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2021 Medicare Remote Patient Monitoring FAQs: CMS Issues Final Rule

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On December 1, 2020, the Centers for Medicare and Medicaid Services (CMS) finalized new policies related to remote patient monitoring aka remote physiologic monitoring or "RPM," reimbursed under the Medicare program. The changes, part of the 2021 Physician Fee Schedule final rule are intended to clarify CMS' position on how it interprets requirements for RPM services. This rule finalizes many of the proposals released in August 2020, and builds upon previous RPM guidance, including changes allowing general supervision for purposes of incident to billing.

The ten RPM Frequently Asked Questions below are based on CMS' policies in the 2021 Final 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?

No. In 2019, CMS initially described RPM as services rendered to patients with *chronic* conditions, but confirmed in the 2021 Final Rule that practitioners may furnish RPM services to remotely collect and analyze physiologic data from patients with acute conditions, as well as patients with chronic conditions.

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

In the 2021 Final Rule, CMS stated that RPM services are limited to "established patients." In support of this position, CMS asserted 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. CMS waived the "established patient" restriction during the Public Health Emergency (PHE) but in the 2021 Final Rule, CMS declined to extend such waiver beyond the PHE. CMS' waiver suggests (but does not explicitly state) that during the PHE, practitioners may render RPM services without first conducting a new patient E/M service. After the PHE waiver expires, there will need to be an established patient-practitioner relationship in order to bill Medicare for CPT 99453, 99454, 99457, and 99458. Typically, this will require the practitioner to conduct a new patient E/M service.

To date, CMS has not issued public guidance on physicians using telehealth to conduct a new patient E/M service prior to 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. Despite requests to allow other providers to bill for RPM services, the 2021 Final Rule confirmed RPM can be ordered and billed only by physicians or non-physician 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 Final Rule, CMS finalized its proposal 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 took this position because "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; that is they *cannot* be furnished and billed by an Independent Diagnostic Testing Facility on the order of a physician.

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. There was no discussion of a temporary or permanent waiver of RPM copayments.

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

In the 2021 Final Rule, CMS stated "interactive communication" for purposes of CPT codes 99457 and 99458 requires, 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.

In the 2021 Proposed Rule, CMS stated there must be at least 20 minutes of interactive communication time with the patient over the course of a calendar month, as opposed to the interactive communication being a component of the overall 20 minutes of RPM service. CMS' interpretation, made for the first time in August 2020, we met with significant surprise and resistance from industry stakeholders, including comments by the American Medical Association, which created those RPM codes and stated, "the time in the descriptor for codes 99457 and 99458 is for all elements of the work related to remote physiologic monitoring (e.g., review, analysis, interpretation, development of treatment plan and treatment management including patient communication) and is not meant to be limited to only synchronous time spent communicating with the patient regarding their treatment plan."

As a companion summarizing the key changes in the 2021 Final Rule, CMS issued a Fact Sheet on December 1, 2020, concurring with AMA's position that the 20-minutes can include time for furnishing care management services as well as for the required interactive communication. It stated:

> "*We clarified that for CPT codes 99457 and 99458, an "interactive communication" is a conversation that occurs in real-time and includes synchronous, two-way interactions that can be enhanced with video or other kinds of data as described by HCPCS code G2012. We further clarified 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*" (emphasis added).

The language in the Fact Sheet indicates CMS' ultimately rejected its proposal to require a full 20 minutes of

time interacting with the patient. However, the advance copy of CMS 2021 Final Rule does not contain this clarification, and appears to directly conflict with CMS' Fact Sheet.

Keep in mind, the advance copy of the 2021 Final Rule has not yet been published in the Federal Register, so it is not yet become the official HHS-approved rule. The 2021 Final Rule is scheduled to be published in the Federal Register on December 28, 2020. Thus, there is time for CMS to make technical corrections to clarify this contradiction. We hope CMS takes such action as the guidance on interactive communication was one of the most controversial, and anticipated, elements of the Final Rule.

As stated in our prior analysis, the idea of requiring 20 minutes of interactive communication with the patient would render RPM an outlier compared to the other similar 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. 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 solely communication with the patient. It is unclear why CMS would take a different approach with respect to RPM than it has with CCM and other similar services.

This is not a trivial distinction. Such an interpretation means the practitioner and clinical staff must use the RPM, analyze the data, assess it, update the care plan accordingly, *and also* spend at least 20 minutes talking on the phone or video with the patient each month. For example, if a doctor spent 40 minutes overall doing these activities, but only 19 minutes of that time was actually talking on the phone/video with the patient, the doctor would not be eligible to bill CPT 99457. Such an interpretation does not seem consistent with the use of RPM technology. Nor does it sufficiently distinguish between RPM and CCM services, the latter designed to have more direct patient intervention/interaction. Indeed, such an interpretation appears inconsistent with CMS' previous guidance that practitioners can "stack" CCM and RPM, billing both in the same month, so long as the practitioner does not double count the minutes. The coupling of RPM and CCM makes sense because they are highly complementary; RPM has the doctor access and analyze data real-time throughout the month, and CCM has the doctor intervene and guide the patient's care throughout the month (ideally drawing on the A more reasonable reading of the code descriptor and intent is what is set forth in the Fact Sheet, i.e., that the interactive communication with the patient is part of the 20 minute minimum, but the practitioner can also include care management time, such as 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 confirmed there is no language in the CPT Codebook indicating the RPM device must be FDA-cleared/registered, but such clearance may be appropriate. Nor did CMS hold the RPM device must be prescribed by a physician, although again such a prescription could be

necessary depending upon the medical device.

The RPM device must digitally (i.e, automatically) upload patient physiologic data (i.e., data cannot be self-recorded or self-reported by the patient). As with any service provided to a Medicare beneficiary, use of an 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 per month must the RPM device monitor and report data?

The 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 these two codes are not to be reported for a patient more than once during a 30-day period. In its commentary, CMS recognized a full 16 days of monitoring may not always be necessary, but stakeholders did not submit to CMS any clinical examples to show how fewer than 16 days would be appropriate. As such, while CMS has waived the 16 day requirement period during the PHE, it will not extend the waiver beyond the PHE. At at the end of the PHE, 16 days of monitoring will be required to bill CPT 99453 and 99454.

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."

CMS also stated, "*medically necessary services associated with all medical devices for a single patient can be billed by only one practitioner, only once per patient per 30 day period and only when at least 16 days of data have been collected*." This means CPT 99454 should not be billed more than once per patient during a 30-day period even when multiple devices are supplied to a patient.

CMS comments about RPM being billed by only one practitioner is new, and when read in context of the Final Rule, it remains unclear if CMS means a practitioner cannot bill multiple RPM services for the same patient in the same month, or if it means CMS will pay only one RPM claim per beneficiary per month. If the former, a patient could enroll in different RPM programs with different specialists during the same time period (e.g., a cardiologist for the patient's heart needs and an endocrinologist for the patient's diabetes) and each specialist could bill Medicare for their respective RPM services. If the latter, a patient could enroll in only one practitioner's RPM program, which is how CCM services are currently structured. CMS's billing guidance for CCM is expressly clear about this restriction, but the RPM guidance does not use a similarly explicit statement, so there remains definite ambiguity.

9. What are the RPM practice expense codes?

CMS described the RPM process as beginning with the two practice expense only codes (99453 and 99454). These codes are 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 physiologic data that are collected and transmitted may be analyzed and interpreted as described by CPT code 99091. This code only includes professional work and is valued to include a total of 40 minutes of physician or non-physician practitioner (NPP) work which includes 5 minutes of preservice work (chart review); 30 minutes of intra-service work (e.g., data analysis and interpretation, report based on the physiologic data and a possible phone call to the patient) and 5 minutes of post-service work (chart documentation.) In its commentary, CMS stated 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 and include work of both professionals and clinical staff.

In the 2021 Final Rule, CMS expressed its position that codes 99091 and 99457 could both be billed during the same time period, provided the same time is not allocated to both codes. CMS took this position despite comments from the AMA that CMS misunderstands the codes because "the CPT code set is clear in the parentheticals associated with both codes that it is not appropriate to report CPT codes 99091 and 99457 together."

Conclusion

Despite some remaining uncertainties, the CMS final rule advances the ability of RPM services to drive revenue and improve the patient care experience. We will continue to monitor CMS for any rule changes or guidance on RPM and the industry.

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