Q&A GUIDE

Providing and Billing Medicare for Remote Patient Monitoring and Treatment Management

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OVERVIEW

Recognizing the many benefits of remote patient monitoring and treatment management services (RPM), the Centers for Medicare & Medicaid Services (CMS) has been reimbursing for these services under the Medicare Physician Fee Schedule 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. Confusion regarding reimbursement rules is one potential reason for this delay. In this white paper, we attempt to provide a simple, straightforward explanation of these rules while highlighting those issues for which additional CMS guidance is needed.

In the 2021 Medicare Physician Fee Schedule Final Rule, CMS wrestled with several outstanding issues. These included the types of data and capabilities of devices required for RPM, the relationship among the CPT codes for the different components of RPM, and the required qualifications of individuals providing and billing for the services.

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MEDICARE REIMBURSEMENT FOR RPM

Q. Who can order and bill for RPM?

A. RPM can be ordered and billed only by physicians and non-physician practitioners (collectively, practitioners) who are eligible to bill Medicare for evaluation and management (E/M) services.

Q. Can independent diagnostic testing facilities (IDTFs) bill for RPM services?

A. Because RPM is not considered diagnostic testing, the service cannot be billed by IDTFs. Nor may rural health clinics or federally qualified health centers bill for RPM.

Q. What relationship between the practitioner and patient is required?

A. To bill for any RPM service, the practitioner must have an established relationship with the beneficiary. For the duration of the COVID-19 public health emergency (PHE), however, CMS permits a practitioner to bill for RPM for a new patient.

TEMPORARY RPM ALLOWANCES

- For the duration of the COVID-19 public health emergency (PHE), CMS permits the following:
  - An eligible practitioner can bill for RPM for a new patient; after the PHE expires, services can only be billed for established patients.
  - Only 2 days of monitoring are required for patients with suspected or confirmed cases of COVID-19 to bill CPT 99453 and 99454.
- Direct supervision can be accomplished using interactive audio/visual real time communications technology through December 31, 2021. The agency will consider whether to extend this permission in the 2022 rulemaking process.

Q. Is consent required to provide and bill for RPM?

A. The practitioner must secure the beneficiary's consent to receive RPM either prior to or at the initiation of the service. Such consent must include an acknowledgement that the beneficiary will be responsible for the co-payment or deductible associated with the services. The beneficiary may consent verbally, but it must be documented in the medical record.

Q. Which beneficiaries are eligible for RPM??

A. CMS has not identified the specific circumstances in which it will make payment for RPM other than to indicate the monitoring should be reasonable, medically necessary, and "used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition." Such justification for RPM should be documented in the patient's medical record.

Q. Under what CPT codes does a practitioner bill for RPM?

A. CMS has clarified that RPM is a process for which each component is billed under a separate CPT code. These components include the following:

1. **Service Initiation** – billed under 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.
2. **Data Transmission** – billed under CPT 99454 – remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; each 30 days.
3. **Data Analysis and Interpretation** – billed under 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.
4. **Treatment Management Services** – billed under CPT 99457 – remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes) and CPT 99458 (additional 20 minutes).

Q. What are the reimbursement rates for RPM?

A. The 2021 national payment rates for the five RPM codes are listed in the table below. These rates are generally less than 2020 national payment rates due to adjustments to the assigned RVUs for each CPT code and slightly reduced in the conversion factor for 2021.

CPT CODE	APC CODES	NON-FACILITY RATE	FACILITY RATE
99453		$19.19	$19.19
	5012	$120.88	
99454		$62.80	$62.80
	5741	$37.76	
99091		$56.87	$56.87
99457		$50.94	$31.75
99458		$41.17	$31.75

Q. What is the reimbursement for RPM services furnished in a hospital outpatient department?

A. For RPM services billed as hospital outpatient services, CMS has assigned CPT 99453 to APC 5012 (Clinic Visit and Related Services) with a 2021 payment rate of approximately $120. CPT 99454 has been assigned to APC 5741 (Level 1 Electronic Analysis of Devices. (Note that CMS has assigned status indicator "Q1" to CPT 99454, meaning it is packaged when billed with another service on the same day.) CMS has not assigned an APC to CPT 99091, 99457, or 99458.

MEDICARE RPM BILLING RULES

Service Initiation and Data Transmission (CPT 99453 and CPT 99454)

Q. For what services do CPT 99453 and 99454 provide reimbursement?

A. The first two RPM codes, CPT 99453 and 99454, reimburse 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.

Q. Are there wRVUs associated with these codes?

A. There is no wRVU assigned to either code as no practitioner work—supervision or otherwise—is required to bill for these services.

Q. What is included in CPT 99453?

A. CPT 99453 is used to report beneficiary education on use of the device(s).

Q. Can CPT 99453 be billed more than once per patient? What if multiple devices are used?

A. According to CPT guidance, CPT 99453 can be billed only once per episode of care (defined as "beginning when the remote monitoring physiologic service is initiated and ends with attainment of targeted treatment goals") even if multiple devices are provided to the beneficiary.

Q. How many days of monitoring are required to bill 99453?

A. CPT guidance states that CPT 99453 should not be reported "if monitoring is less than 16 days." Thus, if a beneficiary receives and is educated on the device(s), but data is not collected for a minimum of 16 days in a 30-day period, one could not bill for CPT 99453.

Note that for the duration of the COVID-19 PHE, only 2 days of monitoring is required for patients with suspected or confirmed cases of COVID-19 to bill CPT 99453.

Q. What services are included in CPT 99454?

A. CPT 99454 is used to report the provision and programming of the device(s) for daily recording or programmed alert transmissions over a 30-day period, provided data is collected for at least 16 days during the 30-day period.

Q. How often can CPT 99454 be billed? What if multiple devices are used?

A. CPT 99454 can be billed only once per 30-day period, even if multiple devices are utilized.

Q. How many days of monitoring/data collection are required to bill 99454?

A. CPT 99454 can be billed provided data is collected for at least 16 days during the 30-day period. For example, if monitoring services commenced for a beneficiary on July 1 and data was recorded each day through September 12, one would bill CPT 99453 in July and CPT 99454 in July and August (but not September).

Note that for the duration of the COVID-19 PHE, only 2 days of monitoring is required for patients with suspected or confirmed cases of COVID-19 to bill CPT 99454.

Q. Are there other circumstances when CPT 99453 and 99454 cannot be reported?

A. CPT guidance states 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)."

Q. Does a practitioner have to bill service initiation and data transmission (CPT 99453 and 99454) to bill for the other RPM codes?

A. CMS does not specifically require a practitioner to bill for data analysis and interpretation (CPT 99091) or treatment management services (CPT 99457) to bill for service initiation and data transmission (CPT 99453 and 99454). Thus, a practitioner still could be reimbursed for service initiation and/or data transmission even if less than 30 minutes of data analysis and interpretation and/or less than 20 minutes of treatment management services were provided (assuming such data collection still was medically necessary).

Q. Can two or more practitioners concurrently bill RPM for the same patient?

A. CMS will not pay more than one practitioner for CPT 99453 for an episode of care or CPT 99454 for a 30-day period, even if each practitioner is arguably furnishing a distinct service. According to CMS, "[t]he medically necessary services associated with all the 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." CMS, however, offers no direction regarding the resolution of claims submitted by multiple practitioners for the same beneficiary for the same time period.

Q. What types of devices can be used for RPM?

A. Regarding the device requirements for CPT 99453 and 99454, CMS has specified that any such device must:

- Meet the definition of "medical device" stated in section 201(h) of the Federal Food, Drug, and Cosmetic Act.
- Automatically upload patient physiologic data (i.e., data are not self-recorded and/or self-reported by the patient).
- Be capable of generating and transmitting either (a) daily recordings of the beneficiary's physiologic data, or (b) an alert if the beneficiary's values fall outside pre-determined parameters.
- 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.
- Be used to collect and transmit reliable and valid physiologic data that allow understanding of a patient's health status in order to develop and manage a plan of treatment.

Q. Do the BioIntelliSense BioSticker and BioButton devices fulfil the requirements to qualify for billing under CPT 99454?

A. Yes, the FDA-cleared BioSticker and medical-grade BioButton devices qualify for reimbursement under 99454. The flagship BioSticker is the first single-use medical device enabling 30 days of continuous multi-parameter monitoring of vital signs, physiologic biometrics and symptomatic events. The disposable, single-use BioButton device is configurable for up to 60 days of continuous vital sign monitoring.

Q. What documentation must be included in the beneficiary's medical record to support a claim for CPT 99453 and 99454? What date of service and place of service should be listed on such claim?

A. 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:

- 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 and the medical necessity of the monitoring device; (c) the beneficiary's consent for RPM services; (d) identification of the device; (e) date of delivery of the device to the patient/caregiver; and (f) date(s) on which training is provided to patient/caregiver.
- The documentation for CPT 99454 would be sufficient to demonstrate monitoring occurred for at least 16 days in a 30-day period.
- The date of service for CPT 99453 would be the date on which the device records the 16th day of data in a 30-day period following initiation of the service (or the last date of that 30-day period).
- 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.
- 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 prior date of service.
- Based on CMS' guidance regarding CCM, the place of service for both codes would be the location at which the billing practitioner maintains his or her practice (i.e., physician office vs. hospital outpatient department).

Data Analysis and Interpretation (CPT 99091)

Q. For what services does CPT 99091 provide reimbursement?

A. According to CMS, "[a]fter the data collection period for CPT 99453 and 99454, the physiologic data that are collected and transmitted may be analyzed and interpreted as described in CPT 99091..."

Q. Who can perform 99091 services? What level of supervision is required?

A. This work may be performed by a physician or non-physician practitioner or by clinical staff if the requirements for "incident to" billing are satisfied. Those requirements include **direct supervision** of the clinical staff by the billing physician or practitioner, i.e., that physician or non-physician practitioner must be physically present in the same suite of offices and immediately available to provide assistance and direction when the service is performed.

Due to the COVID-19 public health emergency, CMS will permit direct supervision be accomplished using interactive audio/visual real time communications technology through December 31, 2021. The agency will consider whether to extend this permission in the 2022 rulemaking process.

Q. What work must be performed to bill for CPT 99091?

A. CPT 99091 is a time-based code, meaning 30 minutes of services furnished over a 30-day period must be documented to bill for this service. CMS notes the valuation for CPT 99091 includes 40 minutes of work, including 5 minutes of pre-service work (e.g., chart review) and 5 minutes of post-service work (e.g., chart documentation). Stated another way, the pre- and post-service work cannot be counted toward the 30-minute requirement.

Q. Does a provider have to submit a claim for CPT 99453 and 99454 to bill for CPT 99091?

A. While a provider is not required to submit a claim for CPT 99453 and 99454 to bill for CPT 99091, it appears CMS requires such data analysis and interpretation to be based on a minimum of 16 days of data. (Refer to the quote in the previous section indicating RPM services "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." (emphasis added)

Note that a practitioner who bills for CPT 99091 without having billed for CPT 99453 and 99454 still would be subject to the established patient and consent requirements discussed in the previous section.

Also note that for the duration of the COVID-19 PHE, only 2 days of monitoring is required for patients with suspected or confirmed cases of COVID-19 to bill for any of the RPM codes.

Q. Do the same device requirements apply to CPT 99091 as CPT 99453 and 99454?

A. CMS has not specifically addressed whether the data analyzed and interpreted must be collected and transmitted by a device that meets the requirements specified for CPT 99453 and 99454. Thus, for example, we cannot state definitively that a practitioner may bill for CPT 99091 based on at least 16 days of data self- recorded or self-reported by the beneficiary (as opposed to data automatically uploaded by the device).

Q. What date of service should be used for CPT 99091? Place of service?

A. As with other time-based code, the date of service for CPT 99091 would be the day on which the 30th minute of services are provided or the last day of the 30-day period. The place of service is the location at which the billing practitioner maintains his or her practice.

Treatment Management Services (CPT 99457 and CPT 99458)

Q. What steps follow data collection and interpretation in RPM?

A. The next steps in the RPM process are the development of a treatment plan informed by the data and the management of that plan until the targeted goals of that plan are attained. CMS refers to this as "treatment management services."

Q. Under what CPT codes are treatment management services billed?

A. These services are billed under CPT 99457 (initial 20 minutes of services) and CPT 99458 (each subsequent 20-minute increment).

Q. How often can CPT 99458 be billed?

A. CMS has not imposed any frequency limitation on CPT 99458. Thus, a provider may bill for CPT 99458 for each additional 20-minute increment of service. For example, a provider furnishing one hour of services would bill one unit of CPT 99457 and two units of CPT 99458.

Q. What provider/patient interaction is required to bill these services?

A. CPT guidance specifies 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…" CMS defines such communication as "real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission." According to the agency, the 20 minutes of time required to bill for CPT 99457 and 99458 can include time for furnishing management services as well as for the required interactive communication.

Q. What level of supervision is required for services furnished by clinical staff?

A. CPT 99457 and 99458 qualify as designated care management services under 42 CFR 410.26(b)(5), meaning these services can be furnished under the general supervision (as opposed to direct supervision) of a physician or practitioner.

Q. Does the supervising practitioner have to be the same individual as the care provider?

A. The supervising practitioner does not have to be the same individual treating the patient more broadly. However, CPT 99457 and CPT 99458 must be billed under the National Provider Identifier (NPI) of the practitioner who supervises the clinical staff performing the service.

Q. Can CPT 99457 and 99458 be billed concurrent with other care management services?

A. The codes can be reported during the same service period as chronic care management services (CPT 99439, 99487, 99489, 99490, and 99491), transitional care management services (CPT 99495 and 99496), and behavioral health integration services (CPT 99484, 99492, 99493, and 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.

Q. Can a practitioner capture time for CPT 99457 and 99458 on the same day as an E/M service?

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

Q. Does a provider have to submit a claim for CPT 99453 and 99454 to bill for CPT 99457?

A. As with CPT 99091, while a provider is not required to submit a claim for CPT 99453 and 99454 to bill for CPT 99457, it appears CMS requires such treatment management services to be based on a minimum of 16 days of data. Also, CMS has not specifically addressed whether such data must be collected and transmitted by a device that meets the requirements specified for CPT 99453 and 99454.

Again, note that a practitioner who bills for CPT 99457 without having billed for CPT 99453 and 99454 still would be subject to the established patient and consent requirements previously discussed.

And, again, note that for the duration of the COVID-19 PHE, only 2 days of monitoring is required for patients with suspected or confirmed cases of COVID-19 to bill CPT 99457.

Q. Can a practitioner bill CPT 99091 and 99457 for the same time period for the same beneficiary?

A. According to the CPT Codebook, CPT 99091 and 99457 cannot both be billed for the same time period for the same beneficiary. CMS, however, has determined that "in some instances when complex data are collected, more time devoted exclusively to data analysis and interpretation by a [practitioner] may be necessary such that the criteria could be met to bill for both CPT codes 99091 and 99457 within a 30-day period." CMS cautions, however, that one cannot use the same time to meet the criteria for both CPT 99091 and 99457.

Q. How does one count time for CPT 99457 and 99458?

A. While CMS has not provided specific guidance on counting minutes for RPM, CMS has provided the following rules with respect to counting 20 minutes for CCM; we assume CMS would apply the same rules to RPM CPTs 99457 and 99458:

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 (e.g., if only 18 minutes, no billable service; if only 38 minutes, bill CPT 99457, but not 99458).
4. Time in excess of 20 minutes (but less than the 20 minutes necessary to bill CPT 99458) in one month cannot be carried forward to the next month.
5. 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; presumably, the same would be true for treatment management services.

Q. How does one document time spent providing treatment management services?

A. CMS has not provided guidance regarding the way time spent providing treatment 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.

Q. What date and place of service should be used to bill CPT 99457 and 99458?

A. 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 for CPT 99457. CPT 99458 should be billed using the date on which each subsequent 20 minutes 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).

CONCLUSION

While not having addressed every outstanding issue, CMS has brought more clarity to RPM reimbursement in the 2021 Medicare Physician Fee Schedule Final Rule. This welcome development—along with technology advancements, beneficiaries' greater willingness to engage in virtual care following the pandemic, and RPM's proven ability to improve outcomes and reduce total cost of care—should pave the way for greater adoption.

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