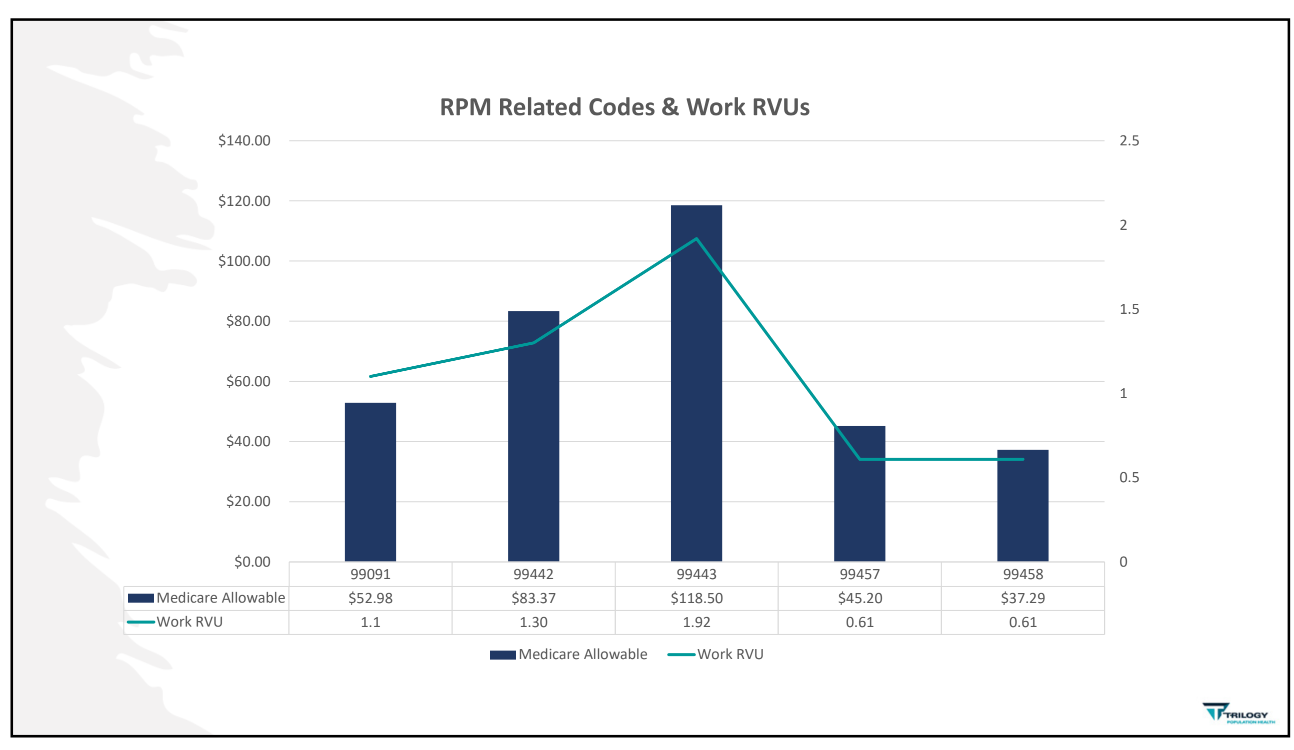
Shared Patient Coordination

Cardiac provider orders Remote Patient Monitoring and able to bill:

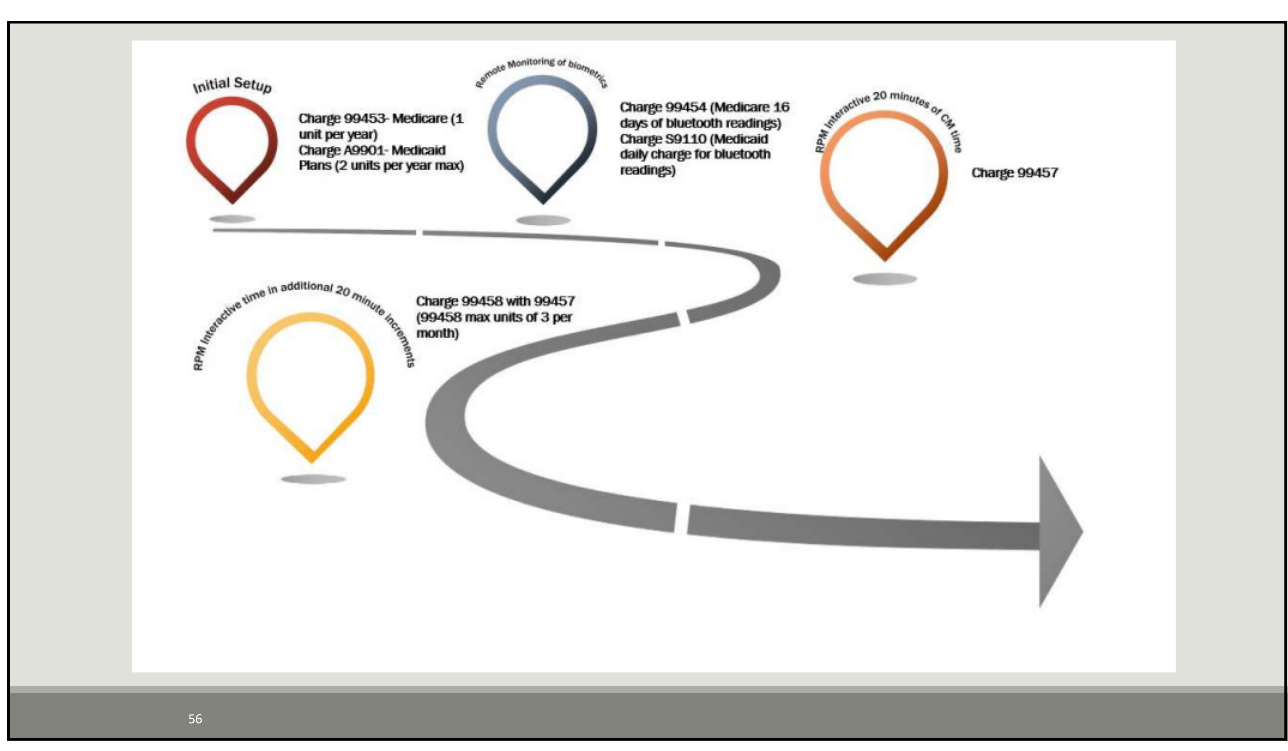
- 99453 - RPM Setup
- 99457 - Clinical time (CM service)
- 99458 - Clinical time (CM service additional time
- 99091 - Provider RPM visit
- 99451 - Provider RPM record review

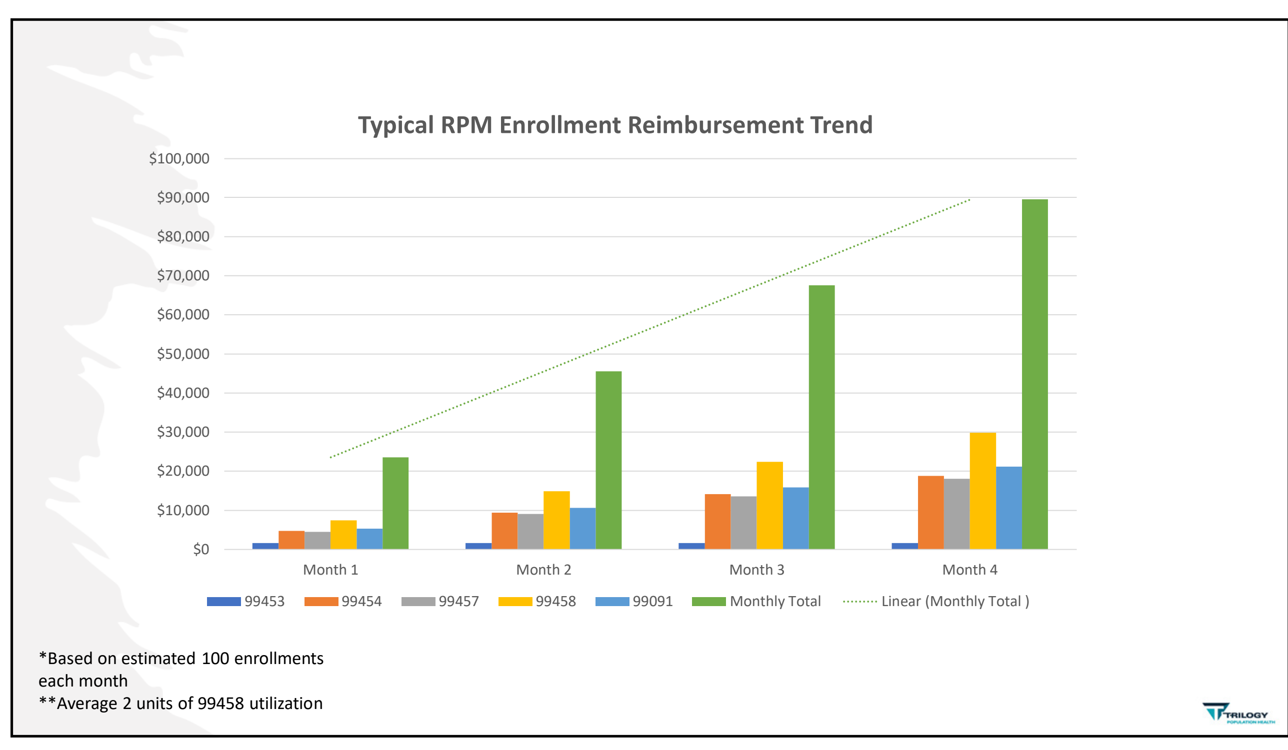
Pulmonary provider who also sees the same patient can bill the following with the RPM being completed by cardiac provider:

99452 - Consulting provider review of RPM record



	99091	99442	99443	99457	99458
Medicare Allowable	$52.98	$83.37	$118.50	$45.20	$37.29
Work RVU	1.1	1.30	1.92	0.61	0.61




Typical RPM Enrollment Reimbursement Trend
$100,000
$90,000
$80,000
$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
Month 1
Month 2
Month 3
Month 4
99453
99454
99457
99458
99091
Monthly Total
Linear (Monthly Total)
*Based on estimated 100 enrollments each month
**Average 2 units of 99458 utilization
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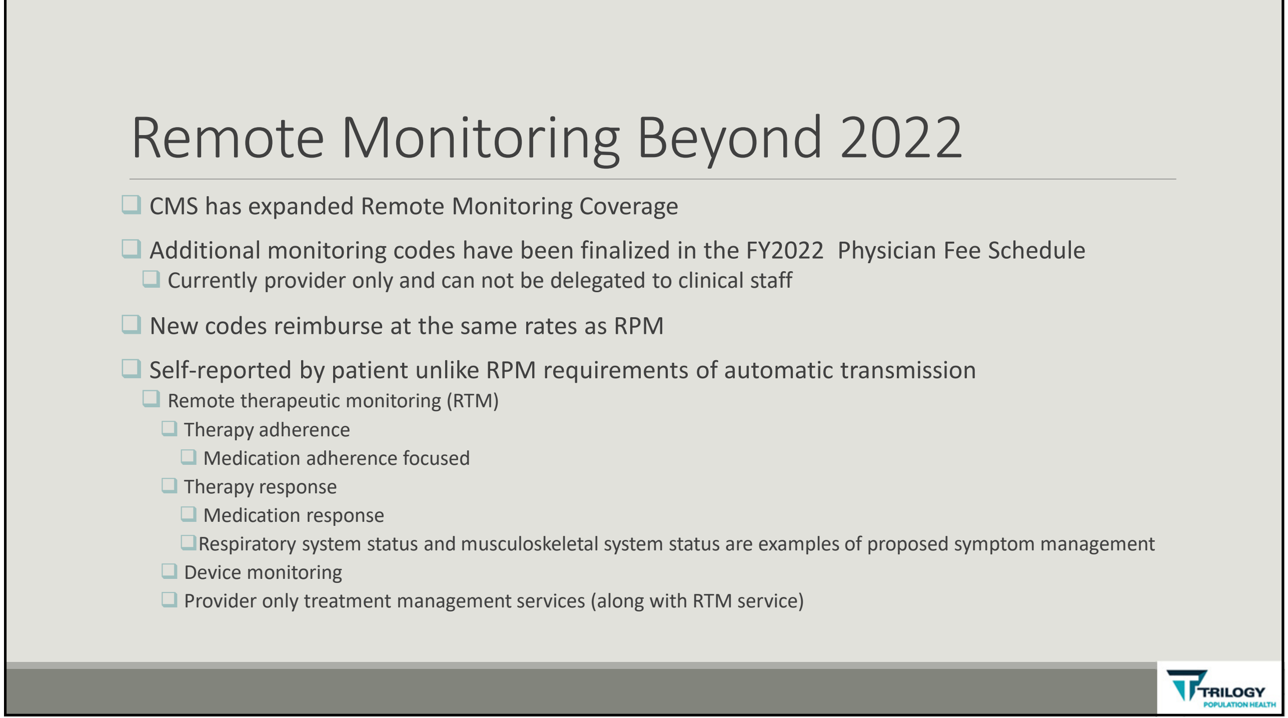
Remote Monitoring Beyond 2022
CMS has expanded Remote Monitoring Coverage
Additional monitoring codes have been finalized in the FY2022 Physician Fee Schedule
Currently provider only and can not be delegated to clinical staff
New codes reimburse at the same rates as RPM
Self-reported by patient unlike RPM requirements of automatic transmission
Remote therapeutic monitoring (RTM)
Therapy adherence
Medication adherence focused
Therapy response
Medication response
Respiratory system status and musculoskeletal system status are examples of proposed symptom management
Device monitoring
Provider only treatment management services (along with RTM service)
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Examples of Patient Testimonial Quotes

- "I don't know why I put this program off for so long because you have made my life so much easier. I have been telling everyone that will listen about this program."
- "I'm glad you are here, and I have you. You've made me want to start taking better care of myself."
- "I am very thankful for this program and have learned so much about getting health and I want you to know how much I appreciate you."
- "I feel so much better after this program. I was having headaches and you got my blood pressure under control by helping me get the care I need. I have also lost weight with your help, so I want you to know how much I appreciate you."

Patient Story Examples

Patient having an active heart attack

- Worked with patient on getting to the hospital for intervention
- Non-Q wave MI and ultimately needed a pacemaker
- Now home and doing great

Patient having an active stroke

- Identified during conversation symptoms of a possible stroke
- Coordinated getting patient to the hospital
- Stroke intervened timely and now home doing great

Patient having an active crisis

- Identified through screening over the phone
- CM team intervened the crisis with RN and SW support
- Crisis team mobilized to the home and patient admitted to facility
- Suicide prevented for timely intervention

Summary

- Population Health Programs provide real revenue today
  - These programs provide a way to prepare for value-based reimbursement
  - A way to bring cash in the door while improving care coordination to prepare for these reimbursement changes
  - Increase in patient satisfaction by pro-active outreach
    - Patients feel more connected to the healthcare team
  - Potential for pull-through revenue with increased outreach and appointments
    - Increase in wellness visits, follow-up and outpatient services

TRILOGY CARE CONNECT

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QUESTIONS?

Brandy Hoell, MSN, RN, CCM
CEO/Partner - Trilogy Care Connect
brandy@trilogy-health.com
911 Flynt Drive
Flowood, MS 39232-9572
Cell: (318) 773-2948