2020

Top 10 Medicare Remote Patient Monitoring (RPM) FAQs for 2021

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On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) issued a number of clarifications and proposals on remote patient monitoring (RPM) services reimbursed under the Medicare program. The changes, part of the advance copy of CMS' proposed 2021 Physician Fee Schedule, are intended to clarify CMS' position on how it reads and interprets the requirements for RPM services. The comments build on prior RPM guidance for Medicare reimbursement, CMS' creation of new RPM codes in 2019 and 2020, and regulatory changes allowing RPM to be delivered under general supervision for purposes of incident to billing.

The ten FAQs below are drafted based on CMS' clarification statements and proposals in the 2021 proposed rule (2021 Proposed Rule).

1. What is remote patient monitoring?

RPM involves the collection and analysis of patient physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. The five primary Medicare RPM codes are CPT codes 99091, 99453, 99454, 99457, and 99458.

2. Must the patient have a chronic condition to qualify for RPM?

Although CMS initially described RPM services in the 2019 PFS final rule as services furnished to patients with chronic conditions, CMS clarified in the 2021 Proposed Rule that practitioners may furnish RPM services to remotely collect and analyze physiologic data from patients with acute conditions, as well as from patients with chronic conditions.

3. Can RPM be used with new and established patients, alike?

In the 2021 Proposed Rule, CMS clarified that RPM services are limited to "established patients." In support of this position, CMS asserts that a physician who has an established relationship with a patient would likely have had an opportunity to provide a new patient E/M service. During that new patient E/M service, the physician would have collected relevant patient history and conducted a physical exam, as appropriate. As a result, the physician would possess information needed to understand the current medical status and needs of the patient prior to ordering RPM services to collect and analyze the patient's physiologic data and to develop a treatment plan. However ,CMS waived this restriction during the Public Health Emergency (PHE), but stated that when the PHE ends, CMS will require that RPM services must be furnished only to established patients. CMS' waiver suggests that during the PHE, practitioners may render RPM services without first conducting a new patient E/M service.

To date, CMS has not published guidance on physicians using telehealth (i.e., real-time interactive audio-video technology) to conduct a new patient E/M service via telehealth in connection with enrolling a beneficiary in an RPM program. However, we do know that, for Medicare telehealth services, CMS allows the use of real-time interactive audio-video technology to satisfy the face-to-face element of an E/M service. And we do know that "new patient E/M service" codes (e.g., CPT Codes 99201-99205) are listed among the Medicare-covered telehealth services. Moreover, CMS generally defers to state laws on

professional practice requirements, clinical standards of care, and valid doctor-patient relationships. Nowadays, state laws allow doctors to use telehealth to create a valid doctor-patient relationship for new patients.

4. Who can order and bill for RPM services?

RPM codes are considered Evaluation and Management (E/M) services. CMS stated they can be ordered and billed only by physicians or nonphysician practitioners who are eligible to bill Medicare for E/M services.

5. Who can furnish RPM services and obtain consent?

While CPT code 99091 can only be furnished by a physician or other qualified healthcare professional, CPT codes 99457 and 99458 can be furnished by a physician or other qualified healthcare professional, or by clinical staff under the general supervision of the physician.

A physician or other qualified healthcare professional is defined in the CPT Codebook as "an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service." When referring to a particular service described by a CPT code for Medicare purposes, a "physician or other qualified healthcare professional" is an individual whose scope of practice and Medicare benefit category includes the service and who is authorized to independently bill Medicare for the service.

A clinical staff member is defined in the CPT Codebook as "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 does not individually report that professional service."

In the 2021 Proposed Rule, CMS proposed to allow auxiliary personnel, in addition to clinical staff, to furnish services described by CPT codes 99453 and 99454 under the general supervision of the billing physician or practitioner. Auxiliary personnel include other individuals who are not clinical staff but are employees, or leased or contracted employees. As noted in the 2021 Proposed Rule, CMS supported its proposal under the idea that "the CPT code descriptors do not specify that clinical staff must perform RPM services."

CMS also stated that RPM services are not considered to be diagnostic tests; they cannot be furnished and billed by an Independent Diagnostic Testing Facility on the order of a physician.

CMS proposed that consent to RPM can be obtained at the time RPM services are furnished. The consent can be obtained by individuals under contract with the billing physician or qualified healthcare professional. CMS did not propose or address a permanent waiver of RPM co-payments.

6. What does it mean to have an 'interactive communication' with a patient?

CMS stated that "interactive communication" for purposes of CPT codes 99457 and 99458 involves, at a minimum, a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission. CMS stated the interactive communication must total at least 20 minutes of interactive time with the patient over the course of a calendar month for CPT code 99457 to be reported. CMS stated that each additional 20 minutes of interactive communication between the patient and the physician/nonphysician practitioner/clinical staff is reported using CPT code 99458. In support of this position, CMS indicated the CPT Codebook states that unless there are code- or code-range specific instructions, parenthetical instructions, or code descriptors to the contrary, time is considered to be the "face-to-face" time with the patient or patient's caregiver/medical decision-maker. Because RPM is a service not typically furnished in person with the patient, CMS stated it interprets time in the 99457 and 99458 code descriptor to mean the time spent in direct, real-time interactive communication with the patient.

This is the first time CMS has addressed, in published guidance, the interactive communication requirement in the context of RPM. Until now, there has been no formal guidance published by CMS as to the scope of this element in CPT codes 99457 and 99458. CMS' new clarification posits that there must be at least 20 minutes of interactive communication with the patient, as opposed to the interactive communication being a component of the overall 20 minutes of RPM service. This position renders RPM an outlier compared to the other similar designated care management services such as chronic care management services (CCM), for which CMS has been clear that the time-based requirements consist of a ***combination*** of patient interactive communication, monitoring, and management of the patient's care plan. Moreover, the very nature of the RPM code descriptors themselves – which include "monitoring and management" as part of the service – suggests the inclusion of time spent other than purely communication with the patient. It is unclear why CMS, in its most recent proposed policy clarification, has taken a different approach with respect to RPM than it has with CCM and other similar services.

This is clearly an issue ripe for stakeholder input during the 60-day public comment period. It may be helpful for the AMA and its digital health council (the group of experts who created the RPM codes in the first place) to offer clarification on whether it actually intended the RPM codes to require a practitioner to spend at least 20 minutes per month of time communicating via audio or video with the patient. A more reasonable reading of the code descriptor and intent is that the interactive communication with the patient is part of the 20 minute minimum, but the practitioner can also include time spent reviewing and analyzing the patient's RPM data and determining how to change the care management accordingly.

7. What type of RPM devices qualify for Medicare purposes?

The RPM device must meet the FDA's definition of a medical device as described in section 201(h) of the Federal, Food, Drug and Cosmetic Act. CMS found no language in the CPT Codebook indicating the RPM device must be FDA-cleared, although such clearance may be appropriate. Nor did CMS find information that the RPM device must be prescribed by a physician, although this could be possible depending upon the medical device. CMS stated the RPM device should digitally (that is, automatically) upload patient physiologic data (that is, data cannot be self-recorded and/or self-reported by the patient). As with any service provided to a Medicare beneficiary, use of a RPM device to digitally collect and transmit a patient's physiologic data must be *reasonable and necessary* for the diagnosis or treatment of the patient's illness or injury or to improve the functioning of a malformed body member. Further, the RPM device must be used to collect and transmit reliable and valid physiologic data that allow understanding of the patient's health status to develop and manage a plan of treatment.

8. How many days must the RPM device monitor per month?

The CPT language indicates that monitoring must occur over at least 16 days of a 30-day period in order for CPT codes 99453 and 99454 to be billed. CMS stated that these two codes are not to be reported for a patient more than once during a 30-day period. CMS stated the CPT language suggests that even when multiple medical devices are provided to a patient, the services associated with all the medical devices can be billed only once per patient per 30-day period and only when at least 16 days of data have been collected. CMS also noted that CPT 99453 can be billed only once per episode of care where an episode of care is defined as "beginning when the remote physiologic monitoring service is initiated and ends with attainment of targeted treatment goals."

9. What are the RPM practice expense codes?

There are two practice expense only codes (99453 and 99454), valued to cover clinical staff time, supplies, and equipment, including the medical device for the typical case of remote monitoring. CPT code 99453 is valued to reflect clinical staff time that includes instructing a patient and/or caregiver about using one or more medical devices. CPT code 99454 is valued to include the medical device or devices supplied to the patient and the programming of the medical device for repeated monitoring. CMS stated that the medical device or devices that are supplied to the patient and used to collect physiologic data

are considered equipment and as such are direct practice expense inputs for the code. Providers should always consult with their certified billing and coding professionals for proper Medicare device billing.

10. What are the RPM monitoring and management codes?

This is another example of first time guidance provided by CMS in which they lay out the "order of events" for an RPM program. CMS stated that after analyzing and interpreting a patient's remotely collected physiologic data, the next step in RPM is the development of a treatment plan informed by the analysis and interpretation of the patient's data. At this point, the physician develops a treatment plan with the patient and then manages the plan until the targeted goals of the treatment plan are attained, which signals the end of the episode of care. CPT code 99457 and its add-on code, CPT code 99458, describe the treatment and management services associated with RPM. This suggests that Codes 99457 and 99458 cannot be billed until after the initial 30 day period of monitoring, as opposed to being billed simultaneously during the same time period. However, CMS does not provide this level of detail, nor does it address whether any of the RPM codes are co-dependent on each other such, for example, whether 99457 or 9458 can be billed even if the requisite elements of 99453 or 99454 are not met, (e.g., if only 15 days of monitoring occurred).