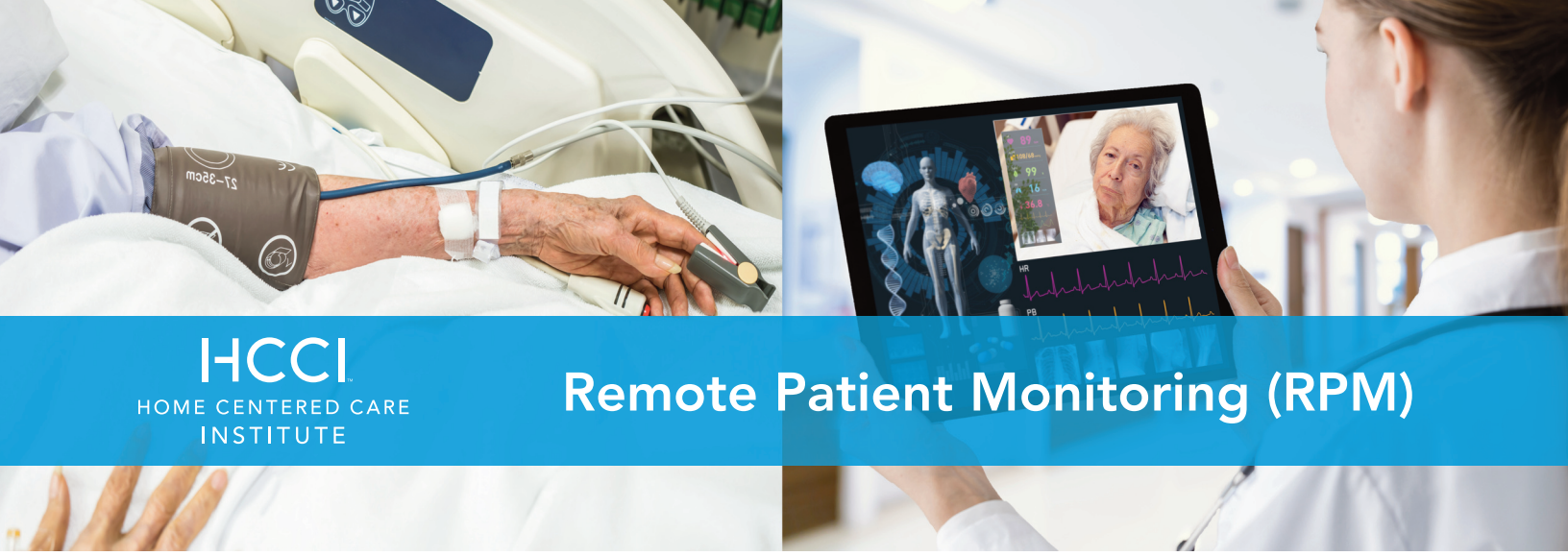

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Remote Patient Monitoring (RPM)

Purpose

This resource is designed to guide house call programs in the use of remote patient monitoring services to care for their patients following the expansion and highlighted need for telemedicine as a result of the COVID-19 pandemic. However, it's important to realize Remote Patient Monitoring is not designated as telehealth by the Centers for Medicare and Medicaid Services (CMS) definition; therefore, the opportunity to use technology and reimbursement opportunities for RPM will continue after the end of the Public Health Emergency (PHE).

Introduction

RPM is defined as using technology via medical devices to collect and analyze patient physiologic data used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. The physiologic data (e.g., blood glucose, blood pressure) must be digitally, which CMS defines as automatically transmitted to the practice. This is not the patients or caregivers calling to self-report vitals and involves a technology vendor.

RPM is billed for by qualified providers (i.e., physicians, nurse practitioners, physician assistants), but the care management services and monitoring of the treatment plan may be provided in collaboration with clinical staff under the billing provider's general supervision.

CMS clarified that during the PHE, RPM services may be provided to new and established patients. When the PHE ends CMS finalized their policy that there must be an established patient-provider relationship to furnish and bill RPM services. RPM requires patient consent; however, it may be obtained at the time services are furnished.

RPM Requirements

It is important that providers understand all the requirements and what needs to be documented before billing for RPM services, including the following:

- Medical necessity still applies, meaning treatment must be supported as necessary for the diagnosis or treatment of the patient's illness or injury or to improve the functioning of a malformed body member.
- RPM services must be initiated during a face-to-face visit (or telehealth during the PHE) for patients not seen within the past year.
- Obtain and document patient consent for services.
- The RPM device must meet the FDA's definition of a "medical device"[1] (does not have to be FDA-approved, but must still meet the definition). The medical device must be used to collect and transmit reliable and valid physiologic data that allow understanding of a patient's health status to develop and manage a plan of treatment.

[1] https://www.fda.gov/industry/regulated-products/medical-device-overview#What%20is%20a%20medical%20device

- CMS designated CPT 99457 and 99458 as care management services, which require the use of interactive communication. As with other care management services, clinical staff's time associated with CPT 99457 and 99458 may be provided under the billing provider's general supervision. Clinical staff refers to a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service but does not individually report that professional service. Refer to the CY 2021 Medicare Physician Fee Schedule Final Rule[2] and CPT codebook for source reference.
- To furnish and bill for RPM services (CPT 99453 and 99454) requires 16 days of data; each 30 days must be collected and transmitted. CMS clarified the 16-day requirement will remain their final policy after the PHE ends.
- RPM can be billed in conjunction with Chronic Care Management (CCM), Transitional Care Management (TCM), and Behavioral Health Integration (BHI) services as long as time and effort are not double-counted.
- Per CPT, do not count any RPM time on a day when the billing provider reports an Evaluation & Management (E/M face-to-face service).

*During the PHE, CMS waived the 16-day minimum requirement to bill for RPM services, but only for patients who have suspected or confirmed COVID-19. In such cases, CMS recognized the value of short-term monitoring (no less than two days) for acute conditions and is allowing payment for CPT codes 99453, 99454, 99091, 99457, and 99458.

Key Definitions:

RPM Care Episode: Begins when the remote physiologic monitoring service is initiated and ends with the attainment of targeted treatment goals.

Interactive Communication (Specific to CPT 99457 & 99458): A real-time synchronous interaction (i.e., conversation) between a patient and billing provider or clinical staff using two-way audio capable of being enhanced with video or other kinds of data transmission.

RPM Care Plan: RPM services include developing a treatment plan informed by analyzing and interpreting the patient's data. After the initial month's data is collected, it's at this point CMS expects the billing provider to develop a treatment plan (defined by CMS as a patient-centered plan of care) with the patient. The provider then must manage the plan until the treatment plan's targeted goals are attained, which signals the end of the episode of care.

Digitally Stored Data Services

CPT Code	Description	Restrictions & Other Guidance	CMS National Non-Facility Payment	wRVU
99453	Remote monitoring of physiologic parameters (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial set-up and patient education on the use of equipment.	• Used to report the initial set-up and patient education on how to use the device. • Report this code towards the end of the month once a minimum of 16-days worth of data has been collected. • Cannot be reported more than once per episode of care, reported one time regardless of the number of medical devices supplied to the patient. • One-time billable use per patient at the start of RPM. • May be provided by auxiliary personnel (including contracted employees) incident to the billing providers services.	$19.19	0
99454	Device supply with daily recordings or programmed alerts, during a 30-day period.	• Used to report the supply of the device for daily recording and programmed alert transmissions. • Cannot be reported for monitoring of fewer than 16 days. Reported once per month, each 30 days, • CPT 99453 and 99454 are used to report remote physiologic monitoring services (e.g., weight, blood pressure, pulse oximetry) during a 30-day period.	$63.16	0

[2] Medicare Physician Fee Schedule Final Rule: https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf

Digitally Stored Data Services cont.

CPT Code	Description	Restrictions & Other Guidance	CMS National Non-Facility Payment	wRVU
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes, each 30 days.	• This code is used to report non-direct patient time personally spent by the billing provider after the initial data collection period when the provider spends their professional work time analyzing and interpreting the data and developing a treatment plan. • Per CMS, 99091 is valued to include a total of 40 minutes of qualified provider time. Broken down as 5 minutes of preservice work (e.g., chart review), 30 minutes of intra-service work (e.g., data analysis and interpretation, and a possible phone call to the patient), and 5 minutes of post-service work, such as chart documentation. • Cannot be reported within the same calendar month as Care Plan Oversight (CPO) and Chronic Care Management (CCM). • Cannot be reported on the same day as an Evaluation & Management (E/M) visit. • CMS clarified that if reasonable and necessary, there may be some instances when it's appropriate to report both 99091 and 99457 for the same patient within the same calendar month.	$56.88	1.10

Remote Physiologic Monitoring Treatment Management Services

CPT Code	Description	Restrictions & Other Guidance	CMS National Non-Facility Payment	wRVU
99457	Remote physiologic monitoring treatment management services, clinical staff, and physician or qualified health care professional time in a calendar month requiring interactive communication with the patient/ caregiver during the month, first 20 minutes.	• May be reported in conjunction with CCM, TCM, and behavioral health integration services; however, time spent must remain separate, do not double-count time. • Requires live interactive communication with the patient/caregiver. • Reported for the first 20 minutes of clinical staff and provider time. • Reported one time each month, regardless of the number of physiologic monitoring modalities performed. • Cannot be reported on the same day as an Evaluation & Management (E/M) visit. • In the CY 2021, Medicare Physician Fee Schedule Fact sheet[3] clarification was provided that the 20-minutes of time required to bill for the services of CPT codes 99457 and 99458 can include time for furnishing care management services as well as for the required interactive communication. CMS subsequently posted a clarification[4] to their CY 2021 final rule supporting this guidance that was initially left out of the published final rule file. Any provider billing RPM services should closely monitor their local MAC's for any forthcoming published guidance.	$50.94	0.61
99458	Each additional 20 minutes (this is an add-on code which can only be billed in conjunction with CPT 99457).	• Add on code only reported in conjunction with 99457. • May be reported in conjunction with CCM, TCM, and behavioral health integration services; however, time spent must remain separate, do not double-count time. • Requires live interactive communication with the patient/caregiver. • Reported for each additional 20 minutes of clinical staff and provider time, cannot report if fewer than 20 minutes. • Cannot be reported on the same day as an Evaluation & Management (E/M) visit.	$41.17	0.61

[3] CMS fact sheet :https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1

[4] https://www.federalregister.gov/documents/2021/01/19/2021-00805/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part

Please be advised that per CMS, CPT 99457 and 99458 are designated as care management services that require a specific treatment plan for RPM services to be established, implemented, revised, and monitored, and include the provision of support services. The treatment plan may relate to one or more chronic conditions that are monitored remotely and can be provided under general supervision. "General supervision" means that, in those situations in which the billing practitioner does not personally perform the service, it is still performed under his or her overall direction and control. However, his or her physical presence is not required.

Due to the above reference included in the Medicare Physician Fee Schedule 2020 Final Rule[5] which requires a treatment plan for RPM services, it's recommended that you maintain a separate and formal care plan that outlines the RPM use and the patient's specific treatment goals.

The sequence and timing of when to submit the various RPM codes can be confusing. Below is a timeline of the sequence of billing in accordance with the guidance CMS outlined within the CY 2021 Medicare Physician Fee Schedule Final Rule[6]:

- **CPT 99453:** reported during the first calendar month of initiating RPM for practice expense reimbursement valued to reflect clinical staff time, including instructing a patient and/or caregiver about using one or more medical devices. (Only billed once per care episode)
- **CPT 99454:** submitted towards the end of the month once you have a minimum of 16 days' worth of physiologic data and is for supplying the patient with the device which automatically and digitally transmits physiologic data to the provider's office (once every 30 days)
- **CPT 99091:** After you have the first 30 days' worth of data, if the provider spends a minimum of 30 minutes (all billing practitioner time) non-direct patient time reviewing and interpreting that data to determine treatment decisions and/or creating or discussing the RPM specific care plan with the patient/caregiver then you submit this code.
- **CPT 99457:** Care management service only billed once you have a minimum of 16 days' worth of data and have developed an RPM-specific care plan for the patient/caregiver. This is a time-based code that requires a minimum of 20 minutes of clinical staff and billing provider time. Requires interactive communication with the patient/caregiver and is for monitoring, interpreting, and communicating with the patient/caregiver about the readings and physiologic data results.
- **CPT 99458:** Care management service is an add-on code only reported in conjunction with CPT 99457 (minimum of 40 minutes per calendar month to bill both 99457 & 99458) requiring the use of interactive communication with the patient/caregiver by the billing practitioner or clinical staff.

[5] https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf

[6] https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1

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