**YOUniversal Care™**

**The Integrated Healthcare Intelligence & Access Platform**

**Healthcare organizations don't need another vendor. They need better intelligence.**

For nearly **20 years**, **Precision Healthcare Technologies** has collaborated with CMS and commercial payers around the compliance grading methodologies used to evaluate provider performance. That experience became the foundation for **YOUniversal Care™**—an integrated healthcare intelligence platform designed to help providers understand how they are being measured and improve performance across **their entire patient population.**

Unlike traditional healthcare vendors, **we don't replace existing systems. We enhance them.**

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**What Makes YOUniversal Care™ Different?**

- **Everything begins with objective compliance intelligence.** Our **Provider Opportunity Assessment** evaluates provider performance using the same standardized CMS compliance methodology used to measure providers nationwide.
- **We don't compare your organization to another practice.** We compare your actual clinical activity to the objective standards by which provider performance is measured.
- **Our assessment identifies exactly how many patients require each of the 17 CMS quality measures, evaluates HCPCS payment performance, quantifies remaining clinical opportunities, and estimates the impact of closing those gaps.**
- **Most analytics stop there. We don't.**
- **Through My MD Hub™, those opportunities become actionable.** Because of secure CMS connectivity and nationally recognized interoperability, we can identify the specific patients associated with those opportunities and help coordinate the next appropriate step in their care.
- **Our intelligence is not limited to Medicare.** Medicare simply provides the standardized benchmark. Once opportunities are identified, **Precision Stealth Workflow Intelligence™** extends those insights across **your entire patient population**—including Medicare, Medicare Advantage, Commercial, Medicaid, and other payer populations.

- **My MD Hub™ has been approved by both the CMS App Library and the CARIN Alliance**, validating its role as a secure platform for patient-authorized health information exchange and interoperability.
- **Providers receive secure, patient-authorized access to coordinated health information, while patients can securely access and share their complete health record across participating providers.**
- **Precision Stealth Workflow Intelligence™ transforms intelligence into coordinated action** by identifying, prioritizing, connecting, and coordinating the right patients to the right services at the right time—improving quality performance, compliance, documentation, reimbursement, and patient outcomes without disrupting existing workflows.

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**Why Organizations Choose YOUniversal Care™**

Most healthcare companies provide **software**.

Some provide **analytics**.

Others provide **patient engagement**.

**YOUniversal Care™ provides the intelligence infrastructure that connects them all.**

It combines:

- **Compliance Intelligence** — understanding how providers are objectively measured.
- **Patient Intelligence** — identifying the specific patients behind every opportunity.
- **Workflow Intelligence** — coordinating the right clinical action at the right time.
- **Healthcare Intelligence** — extending those insights across the provider's **entire patient population**, not just Medicare.

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**One Platform. One Intelligence Layer. Every Patient.**

**YOUniversal Care™ isn't another healthcare application. It is healthcare intelligence infrastructure that has evolved through nearly 20 years of collaboration around CMS and payer compliance methodologies. Rather than replacing existing systems, it connects compliance intelligence, patient intelligence, and workflow intelligence into one coordinated platform—empowering healthcare organizations to improve quality, strengthen compliance, optimize reimbursement, and deliver better care across their entire patient population.**

**YOUniversal Care™**

**The Integrated Healthcare Intelligence & Access Platform**

**One Platform. Complete Visibility. Intelligent Action. Better Outcomes.**

# YOUniversal Care™

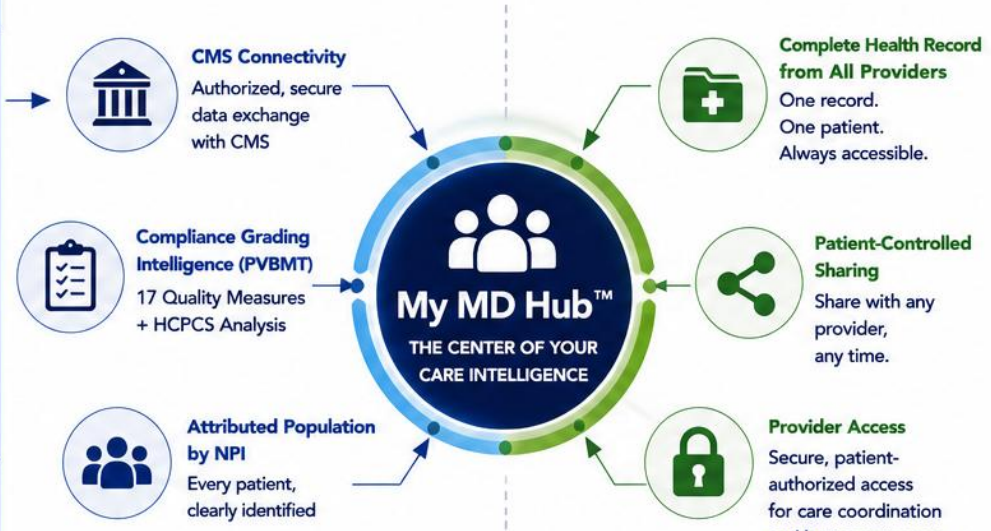
## THE INTEGRATED PATIENT INTELLIGENCE & ACCESS PLATFORM

**PVBMT + My MD Hub GIVE YOU ACCESS to the Compliance Grading. My MD Hub MAKES IT ACTIONABLE.**

### 1. PVBMT™
**Provider Opportunity Assessment**

- ✓ 17 Quality Measures
  Shows how many patients need each service
- ✓ Lists every patient attributed to your NPI
- ✓ Identifies each patient needing each service
- ✓ HCPCS payment performance – what % of allowable was paid
- ✓ Shows what was paid, what was missed, and the opportunity value

Data sources are identified throughout the report so you know where every data point comes from.




### 2. My MD Hub™
**The Patient & Provider Hub**

- ✓ Connects to CMS through authorized, secure pathways
- ✓ Because of this connection, we know WHICH patients need which services
- ✓ Any patient can access their entire health record from **ALL** providers
- ✓ Patients can share their record with **ANY** provider, any time
- ✓ Gives providers secure, patient-authorized access for care coordination

**CMS App Library APPROVED**

**CARIN Alliance MEMBER**

### 3. PRECISION STEALTH WORKFLOW INTELLIGENCE™ The Magic That Turns Data Into Action

**IDENTIFY**
Find patients who need each of the 17 Quality Measures and other high-value services.

**PRIORITIZE**
Focus on the right patients for the greatest clinical and financial impact.

**CONNECT**
Route patients to the appropriate care, services, and follow-up actions electronically.

**COORDINATE**
Close gaps, improve quality, strengthen documentation, and optimize reimbursement.

**IMPROVE OUTCOMES**
Better care.
Better performance.
Better results.

**YOUniversal Care™**
THE INTEGRATED PATIENT INTELLIGENCE & ACCESS PLATFORM

**ONE PLATFORM. ENTIRE PATIENT POPULATION. YOU ARE IN CONTROL.**

**COMPLETE VISIBILITY. BETTER OUTCOMES.**

**Medicare. Medicare Advantage. Commercial. Medicaid. Self-Pay.**
We see the whole picture so you can improve the whole picture.

**PVBMT** reveals the opportunities. My MD Hub connects the data and the people. Precision Workflow Intelligence™ closes the gaps. That's how we help you perform at your best.

# YOUniversal Care

## STEALTH WORKFLOW INTELLIGENCE

*Intelligent. Seamless. Patient-Centered.*

**HEALTHCARE ORGANIZATION, HOSPITAL, PROVIDER**

**INITIAL PATIENT ENGAGEMENT**

**Entire Patient Population Attribution, Triage, Care Direction**

All services are FREE to Shared Risk programs such as ACOs & Medicare Advantage.

**MEDICAL NECESSITIES IDENTIFIED FOR**

**Office or Virtual Visits**
Additional Assessments

**CARE COORDINATION**
Diagnostics

**MANDATED ANCILLARIES**
AWV, CCM, RPM, RCM, BHI, TCM, etc.

**OPTIONAL ANCILLARIES**
Allergy, Sleep, ANS/ABI, etc.

**OUTSIDE REFERRALS**
Referral to Specialist
Referral to Outside Service

**INTERNAL REFERRALS**
Referral to Specialist or Colleague
Referral to Another Department

**INVISIBLE INTEGRATION**
Works within your existing systems and workflows.

**PATIENT-CENTERED CARE**
Right care, right time, right place.

**MAXIMIZE OPPORTUNITIES**
Identify, engage, and close care gaps.

**BETTER OUTCOMES**
Improved health, quality scores, and value.

**INTELLIGENT WORKFLOWS. BETTER CARE. STRONGER PERFORMANCE.**

# YOUniversal Care™

## CONTINUOUS ENGAGEMENT. NEWLY SURFACED CARE. BETTER OUTCOMES.

Precision engages your entire patient population every quarter to identify **newly emerging** opportunities and connect patients to the care they need—**when they need it.**

### 3. CONTINUOUS QUARTERLY ENGAGEMENT WORKFLOW

**EVERY QUARTER:**
A fresh look at your entire population


Continuous visibility into your population drives better care and stronger performance.

**IDENTIFY**

Intelligent workflows review clinical, claims, and SDOH data to identify:

- ✓ Preventive screenings due or overdue
- ✓ Chronic care opportunities
- ✓ Newly emerging medical needs
- ✓ Care gaps and quality measures

**SURFACE**

Newly surfaced, medically necessary care is prioritized and presented in the provider workflow.

Not just yesterday's gaps—tomorrow's opportunities.

**CONNECT**

Patients are connected to the appropriate next step in care, as instructed by the provider:

- ✓ In-office or virtual visits
- ✓ Diagnostics
- ✓ Specialists
- ✓ Education & resources

**DOCUMENT**

Outreach, recommendations, and outcomes are documented to support:

- ✓ Clinical decision making
- ✓ Quality reporting
- ✓ Risk adjustment
- ✓ Compliance with CMS standards

**CONTINUOUSLY REPEAT.**
Patient needs change. Health risks change. Care opportunities change. We keep you ahead.

Quarter after quarter.
Opportunity after opportunity.
Better care—every time.

### BUILT FOR COMPLIANCE. DESIGNED FOR CARE.

**ALIGNED WITH THE CMS STANDARD OF CARE**

When preventive screenings or assessments identify potential medically necessary follow-up services:

- Providers evaluate findings and take appropriate clinical action consistent with their professional judgment.
- Providers instruct how patients are offered available options and connected to the appropriate next step in care.
- Patient participation in recommended follow-up is the patient's choice.
- Quality performance depends on identifying eligible patients, offering appropriate care, and documenting in accordance with each measure's specifications.

You don't have to close every gap.
You have to follow the Standard of Care.
Precision helps you do it—consistently.

### WHY CONTINUOUS ENGAGEMENT WINS

**DYNAMIC VISIBILITY**
See changes in your population as they happen—not once a year.

**NEWLY SURFACED CARE**
Identify new risks and needs before they become bigger problems.

**STRONGER CONNECTIONS**
Patients get the right care at the right time in the right place.

**BETTER PERFORMANCE**
Close more opportunities.
Improve quality scores.
Increase reimbursement.

**BETTER OUTCOMES**
Healthier patients.
Stronger relationships.
Stronger communities.

**YOUniversal Care™**
THE INTEGRATED PATIENT INTELLIGENCE & ACCESS PLATFORM

ONE PLATFORM.
ENTIRE PATIENT POPULATION.
YOU ARE IN CONTROL.

COMPLETE VISIBILITY.
BETTER OUTCOMES.

Medicare. Medicare Advantage.
Commercial. Medicaid. Self-Pay.
We see the whole picture
so you can improve the whole picture.

Intelligent Workflows. Better Care. Stronger Performance.

# PVBMT

## Provider Opportunity Assessment

NPI
Internal Medicine

Report date: 7/25/2026
CMS claims period: last reported full calendar year

## Executive Summary

This assessment integrates Medicare utilization information, healthcare analytics, clinical prevalence modeling, and proprietary PVBMT workflow intelligence to identify provider-specific clinical service opportunities. Configurable planning assumptions are applied solely to support strategic planning and opportunity modeling.

| BENEFICIARIES | CLINICAL SERVICES EVALUATED | SERVICES WITH OPPORTUNITY | ANNUAL OPPORTUNITY VALUE |
|---|---|---|---|
| **342** | **14** | **14** | **$285,385**<br>**POTENTIAL ADDITIONAL ANNUAL REVENUE** |

## Clinical Service Opportunity Summary

**Annual Opportunity Value** represents the estimated additional annual reimbursement opportunity identified through the PVBMT analysis based on provider-specific Medicare utilization, patient population estimates, and recommended clinical service opportunities. The estimate assumes implementation of the recommended clinical services using the planning assumptions described in this report and is intended for strategic planning purposes. It is not a guarantee of future reimbursement.

## Measured Medicare Service Opportunities

Reported utilization uses CMS beneficiary counts as the primary patient measure. Related HCPCS service counts are shown separately as supporting activity.

| CLINICAL SERVICE | ESTIMATED ELIGIBLE | REPORTED MEDICARE BENEFICIARIES | REPORTED MEDICARE SERVICES | REMAINING OPPORTUNITY | COVERAGE | CLINICAL FIT | PLANNING PARTICIPATION | EXPECTED ACTIVE | PLANNING VALUE | ANNUAL OPPORTUNITY VALUE |
|---|---|---|---|---|---|---|---|---|---|---|
| **Annual Wellness Visit**<br>G0438 / G0439 | 342 | **31** | 31 | 311 | 9% | 100%<br>311 patients | 60% | **187** | $175 / service | **$32,725**<br>Very High Opportunity |
| **Chronic Care Management**<br>99490 / 99439 / 99487 / 99489 | 286 | **0** | 0 | 286 | 0% | 100%<br>286 patients | 45% | **129** | $40 / month | **$61,920**<br>High Opportunity |
| **Remote Patient Monitoring**<br>99453 / 99454 / 99457 / 99458 | 291 | **0** | 0 | 291 | 0% | 100%<br>291 patients | 30% | **87** | $50 / month | **$52,200**<br>Moderate Opportunity |
| **Behavioral Health / Mental Health Management**<br>99484 / 99492 / 99493 / 99494 | 205 | **0** | 0 | 205 | 0% | 100%<br>205 patients | 40% | **82** | $80 / month | **$78,720**<br>High Opportunity |

| CLINICAL SERVICE | ESTIMATED ELIGIBLE | REPORTED MEDICARE BENEFICIARIES | REPORTED MEDICARE SERVICES | REMAINING OPPORTUNITY | COVERAGE | CLINICAL FIT | PLANNING PARTICIPATION | EXPECTED ACTIVE | PLANNING VALUE | ANNUAL OPPORTUNITY VALUE |
|---|---|---|---|---|---|---|---|---|---|---|

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Diabetes Self-Management Training**<br>G0108 / G0109 | 154 | **0** | 0 | 154 | 0% | 100%<br>154 patients | 35% | **54** | $50 / service | **$2,700**<br>High Opportunity |
| **ABI / Peripheral Vascular Assessment**<br>93922 / 93923 / 93924 | 274 | **0** | 0 | 274 | 0% | 60%<br>164 patients | 45% | **74** | $80 / service | **$5,920**<br>Moderate Opportunity |

## Modeled Clinical Management Planning

Diagnosis-specific 99212-99214 utilization is not included in available provider-level utilization information. These rows therefore show a planning population, not zero current utilization or measured remaining opportunity.

| CLINICAL SERVICE | ESTIMATED ELIGIBLE | CURRENT UTILIZATION | PLANNING POPULATION | CLINICAL FIT | PLANNING PARTICIPATION | TYPICAL FOLLOW-UP | PLANNING VALUE | ANNUAL OPPORTUNITY VALUE |
|---|---|---|---|---|---|---|---|---|
| **Diabetes Clinical Management Planning**<br>99213 / 99214<br>ICD-10: E08-E13 | 154 | **Not available**<br>Not treated as zero | **43** | 80%<br>123 patients | 35% | 2-4 visits annually | $80 / service | **$6,880**<br>Moderate Opportunity |
| **Hypertension Clinical Management Planning**<br>99212 / 99213 / 99214<br>ICD-10: I10-I16 | 257 | **Not available**<br>Not treated as zero | **68** | 75%<br>193 patients | 35% | 2-3 visits annually | $80 / service | **$10,880**<br>Moderate Opportunity |
| **Heart Failure Clinical Management Planning**<br>99213 / 99214<br>ICD-10: I50 | 133 | **Not available**<br>Not treated as zero | **84** | 90%<br>120 patients | 70% | 2-4 visits annually | $80 / service | **$13,440**<br>Very High Opportunity |
| **Ischemic Heart Disease Clinical Management Planning**<br>99213 / 99214<br>ICD-10: I20-I25 | 140 | **Not available**<br>Not treated as zero | **39** | 70%<br>98 patients | 40% | 1-3 visits annually | $80 / service | **$6,240**<br>Moderate Opportunity |
| **COPD Clinical Management Planning**<br>99213 / 99214<br>ICD-10: J40-J44 | 116 | **Not available**<br>Not treated as zero | **33** | 80%<br>93 patients | 35% | 2-4 visits annually | $80 / service | **$5,280**<br>Moderate Opportunity |
| **Chronic Kidney Disease Clinical Management Planning**<br>99213 / 99214<br>ICD-10: N18 | 130 | **Not available**<br>Not treated as zero | **42** | 80%<br>104 patients | 40% | 2-4 visits annually | $80 / service | **$6,720**<br>High Opportunity |


| CLINICAL SERVICE | ESTIMATED ELIGIBLE | CURRENT UTILIZATION | PLANNING POPULATION | CLINICAL FIT | PLANNING PARTICIPATION | TYPICAL FOLLOW-UP | PLANNING VALUE | ANNUAL OPPORTUNITY VALUE |
|---|---|---|---|---|---|---|---|---|

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Cancer Survivorship Clinical Management Planning**<br>99213 / 99214<br>ICD-10: C00-C96 / Z85 | 41 | **Not available**<br>Not treated as zero | **9** | 75%<br>31 patients | 30% | 1-3 visits annually | $80 / service | **$1,440**<br>Moderate Opportunity |
| **Osteoporosis Clinical Management Planning**<br>99212 / 99213<br>ICD-10: M80-M81 | 21 | **Not available**<br>Not treated as zero | **4** | 70%<br>15 patients | 25% | 1-2 visits annually | $80 / service | **$320**<br>Moderate Opportunity |

**Core assumptions:** One AWV per remaining beneficiary; AWV $175 annually at 60% planning participation; CCM $40/month at 45%; RPM $50/month at 30%; behavioral health $80/month at 40%; DSMT $50 annually at 35%; diabetes and hypertension management at 35%; heart failure at 70%; CKD and ischemic heart disease at 40%; COPD at 35%; cancer survivorship at 30%; osteoporosis at 25%; ABI $80 annually at 60% clinical appropriateness and 45% planning participation.

**Important:** Beneficiaries may qualify for more than one service. Values are presented by service category for planning and are not guaranteed or mutually exclusive revenue.

## Recommended Clinical Programs

| PRIORITY | PROGRAM | EXPECTED ACTIVE PATIENTS | ANNUAL OPPORTUNITY VALUE |
|---|---|---|---|
| 1 | Behavioral Health / Mental Health Management | 82 | $78,720 |
| 2 | Chronic Care Management | 129 | $61,920 |
| 3 | Remote Patient Monitoring | 87 | $52,200 |
| 4 | Annual Wellness Visit | 187 | $32,725 |
| 5 | Heart Failure Clinical Management Planning | 84 | $13,440 |
| 6 | Hypertension Clinical Management Planning | 68 | $10,880 |
| 7 | Diabetes Clinical Management Planning | 43 | $6,880 |
| 8 | Chronic Kidney Disease Clinical Management Planning | 42 | $6,720 |
| 9 | Ischemic Heart Disease Clinical Management Planning | 39 | $6,240 |
| 10 | ABI / Peripheral Vascular Assessment | 74 | $5,920 |
| 11 | COPD Clinical Management Planning | 33 | $5,280 |
| 12 | Diabetes Self-Management Training | 54 | $2,700 |
| 13 | Cancer Survivorship Clinical Management Planning | 9 | $1,440 |
| 14 | Osteoporosis Clinical Management Planning | 4 | $320 |

## Provider Profile

| | | | |
|---|---|---|---|
| **PROVIDER** | | **NPI** | |
| **SPECIALTY** | Internal Medicine | **LOCATION** | |

| | | | |
|---|---|---|---|
| **MEDICARE BENEFICIARIES** | 342 | **RISK SCORE** | 2.29 |
| **REPORTED MEDICARE PAYMENT*** | $62,892 | **CLAIMS PERIOD** | Last reported full calendar year |

* Medicare utilization and payment information is based on the most recent publicly available CMS final-action Medicare Part B fee-for-service claims for the last reported full calendar year.

# Reported Medicare Service Summary

| TOTAL HCPCS CODES | TOTAL SERVICES | TOTAL BENEFICIARIES | AVERAGE PAYMENT / SERVICE |
|---|---|---|---|
| **11** | **888** | **80** | **$65** |

| | | |
|---|---|---|
| **HIGHEST VOLUME SERVICE** | 99232 | 159 services |
| **HIGHEST AVERAGE PAYMENT** | 99223 | $124 |

# Services Provided by This Provider

Full HCPCS detail sorted by total services, highest volume first. Payment % is calculated as average Medicare payment divided by average Medicare allowed amount.

| HCPCS | DESCRIPTION | POS | SERVICES | BENEFICIARIES | AVG ALLOWED | AVG PAYMENT | PAYMENT % |
|---|---|---|---|---|---|---|---|
| 99232 | Subsequent hospital care with moderate levelof medical decision making, if using time, at least 35 minutes | F | 159 | 77 | $75 | $60 | 79.7% |
| 99213 | Established patient office or other outpatient visit with low level od decision making, if using time, 20 minutes or more | O | 152 | 80 | $86 | $53 | 62.1% |
| 99231 | Subsequent hospital care with straightforward or low level of medical decision making, per day, if using time, at least 25 minutes | F | 134 | 44 | $47 | $37 | 78.3% |
| 99308 | Subsequent nursing facility care with straightforward level of medical decision making, per day, if using time, 20 minutes or more | F | 111 | 57 | $71 | $56 | 79.7% |
| 99214 | Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more | O | 68 | 48 | $120 | $73 | 60.5% |
| 99222 | Initial hospital care with straightforward or low-level medical decision making, if using time, at least 55 minutes | F | 65 | 64 | $125 | $98 | 78.4% |
| 99238 | Hospital discharge day management, 30 minutes or less | F | 64 | 61 | $77 | $61 | 79.7% |
| 99233 | Subsequent hospital care with moderate levelof medical decision making, if using time, at least 50 minutes | F | 46 | 25 | $111 | $88 | 79.5% |
| 99239 | Hospital discharge day management, more than 30 minutes | F | 31 | 29 | $105 | $84 | 79.7% |
| G0439 | Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit | O | 31 | 31 | $123 | $123 | 100.0% |
| 99223 | Initial hospital care with moderate level of medical decision making, if using time, at least 75 minutes | F | 27 | 27 | $161 | $124 | 77.1% |

# Chronic Condition Profile

| CONDITION | CMS PERCENTAGE | ESTIMATED PATIENTS |
|---|---|---|

| | | |
|---|---|---|
| ADHD and Other Conduct Disorders | Suppressed / unavailable | Unavailable |
| Alcohol and Drug Use Disorders | 18% | 62 |
| Tobacco Use Disorders | 30% | 103 |
| Alzheimer's and Other Dementia | 27% | 92 |
| Anxiety Disorders | 38% | 130 |
| Bipolar Disorder | 15% | 51 |
| Mood Disorders | 45% | 154 |
| Depression | 37% | 127 |
| Asthma | 17% | 58 |
| Atrial Fibrillation | 29% | 99 |
| Cancer | 12% | 41 |
| Chronic Kidney Disease | 38% | 130 |
| COPD | 34% | 116 |
| Diabetes | 45% | 154 |
| Heart Failure | 39% | 133 |
| Hyperlipidemia | 68% | 233 |
| Hypertension | 75% | 257 |
| Ischemic Heart Disease | 41% | 140 |
| Osteoporosis | 6% | 21 |
| Parkinson's Disease | Suppressed / unavailable | Unavailable |
| Rheumatoid/Osteoarthritis | 53% | 181 |
| Stroke / TIA | 24% | 82 |

# Condition Evidence Supporting Clinical Service Opportunities

## Alzheimer's and Other Dementia Management

ATTRIBUTED PATIENTS
**92**

SERVICES REVIEWED
**4**

ACTIVITY IDENTIFIED
**0**

LIMITED ACTIVITY
**1**

NO ACTIVITY IDENTIFIED
**3**

ROLE IN REPORT
**Supporting evidence**

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with alzheimer's and other dementia management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Cognitive Assessment and Care** | 99483 | Annual when appropriate | **No activity identified** |

| Planning | | | |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Chronic Care Management** | 99490 | Monthly | **No activity identified** |
| **Complex Chronic Care Management** | 99487 | Monthly when applicable | **No activity identified** |

### Current CMS Utilization

**4 services evaluated:** 0 identified, 1 limited, 3 not identified.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Cognitive Assessment and Care Planning (99483), Annual Wellness Visit (G0438/G0439), Chronic Care Management (99490), Complex Chronic Care Management (99487). PVBMT analysis identifies limited or no activity for Annual Cognitive Assessment and Care Planning, Annual Wellness Visit, Chronic Care Management, Complex Chronic Care Management relative to the attributed alzheimer's and other dementia population. These findings may represent opportunities to expand structured alzheimer's and other dementia management workflows where clinically appropriate.

**Recommended focus:** Establish cognitive assessment, care-planning, caregiver support, and recurring follow-up workflows.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Diabetes Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **154** | **4** | **0** |
| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
| **1** | **3** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with diabetes management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Diabetes Self-Management Training** | G0108 / G0109 | 2 encounters annually | **No activity identified** |
| **Continuous Glucose Monitor Training** | 95249 | As needed | **No activity identified** |
| **Chronic Care Management** | 99490 | Monthly | **No activity identified** |

### Current CMS Utilization

**4 services evaluated:** 0 identified, 1 limited, 3 not identified.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Diabetes Self-Management Training (G0108/G0109), Continuous Glucose Monitor Training (95249), Chronic Care Management (99490). PVBMT analysis identifies limited or no activity for Annual Wellness Visit, Diabetes Self-Management Training, Continuous Glucose Monitor Training, Chronic Care Management relative to the attributed diabetes population. These findings may represent opportunities to expand structured diabetes management workflows where clinically appropriate.

**Recommended focus:** Establish structured quarterly diabetes follow-up, medication review, monitoring, and patient education workflows.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Heart Failure Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **133** | **4** | **0** |
| **LIMITED ACTIVITY** | **NO ACTIVITY IDENTIFIED** | **ROLE IN REPORT** |
| **1** | **3** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with heart failure management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Chronic Care Management** | 99490 | Monthly | **No activity identified** |
| **Complex Chronic Care Management** | 99487 / 99489 | Monthly when applicable | **No activity identified** |
| **Remote Patient Monitoring** | 99453 / 99454 / 99457 | Variable | **No activity identified** |

### Current CMS Utilization

**4 services evaluated:** 0 identified, 1 limited, 3 not identified.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Chronic Care Management (99490), Complex Chronic Care Management (99487/99489), Remote Patient Monitoring (99453/99454/99457). PVBMT analysis identifies limited or no activity for Annual Wellness Visit, Chronic Care Management, Complex Chronic Care Management, Remote Patient Monitoring relative to the attributed heart failure population. These findings may represent opportunities to expand structured heart failure management workflows where clinically appropriate.

**Recommended focus:** Use structured quarterly follow-up and care-management workflows for eligible heart-failure patients.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Hypertension Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **257** | **6** | **0** |
| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
| **1** | **4** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with hypertension management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Chronic Care Management** | 99490 | Monthly | **No activity identified** |
| **Remote Patient Monitoring Setup** | 99453 | Once per episode | **No activity identified** |
| **Remote Patient Monitoring Device Supply** | 99454 | Monthly | **No activity identified** |
| **Remote Patient Monitoring Treatment Management** | 99457 | Monthly | **No activity identified** |
| **Medication Therapy Management** | Payer dependent | Payer dependent | **Payer dependent** |

### Current CMS Utilization

**6 services evaluated:** 0 identified, 1 limited, 4 not identified, and 1 payer dependent.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Chronic Care Management (99490), Remote Patient Monitoring Setup (99453), Remote Patient Monitoring Device Supply (99454), Remote Patient Monitoring Treatment Management (99457), Medication Therapy Management. PVBMT analysis identifies limited or no activity for Annual Wellness Visit, Chronic Care Management, Remote Patient Monitoring Setup, Remote Patient Monitoring Device Supply, Remote Patient Monitoring Treatment Management relative to the attributed hypertension population. These findings may represent opportunities to expand structured hypertension management workflows where clinically appropriate.

**Recommended focus:** Implement a structured blood-pressure monitoring and semiannual follow-up program.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Anxiety Disorders Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **130** | **3** | **0** |

| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
|---|---|---|
| **0** | **3** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with anxiety disorders management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Brief Emotional/Behavioral Assessment** | 96127 | As indicated | **No activity identified** |
| **Behavioral Health Integration** | 99484 | Monthly | **No activity identified** |
| **Psychiatric Collaborative Care Management** | 99492 / 99493 / 99494 | Monthly when applicable | **No activity identified** |

### Current CMS Utilization

**3 services evaluated:** 0 identified, 0 limited, 3 not identified.

**No related HCPCS activity identified for the common anxiety disorders services reviewed.**

### Condition Evidence

PVBMT reviewed Brief Emotional/Behavioral Assessment (96127), Behavioral Health Integration (99484), Psychiatric Collaborative Care Management (99492/99493/99494). PVBMT analysis identifies limited or no activity for Brief Emotional/Behavioral Assessment, Behavioral Health Integration, Psychiatric Collaborative Care Management relative to the attributed anxiety disorders population. These findings may represent opportunities to expand structured anxiety disorders management workflows where clinically appropriate.

**Recommended focus:** Use structured screening and follow-up for clinically appropriate patients.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Depression Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **127** | **4** | **0** |

| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
|---|---|---|
| **0** | **4** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with depression management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Depression Screening** | G0444 | Annual | **No activity identified** |
| **Brief Emotional/Behavioral Assessment** | 96127 | As indicated | **No activity identified** |
| **Behavioral Health Integration** | 99484 | Monthly | **No activity identified** |
| **Psychiatric Collaborative Care Management** | 99492 / 99493 / 99494 | Monthly when applicable | **No activity identified** |

### Current CMS Utilization

**4 services evaluated:** 0 identified, 0 limited, 4 not identified.

**No related HCPCS activity identified for the common depression services reviewed.**

### Condition Evidence

PVBMT reviewed Annual Depression Screening (G0444), Brief Emotional/Behavioral Assessment (96127), Behavioral Health Integration (99484), Psychiatric Collaborative Care Management (99492/99493/99494). PVBMT analysis identifies limited or no activity for Annual Depression Screening, Brief Emotional/Behavioral Assessment, Behavioral Health Integration, Psychiatric Collaborative Care Management relative to the attributed depression population. These findings may represent opportunities to expand structured depression management workflows where clinically appropriate.

**Recommended focus:** Implement screening, follow-up, and behavioral-health integration workflows where clinically appropriate.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Ischemic Heart Disease Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **140** | **4** | **0** |
| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
| **1** | **3** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with ischemic heart disease management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Electrocardiogram** | 93000 / 93010 | As indicated | **No activity identified** |
| **Echocardiography** | 93306 | As indicated | **No activity identified** |
| **Chronic Care Management** | 99490 | Monthly | **No activity identified** |

### Current CMS Utilization

**4 services evaluated:** 0 identified, 1 limited, 3 not identified.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Electrocardiogram (93000/93010), Echocardiography (93306), Chronic Care Management (99490). PVBMT analysis identifies limited or no activity for Annual Wellness Visit, Electrocardiogram, Echocardiography, Chronic Care Management relative to the attributed ischemic heart disease population. These findings may represent opportunities to expand structured ischemic heart disease management workflows where clinically appropriate.

**Recommended focus:** Use structured cardiovascular risk, medication, and symptom follow-up.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Chronic Kidney Disease Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **130** | **4** | **0** |
| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
| **1** | **3** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with chronic kidney disease management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Chronic Care Management** | 99490 | Monthly | **No activity identified** |
| **Complex Chronic Care Management** | 99487 / 99489 | Monthly when applicable | **No activity identified** |
| **Transitional Care Management** | 99495 / 99496 | After qualifying discharge | **No activity identified** |

### Current CMS Utilization

**4 services evaluated:** 0 identified, 1 limited, 3 not identified.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Chronic Care Management (99490), Complex Chronic Care Management (99487/99489), Transitional Care Management (99495/99496). PVBMT analysis identifies limited or no activity for Annual Wellness Visit, Chronic Care Management, Complex Chronic Care Management, Transitional Care Management relative to the attributed chronic kidney disease population. These findings may represent opportunities to expand structured chronic kidney disease management workflows where clinically appropriate.

**Recommended focus:** Create a recurring kidney-health monitoring, medication review, and care-coordination pathway.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Rheumatoid/Osteoarthritis Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **181** | **5** | **0** |

| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
|---|---|---|
| **1** | **4** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with rheumatoid/osteoarthritis management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Chronic Care Management** | 99490 | Monthly | **No activity identified** |
| **Therapeutic Exercise** | 97110 | As indicated | **No activity identified** |
| **Neuromuscular Reeducation** | 97112 | As indicated | **No activity identified** |
| **Therapeutic Activities** | 97530 | As indicated | **No activity identified** |

### Current CMS Utilization

**5 services evaluated:** 0 identified, 1 limited, 4 not identified.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Chronic Care Management (99490), Therapeutic Exercise (97110), Neuromuscular Reeducation (97112), Therapeutic Activities (97530). PVBMT analysis identifies limited or no activity for Annual Wellness Visit, Chronic Care Management, Therapeutic Exercise, Neuromuscular Reeducation, Therapeutic Activities relative to the attributed rheumatoid/osteoarthritis population. These findings may represent opportunities to expand structured rheumatoid/osteoarthritis management workflows where clinically appropriate.

**Recommended focus:** Develop a recurring pain, mobility, medication, and functional-status follow-up pathway.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## COPD Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **116** | **5** | **0** |

| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
|---|---|---|
| **1** | **4** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with copd management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Spirometry** | 94010 | As indicated | **No activity identified** |
| **Inhaler Education** | 94664 | As indicated | **No activity identified** |

| | | | |
|---|---|---|---|
| **Smoking and Tobacco Use Cessation Counseling** | 99406 / 99407 | As indicated | **No activity identified** |
| **Chronic Care Management** | 99490 | Monthly | **No activity identified** |

### Current CMS Utilization

**5 services evaluated:** 0 identified, 1 limited, 4 not identified.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Spirometry (94010), Inhaler Education (94664), Smoking and Tobacco Use Cessation Counseling (99406/99407), Chronic Care Management (99490). PVBMT analysis identifies limited or no activity for Annual Wellness Visit, Spirometry, Inhaler Education, Smoking and Tobacco Use Cessation Counseling, Chronic Care Management relative to the attributed copd population. These findings may represent opportunities to expand structured copd management workflows where clinically appropriate.

**Recommended focus:** Implement recurring COPD assessment, inhaler education, monitoring, and exacerbation-prevention follow-up.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Mood Disorders Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **154** | **3** | **0** |
| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
| **0** | **3** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with mood disorders management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Brief Emotional/Behavioral Assessment** | 96127 | As indicated | **No activity identified** |
| **Behavioral Health Integration** | 99484 | Monthly | **No activity identified** |
| **Psychiatric Collaborative Care Management** | 99492 / 99493 / 99494 | Monthly when applicable | **No activity identified** |

### Current CMS Utilization

**3 services evaluated:** 0 identified, 0 limited, 3 not identified.

**No related HCPCS activity identified for the common mood disorders services reviewed.**

### Condition Evidence

PVBMT reviewed Brief Emotional/Behavioral Assessment (96127), Behavioral Health Integration (99484), Psychiatric

Collaborative Care Management (99492/99493/99494). PVBMT analysis identifies limited or no activity for Brief Emotional/Behavioral Assessment, Behavioral Health Integration, Psychiatric Collaborative Care Management relative to the attributed mood disorders population. These findings may represent opportunities to expand structured mood disorders management workflows where clinically appropriate.

**Recommended focus:** Create a recurring behavioral-health follow-up pathway for eligible patients.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Atrial Fibrillation Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **99** | **4** | **0** |
| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
| **1** | **3** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with atrial fibrillation management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Electrocardiogram** | 93000 / 93010 | As indicated | **No activity identified** |
| **Ambulatory Rhythm Monitoring** | 93224 / 93225 / 93226 / 93227 | As indicated | **No activity identified** |
| **Chronic Care Management** | 99490 | Monthly | **No activity identified** |

### Current CMS Utilization

**4 services evaluated:** 0 identified, 1 limited, 3 not identified.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Electrocardiogram (93000/93010), Ambulatory Rhythm Monitoring (93224/93225/93226/93227), Chronic Care Management (99490). PVBMT analysis identifies limited or no activity for Annual Wellness Visit, Electrocardiogram, Ambulatory Rhythm Monitoring, Chronic Care Management relative to the attributed atrial fibrillation population. These findings may represent opportunities to expand structured atrial fibrillation management workflows where clinically appropriate.

**Recommended focus:** Develop recurring rhythm, medication, and anticoagulation follow-up for clinically appropriate patients.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Stroke / TIA Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **82** | **4** | **0** |
| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
| **0** | **4** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with stroke / tia management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Transitional Care Management** | 99495 / 99496 | After qualifying discharge | **No activity identified** |
| **Chronic Care Management** | 99490 | Monthly | **No activity identified** |
| **Therapeutic Exercise** | 97110 | As indicated | **No activity identified** |
| **Therapeutic Activities** | 97530 | As indicated | **No activity identified** |

### Current CMS Utilization

**4 services evaluated:** 0 identified, 0 limited, 4 not identified.

**No related HCPCS activity identified for the common stroke / tia services reviewed.**

### Condition Evidence

PVBMT reviewed Transitional Care Management (99495/99496), Chronic Care Management (99490), Therapeutic Exercise (97110), Therapeutic Activities (97530). PVBMT analysis identifies limited or no activity for Transitional Care Management, Chronic Care Management, Therapeutic Exercise, Therapeutic Activities relative to the attributed stroke / tia population. These findings may represent opportunities to expand structured stroke / tia management workflows where clinically appropriate.

**Recommended focus:** Use structured post-event and recurring risk-reduction follow-up for eligible patients.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Hyperlipidemia Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **233** | **4** | **0** |
| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
| **1** | **3** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with hyperlipidemia management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|

| | | | |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Cardiovascular Disease Risk Reduction Counseling** | G0446 | Annual when eligible | **No activity identified** |
| **Lipid Panel** | 80061 | As indicated | **No activity identified** |
| **Direct LDL Measurement** | 83721 | As indicated | **No activity identified** |

### Current CMS Utilization

**4 services evaluated:** 0 identified, 1 limited, 3 not identified.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Cardiovascular Disease Risk Reduction Counseling (G0446), Lipid Panel (80061), Direct LDL Measurement (83721). PVBMT analysis identifies limited or no activity for Annual Wellness Visit, Cardiovascular Disease Risk Reduction Counseling, Lipid Panel, Direct LDL Measurement relative to the attributed hyperlipidemia population. These findings may represent opportunities to expand structured hyperlipidemia management workflows where clinically appropriate.

**Recommended focus:** Use an annual lipid-management and medication-adherence review workflow.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Asthma Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **58** | **4** | **0** |
| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
| **1** | **3** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with asthma management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Spirometry** | 94010 / 94060 | As indicated | **No activity identified** |
| **Inhaler Education** | 94664 | As indicated | **No activity identified** |
| **Chronic Care Management** | 99490 | Monthly when eligible | **No activity identified** |

### Current CMS Utilization

**4 services evaluated:** 0 identified, 1 limited, 3 not identified.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Spirometry (94010/94060), Inhaler Education (94664), Chronic Care Management (99490). PVBMT analysis identifies limited or no activity for Annual Wellness Visit, Spirometry, Inhaler Education, Chronic Care Management relative to the attributed asthma population. These findings may represent opportunities to expand structured asthma management workflows where clinically appropriate.

**Recommended focus:** Establish routine asthma control assessment and inhaler-use follow-up.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Cancer Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **41** | **4** | **0** |
| **LIMITED ACTIVITY** | **NO ACTIVITY IDENTIFIED** | **ROLE IN REPORT** |
| **1** | **3** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with cancer management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Limited activity identified (31)** |
| **Chronic Care Management** | 99490 | Monthly | **No activity identified** |
| **Complex Chronic Care Management** | 99487 | Monthly when applicable | **No activity identified** |
| **Transitional Care Management** | 99495 / 99496 | After qualifying discharge | **No activity identified** |

### Current CMS Utilization

**4 services evaluated:** 0 identified, 1 limited, 3 not identified.

**Current activity identified for 31 related HCPCS services, below the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Chronic Care Management (99490), Complex Chronic Care Management (99487), Transitional Care Management (99495/99496). PVBMT analysis identifies limited or no activity for Annual Wellness Visit, Chronic Care Management, Complex Chronic Care Management, Transitional Care Management relative to the attributed cancer population. These findings may represent opportunities to expand structured cancer management workflows where clinically appropriate.

**Recommended focus:** Create a survivorship, medication, symptom, and care-coordination follow-up pathway.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

## Osteoporosis Management

| ATTRIBUTED PATIENTS | SERVICES REVIEWED | ACTIVITY IDENTIFIED |
|---|---|---|
| **21** | **3** | **1** |
| LIMITED ACTIVITY | NO ACTIVITY IDENTIFIED | ROLE IN REPORT |
| **0** | **1** | **Supporting evidence** |

### Potential Clinical Service Opportunities Reviewed

PVBMT evaluated the following services commonly associated with osteoporosis management.

| CLINICAL SERVICE | TYPICAL CPT / HCPCS | PLANNING FREQUENCY | CMS ACTIVITY |
|---|---|---|---|
| **Annual Wellness Visit** | G0438 / G0439 | Annual | **Activity identified (31)** |
| **Bone Density Study** | 77080 / 77081 / 77085 | As indicated | **No activity identified** |
| **Fall Risk Assessment** | Payer dependent | Preventive workflow | **Payer dependent** |

### Current CMS Utilization

**3 services evaluated:** 1 identified, 0 limited, 1 not identified, and 1 payer dependent.

**Current activity identified for 31 related HCPCS services, meeting or exceeding the configured planning frequency.**

### Condition Evidence

PVBMT reviewed Annual Wellness Visit (G0438/G0439), Bone Density Study (77080/77081/77085), Fall Risk Assessment. PVBMT analysis identifies limited or no activity for Bone Density Study relative to the attributed osteoporosis population. These findings may represent opportunities to expand structured osteoporosis management workflows where clinically appropriate.

**Recommended focus:** Use an annual bone-health, fall-risk, medication, and screening review.

**Planning Considerations:** Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

# Condition Evidence Summary

These condition populations support the clinical-service opportunities calculated in the Executive Summary. They are not separately added to the financial total.

| CONDITION | ATTRIBUTED PATIENTS | SERVICES REVIEWED | IDENTIFIED | LIMITED | NOT IDENTIFIED | RECOMMENDED FOCUS |
|---|---|---|---|---|---|---|
| Alzheimer's and Other Dementia | 92 | 4 | 0 | 1 | 3 | Establish cognitive assessment, care-planning, caregiver support, and recurring follow-up workflows. |
| Diabetes | 154 | 4 | 0 | 1 | 3 | Establish structured quarterly diabetes follow-up, medication review, monitoring, and patient education workflows. |
| Heart Failure | 133 | 4 | 0 | 1 | 3 | Use structured quarterly follow-up and care-management workflows for eligible heart-failure patients. |

| | | | | | | |
|---|---|---|---|---|---|---|
| Hypertension | 257 | 6 | 0 | 1 | 4 | Implement a structured blood-pressure monitoring and semiannual follow-up program. |
| Anxiety Disorders | 130 | 3 | 0 | 0 | 3 | Use structured screening and follow-up for clinically appropriate patients. |
| Depression | 127 | 4 | 0 | 0 | 4 | Implement screening, follow-up, and behavioral-health integration workflows where clinically appropriate. |
| Ischemic Heart Disease | 140 | 4 | 0 | 1 | 3 | Use structured cardiovascular risk, medication, and symptom follow-up. |
| Chronic Kidney Disease | 130 | 4 | 0 | 1 | 3 | Create a recurring kidney-health monitoring, medication review, and care-coordination pathway. |
| Rheumatoid/Osteoarthritis | 181 | 5 | 0 | 1 | 4 | Develop a recurring pain, mobility, medication, and functional-status follow-up pathway. |
| COPD | 116 | 5 | 0 | 1 | 4 | Implement recurring COPD assessment, inhaler education, monitoring, and exacerbation-prevention follow-up. |
| Mood Disorders | 154 | 3 | 0 | 0 | 3 | Create a recurring behavioral-health follow-up pathway for eligible patients. |
| Atrial Fibrillation | 99 | 4 | 0 | 1 | 3 | Develop recurring rhythm, medication, and anticoagulation follow-up for clinically appropriate patients. |
| Stroke / TIA | 82 | 4 | 0 | 0 | 4 | Use structured post-event and recurring risk-reduction follow-up for eligible patients. |
| Hyperlipidemia | 233 | 4 | 0 | 1 | 3 | Use an annual lipid-management and medication-adherence review workflow. |
| Asthma | 58 | 4 | 0 | 1 | 3 | Establish routine asthma control assessment and inhaler-use follow-up. |
| Cancer | 41 | 4 | 0 | 1 | 3 | Create a survivorship, medication, symptom, and care-coordination follow-up pathway. |
| Osteoporosis | 21 | 3 | 1 | 0 | 1 | Use an annual bone-health, fall-risk, medication, and screening review. |

# Methodology & Limitations

PVBMT analyzes Medicare utilization information together with proprietary workflow intelligence, healthcare analytics, clinical modeling, and configurable planning assumptions to identify provider-specific clinical service opportunities. Annual Wellness Visit, chronic care management, remote patient monitoring, behavioral health, ABI, and related service opportunities are estimated using PVBMT planning methodologies. Planning assumptions are applied solely for strategic planning and opportunity modeling.

Available Medicare utilization information does not capture every clinical service, payer, billing practitioner, documentation pathway, or patient interaction. Accordingly, this analysis is intended solely as a strategic planning tool and should not be interpreted as a billing, coding, compliance, reimbursement, or legal determination.

All opportunity estimates are illustrative planning estimates only. Actual reimbursement depends on eligibility, payer requirements, coverage, medical necessity, documentation, coding, supervision, place of service, frequency limits, and other applicable requirements. This report is not a guarantee of reimbursement or revenue and is not clinical, coding, billing, or legal advice.