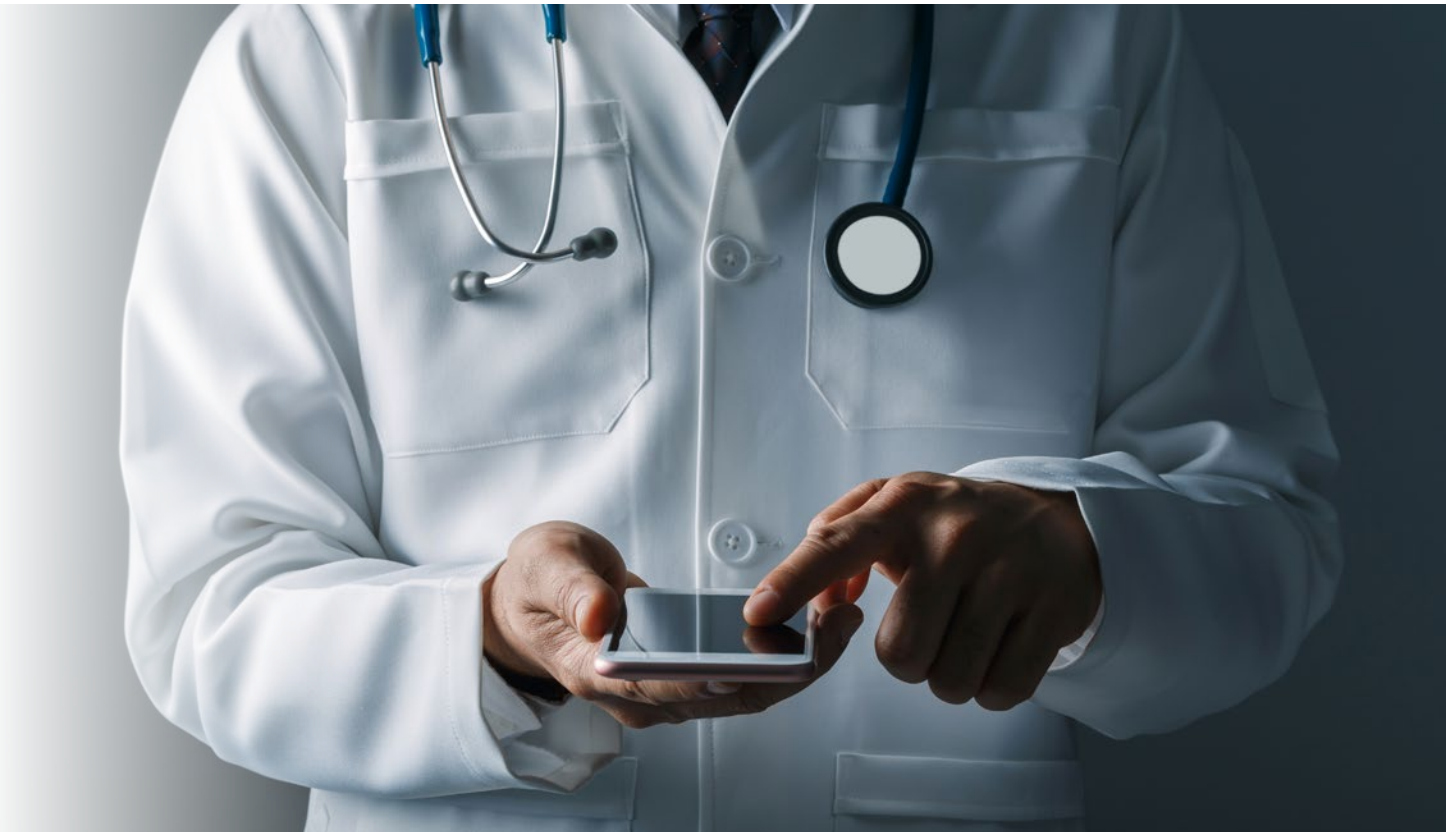
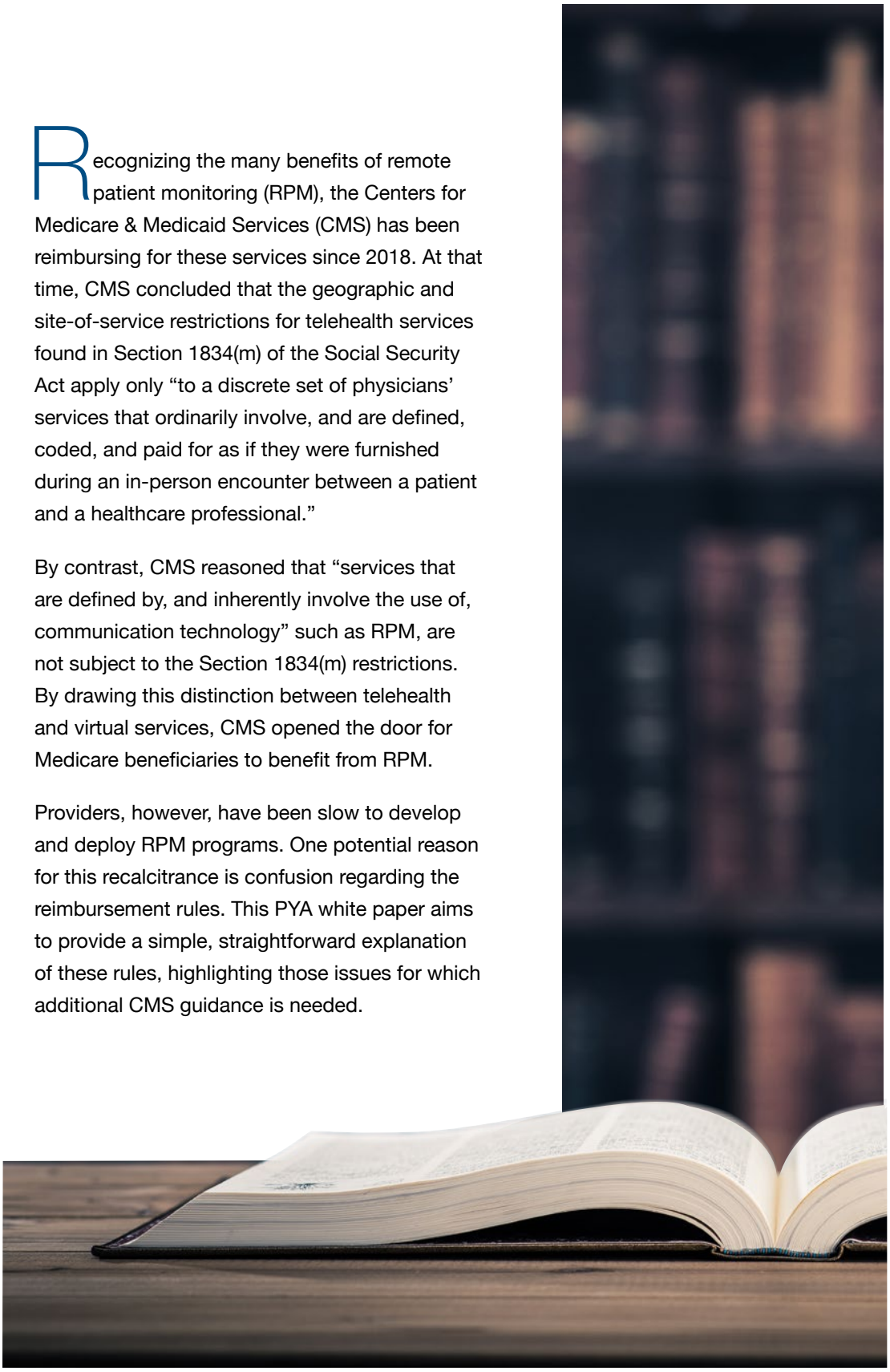
Providing and Billing Medicare for Remote Patient Monitoring



Recognizing the many benefits of remote patient monitoring (RPM), the Centers for Medicare & Medicaid Services (CMS) has been reimbursing for these services since 2018. At that time, CMS concluded that the geographic and site-of-service restrictions for telehealth services found in Section 1834(m) of the Social Security Act apply only "to a discrete set of physicians' services that ordinarily involve, and are defined, coded, and paid for as if they were furnished during an in-person encounter between a patient and a healthcare professional."

By contrast, CMS reasoned that "services that are defined by, and inherently involve the use of, communication technology" such as RPM, are not subject to the Section 1834(m) restrictions. By drawing this distinction between telehealth and virtual services, CMS opened the door for Medicare beneficiaries to benefit from RPM.

Providers, however, have been slow to develop and deploy RPM programs. One potential reason for this recalcitrance is confusion regarding the reimbursement rules. This PYA white paper aims to provide a simple, straightforward explanation of these rules, highlighting those issues for which additional CMS guidance is needed.



I. Medicare Reimbursement for RPM Under CPT 99091

Starting January 1, 2018, CMS began reimbursing for RPM under CPT®[1] 99091, a code initially introduced in 2002. For years, CMS had considered a physician's work in reviewing and interpreting data transmitted by a patient to be covered by the management services codes already billed by the physician. Stated another way, CPT 99091 was "bundled" with other management services codes and was not separately reimbursable.

In the wake of technological advancements that make RPM a valuable tool for physicians managing patients with chronic conditions, CMS "unbundled" the code, thus permitting separate payment under CPT 99091. At the time, CMS noted this was a stop-gap measure until the CPT Editorial Panel finalized a new set of RPM codes.

> **CPT 99091**: Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days.

To address concerns regarding the broad nature of the code, CMS elected to "apply some of the current requirements regarding chronic care management services (CCM) to identify circumstances appropriate for reporting the code."

> Specifically, given the non-face-to-face nature of the services described by CPT code 99091, we are requiring that the practitioner obtain advance beneficiary consent for the service and document this in the patient's medical record.
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> Additionally, for new patients or patients not seen by the billing practitioner within 1 year prior to billing CPT code 99091, we are requiring initiation of the service during a face-to-face visit with the billing practitioner. . . . We are also adopting the prefatory language for CPT code 99091, including the requirement that it "should be reported no more than once in a 30-day period to include the physician or other qualified health care professional time involved with data accession, review and interpretation, modification of care plan as necessary (including communication to patient and/or caregiver), and associated documentation.[2]

Despite the initial excitement regarding new Medicare reimbursement for RPM, a closer look revealed serious shortcomings. CPT 99091 requires the 30 minutes of service be personally performed by the practitioner as opposed to clinical staff. Given that (1) the national payment amount for CPT 99091 was approximately $57 compared to approximately $74 for a routine office visit (CPT 99213), and (2) there was no reimbursement for the expenses associated with the necessary equipment or transmission of data, the financial incentive was not worth the effort involved in providing this new service.

1 Current Procedural Terminology (CPT®) is a registered trademark of the American Medical Association.

2 82 Fed. Reg. 53,014 (Nov. 15, 2017).

II. Medicare Reimbursement for RPM Under New CPT Codes

True to its word, CMS announced in the 2019 Medicare Physician Fee Schedule Final Rule that it would reimburse three new RPM codes approved by the CPT Editorial Panel in September 2018, effective January 1, 2019:

> **CPT 99453**: Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.

> **CPT 99454**: Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; each 30 days.

> **CPT 99457**: Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.

The 2019 national payment rates for the three RPM codes are included in the table below:

CPT Code	Non-Facility Rate	Facility Rate
99453	$19.46	Same
99454	$64.15	Same
99457	$51.54	$32.44

CPT 99453 and 99454 represent CMS' attempt to provide reimbursement for the practice expense associated with furnishing RPM services, including the cost associated with the monitoring device, its placement with the beneficiary, and the transmission of data to the billing practice. No physician work is required to bill for either code.

In the 2019 Hospital Outpatient Prospective Payment System Final Rule, CMS assigned CPT 99453 to APC 5012 (Clinic Visit and Related Services) with a payment rate of approximately $116 and CPT 99454 to APC 5741 (Level 1 Electronic Analysis of Devices) with a payment rate of approximately $36. CMS did not assign an APC to CPT 99457.[3]

On August 14, 2019, CMS published the 2020 Medicare Physician Fee Schedule Proposed Rule,[4] which includes a new RPM add-on code, CPT 994X0, to report subsequent 20-minute intervals of treatment management services. While CMS has assigned a work relative value unit (wRVU) of 0.61 to CPT 99457, it proposes to assign a wRVU of 0.50 to CPT 994X0, meaning the reimbursement for the new code will be slightly less.

Also, in the 2020 proposed rule, CMS reaffirmed that use of RPM technology in a hospital outpatient setting reported with CPT 99453 is assigned to APC 5012 with a proposed 2020 payment rate of $120.16. Monitoring reported with CPT 99454 is assigned to APC 5741 with a proposed 2020 payment rate of $38.04.

Note that APC 5741 has a status indicator "T" (i.e., it is packaged when billed with another service with the same date of service). APC 5012 has status indicator "S"—this means it will be paid separately even if billed with another service with the same date of service. Thus, if APC 5741 and 5012 were billed with the same date of service, the hospital would receive only the payment associated with APC 5012.

3 83 Fed. Reg. 59,452 (Nov. 11, 2018).

4 84 Fed. Reg. 40,482 (Aug. 14, 2019).

III. Medicare RPM Billing Rules

A. Medical Necessity for RPM

CMS has not directly addressed medical necessity for RPM (i.e., identified the specific circumstances in which CMS will make payment for RPM) other than to indicate the monitoring should relate to a chronic condition. Presumably, a practitioner should order RPM only if the provided data regarding the patient would be directly relevant to how the practitioner would manage the patient. Such justification for RPM should be documented in the patient's medical record.

B. Technology Requirements

The code descriptor for CPT 99454 states "device(s) supply with daily recording(s) or programmed alter(s) transmission. . . ." We interpret this to mean the device must be capable of generating and transmitting either (a) daily recordings of the patient's physiologic data, or (b) an alert if the patient's values fall outside pre-determined parameters.

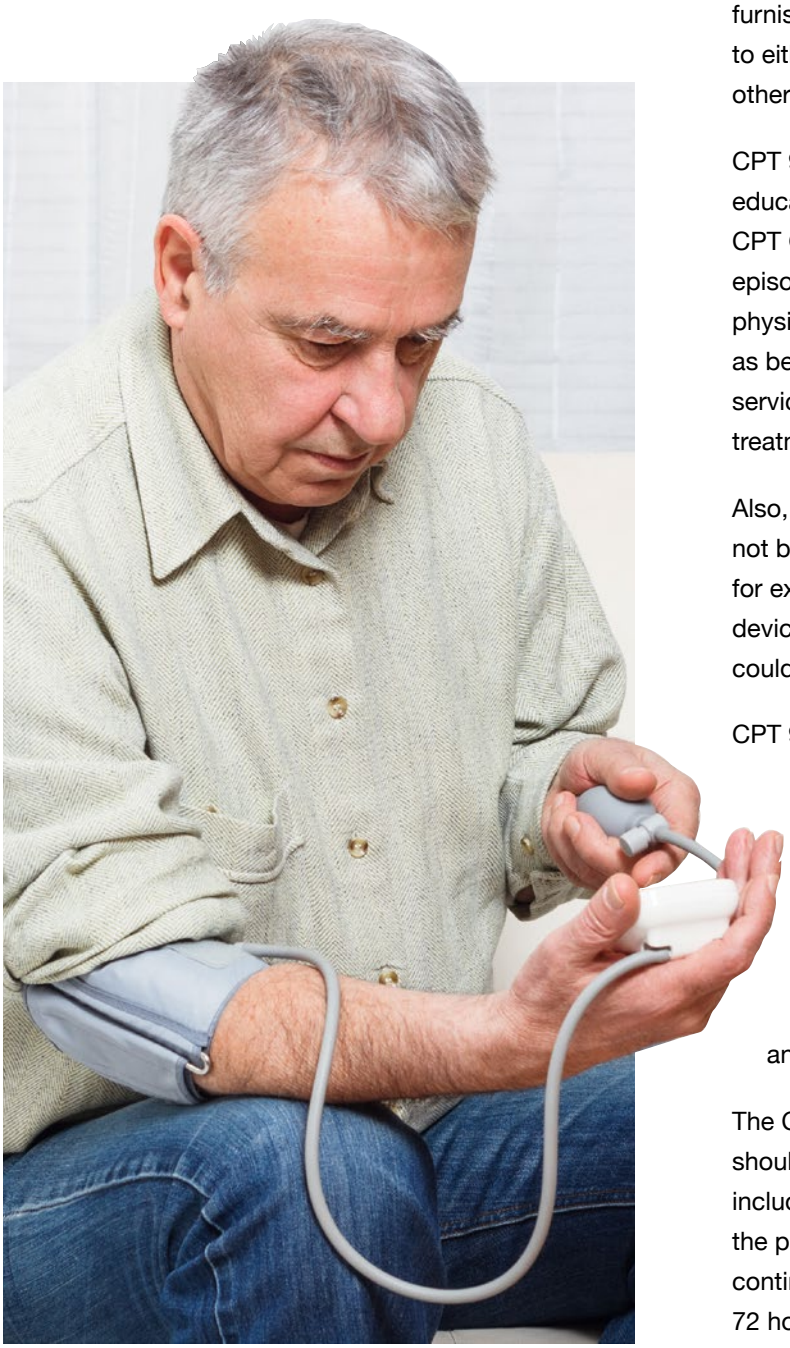
In the 2019 Final Rule, CMS summarized the comments it received seeking clarification on several matters, including technology requirements:

> Many commenters requested that CMS clarify the kinds of technology covered under [these CPT codes]. Commenters provided examples of the kinds of technology these codes should cover including software applications that could be integrated into a beneficiary's smart phone, Holter-Monitors, Fit-Bits, or artificial intelligence messaging. One commenter suggested that behavioral health data and data from wellness applications be included as well. Another commenter stated that the description should include results of patients' self-care tasks. Many commenters stated that CMS should clarify certain elements in the scope of service and code descriptors and issue appropriate sub-regulatory guidance. Commenters inquired as to whether CPT code 99453 can be furnished via telecommunication technology, if it can be billed again if the number of parameters changed in the future. Commenters requested that CMS clarify the meaning of "programmed alerts transmission" in the descriptor for CPT code 99454, and whether it included transmissions that occurred other than daily. Commenters also encouraged CMS to allow flexibility in the time frame covered by these services.[5]

In response, CMS stated that it plans "to issue guidance to help inform practitioners and stakeholders on these issues." To date, no such guidance has been released, and there is no timeline for its publication. Nor has any Medicare Administrative Contractor issued any guidance regarding RPM.

At present, the only guidance regarding technology requirements is found in the CPT Guidelines for CPT 99453 and 99454, which state the monitoring device "must be a medical device as defined by the FDA. . . ."

5 83 Fed. Reg. 59,574 (Nov. 23, 2018).



C. CPT 99453 and 99454

The first two RPM codes, CPT 99453 and 99454, reimburse for the practice expense associated with furnishing RPM services. There is no wRVU assigned to either code; no practitioner work—supervision or otherwise—is required to bill for these services.

CPT 99453 is used to report the set-up and patient education on use of the device(s). According to the CPT Guidelines, CPT 99453 "is reported for each episode of care. For coding remote monitoring of physiologic parameters, an episode of care is defined as beginning when the remote monitoring physiologic service is initiated, and ends with attainment of targeted treatment goals."

Also, the CPT Guidelines state that CPT 99453 should not be reported "if monitoring is less than 16 days." If, for example, a patient receives and is educated on the device, but no data is transmitted by the device, one could not bill for CPT 99453.

CPT 99454 is used to report the supply of the device for daily recording or programmed alert transmissions over a 30-day period, provided monitoring occurs during at least 16 days during the 30-day period. For example, if a patient initiated monitoring on July 1 and continued through September 12, one would report CPT 99453 in July and CPT 99454 in July and August (but not September).

The CPT Guidelines also state CPT 99453 and 99454 should not be reported "when these services are included in other codes for the duration of time of the physiologic monitoring service (e.g., 95250 for continuous glucose monitoring requires a minimum of 72 hours of monitoring)."

CMS has not stated any requirements nor offered any guidance regarding the documentation necessary to support a claim under CPT 99453 or 99454, or the appropriate date or place of service to be listed on the claim form. Absent such direction, we recommend the following:

1. Based on CMS' guidance regarding CCM, the place of service for both codes would be the location at which the billing physician maintains his or her practice (i.e., physician office vs. hospital outpatient department).
2. The date of service for CPT 99453 would be the date on which the device is delivered to the patient or caregiver or the training on the device is completed, whichever is later.
3. The documentation for CPT 99453 would include (a) a practitioner order for deployment of the device; (b) the condition for which the beneficiary is being monitored; (c) identification of the device; (d) date of delivery of the device to the patient/caregiver; and (e) date(s) on which training is provided to patient/caregiver.[6]
4. If the device records and transmits data for at least 16 days, but not more than 30 days, the date of service for CPT 99454 would be the last day the device records data and transmits it to the provider.
5. If the device records and transmits data for more than 30 days, the date of service for the first instance of CPT 99454 for a given beneficiary would be 30 days following the delivery of the device or completion of training (whichever occurred later). The date of service for each instance thereafter would be 30 days from the prior date of billing, provided the use of the device continued at least 16 days after the date of service.
6. The documentation for CPT 99454 would be sufficient to demonstrate the transmission of daily recordings or alerts.

6 If, for some reason, CPT 99453 was not billed for the deployment of a specific device, the practice still should maintain this documentation to support claims under CPT 99454.

It is not necessary to bill CPT 99457 in order to bill for CPT 99454, and vice versa. Thus, a practice still could be reimbursed for setting up the device (CPT 99454) even if less than 20 minutes were devoted to interpreting and acting on the transmitted data. And similarly, a practice could bill for CPT 99457 if 20 minutes or more were spent in a month interpreting and acting on the transmitted data, but the device was deployed with the patient for less than 16 days.

D. CPT 99457

CPT Guidelines specify that "[r]emote physiologic monitoring treatment management services are provided when clinical staff/physician/other qualified health care professional use the results of remote physiological monitoring to manage a patient under a specific treatment plan. . . . [CPT] 99457 requires a live, interactive communication with the patient/caregiver and 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month."

Presently, time spent by clinical staff[7] may be counted toward the 20 minutes only if services are furnished under direct supervision (i.e., the billing practitioner is physically present in the same suite of offices at the time the services are performed and is immediately available to provide assistance).

However, CMS now proposes to permit general supervision effective for services furnished on or after January 1, 2020:

> We are proposing that RPM services reported with CPT codes 99457 and 994X0 may be furnished under general supervision rather than the currently required direct supervision. Because care management services include establishing, implementing, revising, or monitoring treatment plans, as well as providing support services, and because RPM services (that is, CPT codes 99457 and 994X0) include establishing, implementing, revising, and monitoring a specific treatment plan for a patient related to one or more chronic conditions that are monitored remotely, ***we believe that CPT codes 99457 and 994X0 should be included as designated care management services. Designated care management services can be furnished under general supervision.*** Section 410.26(b)(5) of our regulations states that designated care management services can be furnished under the general supervision of the "physician or other qualified health care professional (who is qualified by education, training, licensure/regulation and facility privileging)" (see also 2019 CPT Codebook, page xii) when these services or supplies are provided incident to the services of a physician or other qualified healthcare professional. The physician or other qualified healthcare professional supervising the auxiliary personnel need not be the same individual treating the patient more broadly. However, only the supervising physician or other qualified healthcare professional may bill Medicare for incident to services.

7 "Clinical staff" comprises those individuals included in the CPT definition of clinical staff who comply with the "incident to" rules in 42 C.F.R. 410.26. The CPT definition of clinical staff is "a person who works under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service." A clinical staff member must practice within the scope of his or her licensure, training, and experience; subject to general supervision of a physician or other qualified non-physician practitioner (which need not be the practitioner who bills CCM); and under an appropriate contractual relationship with the practitioner. It is the responsibility of the billing practitioner to determine whether a clinical staff member is competent and capable of performing a specific service under appropriate supervision.

The CPT Guidelines provide the following clarifications regarding the circumstances in which CPT 99457 may be billed:

1. "99457 may be reported during the same service period as chronic care management services (99487, 99489, 99490), transitional care management services (99495, 99496), and behavioral health integration services (99484, 99492, 99493, 99494). However, time spent performing these services should remain separate and no time should be counted toward the required time for both services in a single month."

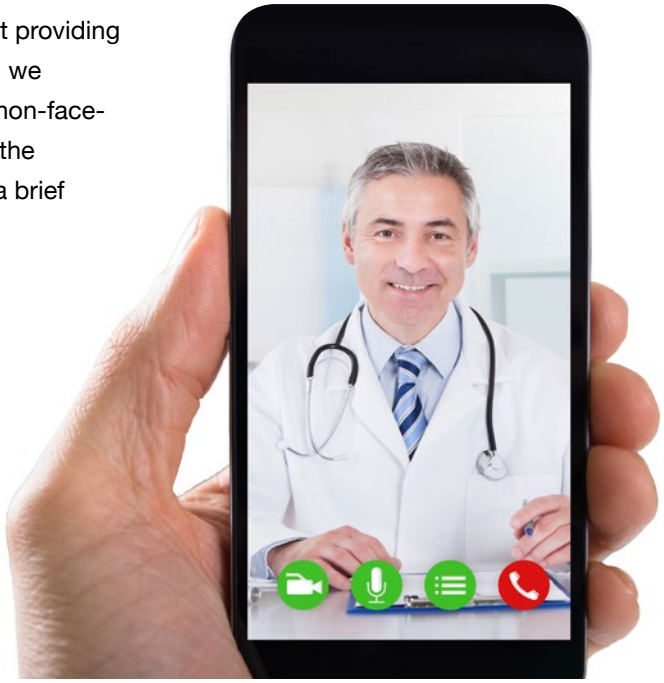
2. Do not count any time on a day when the physician or other qualified healthcare professional reports an E/M service (office or other outpatient services 99201, 99202, 99203-99205, 99211-99215, domiciliary, rest home services 99324-99328, 99334-99337, home services 99341-99345 and 99347-99350). Do not count any time related to other reported services (e.g., 93290).

3. Report CPT 99457 one time regardless of the number of physiologic monitoring modalities performed in a given calendar month.

Additionally, CMS has provided the following rules with respect to counting 20 minutes for CCM, and we assume CMS would apply the same rules for CPT 99457: (1) time spent providing services on different days, or by different clinical staff members in the same calendar month, may be aggregated to total 20 minutes; (2) if two staff members are furnishing services at the same time (e.g., discussing together the beneficiary's condition), only the time spent by one individual may be counted; (3) time of less than 20 minutes during a calendar month cannot be rounded up to meet this requirement; and (4) time in excess of 20 minutes in one month cannot be carried forward to the next month.

For CCM, one may count time a practitioner or clinical staff member spends with more than one beneficiary (e.g., educating two beneficiaries at the same time) toward the total minutes for all participating beneficiaries. However, CMS has not clarified whether or how "exception monitoring" (e.g., using a technology that monitors multiple individuals' data to identify any results outside pre-determined ranges) would be counted toward the required 20 minutes for each beneficiary.

CMS has not provided guidance regarding the way time spent providing care management services should be documented. For RPM, we recommend capturing the date and time spent providing the non-face-to-face services (including start and stop times), the name of the care team member providing services (with credentials), and a brief description of the services provided.



CPT 99457 also requires there be "live interactive communication" during the month with the patient or caregiver for the service to be billable. Although CMS has not defined what constitutes a "live interactive communication," we assume a face-to-face visit, an interactive video conference (e.g., FaceTime), or a conversation by telephone or text message would be sufficient. A record of such communication should be included within the documentation for the service.

Although CMS has not addressed the issue, we believe, based on CMS' guidance regarding CCM, that the date of service on the claim would be the date on which the 20th minute of work occurs or any date thereafter in the calendar month. The place of service would be the location at which the billing physician maintains his or her practice (i.e., physician office vs. hospital outpatient department).

None of the RPM codes may be billed as rural health clinic (RHC) or federally qualified health center (FQHC) services. In the case of TCM and CCM, CMS subsequently permitted RHCs and FQHCs to bill for these services, and hopefully it will do the same for RPM in the near future.

CMS permits only one practitioner to bill for CCM for a given patient in a given month. CMS has made no similar statement regarding RPM. Presumably, a beneficiary may have two monitoring devices with one supplied by the physician monitoring one chronic condition and one by another physician monitoring another condition, and both physicians would be eligible for payment. Nor has CMS clarified whether the same physician may bill for multiple units of any of the RPM codes if he or she deploys more than one device with the patient.

E. Consent and Face-to-Face Visit

As described earlier, CMS requires a practitioner billing for RPM under CPT 99091 to (1) obtain advance beneficiary consent for the service, and document this in the patient's medical record, and (2) initiate the service during a face-to-face visit, unless the practitioner has seen the patient within one year prior to billing CPT 99091. CMS explained in the 2018 Medicare Physician Fee Schedule Final Rule that it was imposing these additional requirements applicable to CCM due to concerns regarding the broad nature of CPT 99091.

CMS, however, made no reference to these requirements in its discussions of the new RPM codes in the 2019 Medicare Physician Fee Schedule Proposed and Final Rules or the 2020 Medicare Physician Fee Schedule Proposed Rule. In the 2020 proposed rule, CMS is suggesting new reimbursement for a specific bundle of services relating to opioid use disorder (OUD). CMS includes in its proposal a requirement that the services be initiated as part of a face-to-face visit. The agency offers the following explanation for this requirement:

> We are proposing that practitioners reporting the OUD bundle must furnish a separately reportable initiating visit in association with the onset of OUD treatment, since the bundle requires a level of care coordination that cannot be effective without appropriate evaluation of the patient's needs. This is similar to the requirements for chronic care management (CCM) services (CPT codes 99487, 99489, 99490, and 99491) and BHI [behavioral health integration] services (CPT codes 99484, 99492, 99493, and 99494) finalized in the CY 2017 PFS [Physician Fee Schedule] final rule (81 FR 80239). . . . We propose that the same services that can serve as the initiating visit for CCM services and BHI services can serve as the initiating visit for the proposed services described by HCPCS codes GYYY1-GYYY3.

For more information about providing and billing Medicare for RPM, contact:

Martie Ross
Principal
mross@pyapc.com
(800) 270-9629

Lori Foley
Principal
lfoley@pyapc.com
(800) 270-9629

Importantly, CMS does not reference a face-to-face requirement associated with RPM, despite having previously imposed such a requirement for CPT 99091. This omission supports the interpretation that CMS did not intend to carry forward the consent and face-to-face visit requirements for the new RPM codes; these limits apply only to RPM services reported under CPT 99091.

IV. Conclusion

The addition of Medicare reimbursement for RPM holds great promise for improving care and outcomes for patients requiring ongoing monitoring. An amazing array of technology solutions are already available, and in use, to enable these services, and more are entering the market every day.

While the Medicare billing rules for RPM are challenging, these rules should not be viewed as an absolute barrier to providing this important service. Instead, practitioners should be familiar with, and structure, their service delivery models to meet the requirements. With our experience and expertise, PYA can assist your organization in building a successful ambulatory care management program, including the provision of RPM services.