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Remote Patient Monitoring: Reimbursement, RPM Success Stories, and Adoption

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Rebecca's practice encompasses a broad range of regulatory, fraud and abuse, and reimbursement issues that affect physicians, hospitals, transplant centers, diagnostic testing facilities, and providers of telemedicine and remote patient monitoring. She regularly represents clients before the Centers for Medicare and Medicaid Services and other federal agencies on such matters as Medicare and Medicaid payment, coverage and coding.



From her representation of organizations and coalitions, and a long-time role as outside general counsel to a physician specialty organization, Rebecca has developed not only a specialization in the federal laws and regulations governing healthcare, but also an understanding of general association law matters and related issues including HIPAA, antitrust, tax-exemption organizations, and the private insurance marketplace.

With her extensive experience and insight, Rebecca is a frequent contributor to publications in the healthcare area, writing columns and newsletters primarily for physician-focused publications, but also for the general trade press.

REMOTE PATIENT MONITORING REIMBURSEMENT – FREQUENTLY ASKED QUESTIONS

MEDICARE

1. Can RPM services be provided by clinical staff such as RNs?

Yes. CMS has clarified that the 20 minutes or more of time called for in CPT Code 99457 can be provided under Medicare “incident to” rules. Those rules require “direct supervision” which means the physician or qualified health professional (QHP) (e.g., PA, NP) must be on-site when the services are furnished. Stakeholders have urged CMS to allow “general supervision” which would permit clinical staff to provide the services without the requirement that a physician/QHP be on site.

2. The CPT prefatory language states that the RPM codes can only be used in connection with a device that meets FDA’s definition of a “medical device.” What does this mean?

FDA defines a “medical device” as something that is “intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment or prevention of disease . . .” and that does not achieve its primary intended purpose through chemical action or reaction. (Section 201(h) of the Food Drug and Cosmetic Act.) This definition was amended by the 21st Century Cures Act to exclude certain types of medical software from the definition of “medical device.”

The FDA has stated that it will exercise enforcement discretion with respect to mobile medical apps that may meet the definition of medical devices but which the FDA believes pose a low risk to the public. In other words, the FDA may not require that they go through the agency’s device approval process. For a list of these apps as well as those which are and are not considered medical devices see <https://www.fda.gov/medical-devices/mobile-medical-applications/examples-mobile-apps-are-not-medical-devices>.

The list of mobile apps on the “enforcement discretion” list are therefore in a gray area in that it is not clear whether they are actually “medical devices” within the FDA’s definition or not. If not, than use of the RPM codes may not be permitted. Stakeholders have asked the FDA for clarification as to whether services provided with these devices can qualify under CPT Codes 99453-99457.

3. Has CMS clarified what types of physiologic parameters can be billed using the new RPM Codes 99091 and 99453-99457?

Not yet. CMS stated in the final 2019 fee schedule rule that guidance on this and other RPM issues would be forthcoming. However, that guidance has not been issued yet. We understand that it is being worked on but there is no indication of when it will be released.

4. Does patient cost-sharing apply to RPM services?

Yes, patients are required to pay coinsurance. CMS does not have the authority to waive this requirement which is statutory.

5. Can CPT Codes 99453-99457 be used if there is a more specific CPT Code?

No. If there is a more specific code (e.g., home glucose monitoring, cardiac event monitoring, etc.) you must use the more specific code.

6. Can hospitals get reimbursed for RPM services to outpatients?

Yes, hospitals can bill the RPM technical codes (99453 and 99454) under the outpatient prospective payment system (OPPS). Note that Medicare reimbursement amounts under OPPS can be significantly different (and usually higher) than the physician fee schedule payment.

7. Can FQHC and RHCs bill the new RPM codes?

No. The Medicare reimbursement methodology for FQHCs and RHCs does not allow for this. CMS has created G codes for other telehealth services but they do not include RPM.

8. Can Home Health Agencies provide and bill for RPM using the new CPT Codes?

No. Home health agencies cannot bill the new RPM CPT Codes. However, beginning in cost reporting year 2019, HHAs may include RPM costs as allowable administrative costs (i.e., operating expenses) on their cost reports when used to augment the care process. These costs are factored into the cost per visit. Allowable costs include “equipment, set-up and service.” See 42 CFR § 409.46

However, RPM cannot substitute for in-person care and RPM alone or a visit solely for purpose of setting up RPM equipment and training patient is not a justification for coverage of home health services under Medicare home health benefit. Nor is such a visit billable separately.

9. What HH professionals can use RPM?

RPM is an allowable cost when furnished by therapists and other professionals (e.g., RNs) to augment care they furnish. However, the home health agency cannot claim RPM services as allowable costs if they are also claimed by another provider and paid for under the physician fee schedule.

10. Can Independent Diagnostic Testing Facilities (IDTFs) provide the RPM technical services?

CMS has informed us that they see no impediment to IDTFs providing the technical RPM services, including the set-up, patient education, and remote monitoring described in CPT Codes 99453 and 99454. However, individual Medicare Administrative Contractors (MACs) may establish coverage limitations.

11. When during the monitoring period can RPM services be billed?

The initial set-up code (99453) can be billed after 16 days of monitoring. The transmission code (99454) should be billed at the end of each 30-day monitoring period or after monitoring has ended (if less than 30 days) based on CMS guidance on other remote monitoring services. According to an MLN issued in January 2019 (SE 17023), 30-day remote cardiac monitoring services must be billed after monitoring is completed. Although CMS has not stated explicitly, we believe the same principle would apply to other RPM services. Therefore, providers should bill at the end of each 30-day monitoring period or, if monitoring lasts less than 30 days, when monitoring ends. (Remember, however, monitoring must last at least 16 days to be billed.)

12. Do Medicaid Advantage plans cover RPM?

Yes. Medicare Advantage plans are required to cover all services covered by original Medicare. Since original Medicare now covers RPM services, they are also covered by Medicare Advantage plans. However, Medicare Advantage plans can also go beyond what Medicare covers.

MEDICAID

13. Is RPM covered by state Medicaid programs?

There are currently 20 states that cover some form of RPM through their state Medicaid programs. They are:

Alabama, Alaska, Arizona, Colorado, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, South Carolina, Texas, Utah, Vermont, Virginia, and Washington

However, it is important to check state law for any limitations on the types of RPM services covered. Some states only provide Medicaid coverage of RPM for home health care. Others limit it to specific conditions and some impose limits on the types of monitoring devices. Four states (DC, HI, NY and NJ) have enacted laws requiring their state Medicaid program to reimburse for RPM but we are not aware that the state Medicaid agencies have issued policies to implement coverage and reimbursement.

Private Payers

14. What is the state of private payer coverage and reimbursement for RPM services?

In states with telehealth coverage and/or reimbursement parity that include RPM in the definition of telehealth, coverage and payment may be required, depending on how the state law is written. One example is Virginia, which just passed a law requiring commercial payers to cover RPM.

Some payers are starting their own programs or are partnering with health systems. Many see it as a way to keep patients out of the hospital or doctor's office. However, unless coverage is mandated by state law, it will vary by payer.

For questions, contact Rebecca Burke, Powers Pyles Sutter & Verville,
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Remote Patient Monitoring Cheat Sheet

CPT Code	Description	Who Can Bill	Medicare PFS Payment	Medicare OPFS	Coding Tips	Issues in Need of Clarification by CMS
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate; initial set-up of technology and patient education (technical component))	Physician/ QHP IDTF Hospital Outpatient Dept.	~\$19	~\$120	<ul style="list-style-type: none"> ➤ Bill only once per episode of care; ➤ Do not bill if monitoring lasts less than 16 days. ➤ Must be medical device as defined by FDA 	Would devices placed under “enforcement discretion” by the FDA be considered “medical devices?”
99454	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.	Physician/ QHP IDTF Hospital Outpatient Dept.	~\$64	~\$37 (but may be bundled with 99453 payment)	<ul style="list-style-type: none"> ➤ Do not bill if monitoring lasts less than 16 days ➤ Can be reported only once every 30 days ➤ Must be medical device as defined by FDA ➤ Do not bill if there is more specific physiologic parameter monitoring code (e.g., remote cardiac event monitoring, home sleep testing, home glucose monitoring). Use more specific code. 	<p>What is meant by “programmed alert transmission?”</p> <p>Can patient –self reported data satisfy the requirements (e.g., patient uses medical device to record measurements and emails readings to physician)?</p>
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	Physician/ QHP	~\$51	N/A	<ul style="list-style-type: none"> ➤ Do not bill if monitoring is less than 16 days ➤ Can be reported only once every calendar month ➤ Do not bill with CPT Code 99091 ➤ Must be medical device as defined by FDA ➤ May be billed with chronic care management, transitional care management, and behavioral health integration. But overlapping time cannot be reported to both services. 	What is meant by a “a live interactive communication”

CPT Code	Description	Who Can Bill	Medicare PFS Payment	Medicare OPPS	Coding Tips	Issues in Need of Clarification by CMS
					<ul style="list-style-type: none"> ➤ Interaction with patient required ➤ Can be done by “auxiliary personnel” under direct supervision 	
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/regulations (when applicable) requiring a minimum of 30 minutes of time, each 30 days.	Physician/ QHP	~\$58	N/A	<ul style="list-style-type: none"> ➤ May be billed only once per 30 days ➤ Interaction with patient not required. ➤ Does not include payment for equipment, clinical staff, and supplies ➤ Cannot be billed with other care management codes. 	

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