TeleCARE

RPM

A **Game Changer** for Medicare & Patient Care

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RPM: A **GAME CHANGER** FOR MEDICARE & PATIENT CARE

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Abstract: This white paper delves into the evolution of Remote Physiologic Monitoring (RPM) and its recent inclusion in Medicare coverage, starting January 1, 2024. It highlights the underutilization of RPM in the medical profession and argues for its profitability and patient benefits.

Introduction

- Brief overview of RPM and its significance.
- Statistics on RPM billing by medical professionals in 2021.
- Aim of the paper.

This White Paper will discuss the recent history of Remote Physiologic Monitoring and the new coverage for RPM Starting January 1, 2024. Less than 1% of medical professionals in the country were billing Medicare for RPM in 2021, as most are not aware of not only how profitable it is, but the true benefit to the patient and the insurance payers for those patients receiving the services. This paper will help enlighten the reader to the benefits achieved by RPM and why the Centers for Medicare & Medicaid Services are not only eagerly paying for it, but also expanding the coverage for it.

Background

- Historical context: Introduction of AMA code 99091 in 2002 and subsequent change s.
- Medicare's response and payment structures for RPM. Distinction between RPM and other telemedicine services.

2002 saw the AMA create code 99091. In 2018, Medicare Part B (and other carriers) added the code to the Medicare Physician Fee Schedule and started paying separately for “chronic care remote physiologic monitoring”, to a lesser degree, only to fee for service clinics with code 99091. (Note – in 2021, they dropped the words “chronic care” from the description).

This code is described in the AMA's Current Procedural Terminology (CPT®) as "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." Code 99091 was not (and is still not) profitable enough to justify the minimum 30 minutes required in time by the physician, Nurse Practitioner or Physician Assistant (in our opinion). In 2024, the average Medicare Physician Fee Schedule for CPT code 99091 is $53.77. By valuing that code at this amount, and requiring the service be performed by the medical professional, they are stating that the physician's time is worth only $107.44 per hour, which is approximately 22% of where it should be assessed (in our estimation).

One other, but noteworthy element that the AMA accomplished by unbundling the 99091 services was that they separated the remote physiologic monitoring from other telemedicine or telehealth services. CMS ruled that the procedures or services utilizing the communication technology (as those required by RPM) did not fall within the Social Security Section 1834 (1) restrictions regarding section (m) Payment for Telehealth Services).

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RPM Code Analysis

- Detailed analysis of CPT codes 99453, 99454, & 99457.
- Challenges and misconceptions in implementation.
- Billing and compliance issues with RPM codes.

In mid 2018, the AMA announced (2) three new CPT codes (99453, 99454 & 99457) that would be paid (again – only to fee for service clinics and not Rural Health Clinics or Federally Qualified Health Centers) by Medicare Part B (and therefore by Medicare Part C Advantage plans as well) starting in 2019.

The three codes are described as:

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
99454: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days, 16-day minimum
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

When these codes, and descriptions were originally released in the Federal Register and AMA code book, there was quite a bit of confusion, which CMS eventually addressed, altered, and improved upon. Consequently, clinic managers, physicians and coders believed many of the misrepresentations expressed to them by consultants or salespeople that started selling their devices and services in January of 2019.

One of those was that these three codes fall within the same category as the Medicare annual wellness visits and were not subject to the 80/20 rule. That one was easily refuted when clinics filed their claims, and the patients were hit with the 20% co-insurance invoice by the clinics. That dissuaded some patients from ascribing to the idea of taking a monitor home from the clinic. Of course, this is effectively addressed for the destitute or financially impoverished patients by utilizing the hardship discount application to establish whether the patient qualifies to have the co-insurance and/or deductible waived (3) which meets the PRM15-1, CHAPTER 3, SECTION 312 rule

that provides that a provider may deem Medicare beneficiaries indigent or medically indigent when:

The patient's indigence must be determined by the provider, not by the patient (i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence), the provider should consider a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertibles to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses.

In making this analysis the provider should consider any extenuating circumstances that would affect the determination of the patient's indigence, the provider must determine that no source other than the patient would be legally responsible for the patient's medical bill, e.g., Title XIX, local welfare agency and guardian and, the patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible, from the beneficiary, without applying the procedures outlined in PRM 15-1, Chapter 3, Section 310 (Reasonable Collection Effort). (Note that Section 310 requires the provider issue statements, past due notices, collection letters, phone calls, etc.

If a patient is determined to be indigent or medically indigent in Section 312, then Section 310 collection efforts is not required)

The first year of RPM coverage with the three 9945x codes proved interesting from a compliance standpoint.

1.Some providers discovered that their own staff would quickly tire of the added duties of training patients on equipment, which resulted in a smaller number of patients receiving RPM than the investment warranted. (At Telecare-USA, we spotted this about halfway through 2019 and started providing the monitoring services for our clients, thereby freeing up the nurse and medical assistant time in the clinic for other duties. This has been a huge success as providers immediately increased the usage of RPM as a result.

2. Not all RPM vendors ensured that the interactive communication with the patient during the month (as required by CPT code 99457) was accomplished, resulting in the clinic at increased risk of audits and CMP (Civil Money Penalties).

3. Patients turned out to be less compliant than expected by testing less than 16 days a month, thereby not meeting the requirement for billing code 99454.

4. Until CMS clarified the coverage requirements many providers billed out code 99453 without ensuring that 16 days of testing had occurred within the first 30-day period.

5. The American Medical Association created two of the CPT codes (99453 and 99454) to be 30-day codes and the 99457 as a calendar month code. This caused all kinds of problems for the billers and coders selecting the appropriate dates to place on the claims. We have requested CMS to change 99453 and 99454 to monthly codes also, to no avail.

Financial and Clinical Impact of RPM

- Profitability analysis of RPM services.
- Ethical considerations in healthcare service offerings.
- Introduction of new CPT code 99458 in 2020 and its implications.
- Determining whether 99458 is a “mid-point” timed code

Possibly due to the low number of providers performing the service in the first year (2019), CMS categorized RPM services into the same Care Management Category as Chronic Care Management, thereby allowing the service to be provided by outside vendors. This meant the providers could contract the services to be performed by outside vendors paid by the provider and the provider allowed to bill Medicare and keep the difference between what was paid and what the provider paid the vender rendering the service.

As of the publication of this paper, there are only three Care Management services that we're away of that allow the provider to do "pass-through" billing as described above.

- o Chronic Care Management (CCM)
- o Remote Patient Monitoring (RPM)
- o Remote Therapy Monitoring (RTM)

Unfortunately, many providers listen to vendors offering other services as "pass-through" billing, such as providers of ultrasound services, lab testing, DNA testing and other diagnostic testing, resulting in the provider getting penalties, fines and even expulsion from the Medicare program.

As an owner of an RPM company, we receive requests from time to time to provide our RPM services on a "percentage basis", which we will not do. Based on advice from a nationally known Healthcare attorney, Robert Liles JD (4) we believe that offering any service involved in healthcare delivery on a percentage basis to be a violation of the Federal Anti-Kickback statute (42 U.S.C. § 1320a-7b) as well as the Stark law (42 U.S.C. § 1395nn. Unfortunately, not all vendors of these 3 services ascribe to the same ethics and believe it is easier to sell their services to providers on a percentage compensation agreement – thereby putting the providers at a huge risk (in our opinion).

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The 2020 AMA created a new CPT code 99458 to be used to denote each additional 20 minutes "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; each additional 20 minutes (List separately in addition to code for primary procedure)". This code enabled providers to bill for the additional time, resulting in multiple 99458s being billed. CMS assigned a 2 to the MUE (Medically Unlikely Edits) (5) for CPT code 99458 at first and then in July 2023, changed it to 3 (so that Medicare will pay for up to 3 units per month), while the other 3 codes (99453, 99454 and 99457) only allowed one to be billed within the same 30 day or calendar month period.

One question that has been avoided by CMS was whether the 99458 is a mid-point code, in the way the code is written ("each additional 20 minutes"). We found direction from CMS regarding timed codes when they were discussing Advanced Care Planning in a pdf on CMS' website (6) for another "each additional xx minutes" code 99498.

When discussing CPT code 99498 in that same document for Advanced Care Planning is quoted as "**each additional 30 minutes**" by CMS. This gives us a precedent in determining how to bill a service with the same language "each additional 30 minutes" as the CMS document states:

*"In the calendar year (CY) 2016 PFS final rule (80 Fed. Reg. 70956), we adopted the CPT codes and CPT provisions regarding the reporting of timed services**. Practitioners should consult CPT provisions regarding minimum time required to report timed services."***

This is important because CMS is telling us to use CPT provisions for time-based services. If we use the **CPT Assistant**, which is owned by the AMA, sourced in the attachments, to look up the 99498, it clearly says on page 3:

> *"Because advanced care planning codes 99497 and 99498 are time-based codes, it is important to **note that a unit of time is attained when the mid-point is passed.** For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes.) A second hour is attained when a total of 91 minutes has elapsed."*

Since both 99458 and 99498 use the exact wording "each additional" in front of their time provision, we chose at Telecare-USA to use the provisions set by CPT, which were adopted by CMS. Thus, the 99458 would be a midpoint code using the precedent of 99498.

The COVID-19 Impact

- Adjustments in RPM billing during the pandemic.
- Misconceptions and corrections post-COVID-19.

2020 also brought the Covid-19 Public Health Emergency, which forced many in the healthcare field to modify their delivery system of medical care, opening telehealth to new levels never seen prior to the emergency. One of the decisions by then administrator of the Centers for Medicare and Medicaid Services, Seema Verma, was to reduce the number of days from 16 to 2 for billing codes 99453 and 99454 on Covid patients and those suspected of having Covid-19.

Unfortunately, many equipment vendors and RPM service vendors conveyed incorrect information to the providers, so that many believed the reduction from 16 days to 2 days extended to all patients during the Public Health Emergency. The reduction in required days of testing ended on May 11, 2023, upon the declared end of the PHE by Health and Human Services (HHS).

Expansion to RHCs and FQHCs in 2024

- New opportunities for RPM services in Rural Health Clinics and FQHCs.
- Analysis of HCPCS code G0511 and its applications.

The 2024 Final Rules in the November 16, ,2023 Federal Register announced another change in the RPM Medicare world by revealing that Medicare will no longer cover just fee-for-service providers but will also create coverage for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) with HCPCs code G0511 (General Care Management Service). Medicare has been paying RHCs and FQHCs for the same code G0511 for chronic care management and personal care management services since 2018, but the addition of RPM and RTM (Remote Therapy Monitoring) with the same code G0511 opens new opportunities. A 2019 report on RHC population (7) indicated that the top two diagnosis of RHC patients is hypertension and diabetes. Both diagnoses typically require remote physiologic monitoring for best patient care.

A couple of questions were generated by the November 2023 Final Rule:

1. Can multiple services (CCM and RPM) both be rendered to the same patient in the same month by RHCs and FQHCs and be covered by Medicare.

2. Will Medicare cover more than one unit of G0511 for a specific General Care Management Service?

Two RPM Service vendors (at least) reached out to CMS for the answers. Tony Clayton with 9X Plus (based in California and me, entreated these questions to the FQHC Division of the CMS.

1. A possible billing scenario was sent, asking whether the statement was true or false.

> *"An FQHC is able to bill one instance of G0511 for equipment [the equivalent of CPT 99454] and another (2nd) instance of G0511 for 1st 20 mins of work on the RPM patient [the equivalent of 99457], per patient per month (pppm)"*

The response from the FQHC department of CMS was to the affirmative or "true".

2: “What code does an FQHC use for Patient Education/Orientation [99453] and the 2nd 20 mins [99458]?”

“For FQHCs, only the codes listed below can be billed as a general care management service using HCPCS code G0511. You can bill HCPCS code G0511 multiple times in a calendar. However, each CPT code listed below can be billed using HCPCS code G0511 only once per calendar month for a single patient if all the requirements are met for each service and there is no overlapping of resource time. For example, an FQHC could bill RPM services using HCPCS code G0511 four times in a calendar month, once for each CPT code listed for RPM in the table below.”

3. Is an FQHC not permitted to bill for Patient Education/Orientation?

Yes. An FQHC is permitted to bill for Patient Education/Orientation (CPT code 99453).

4. Is an FQHC permitted to bill for a 2nd 20 minutes (similar to 99458)?

FQHCs do not pay their practitioners based on additional minutes spent by practitioners, as is the case for practitioners paid under the PFS. The service period for billing CCM services in FQHCs is one calendar month, and we expect the FQHC to continue furnishing services during a given month as applicable even after the 20-minute time threshold to bill the service is met.

The CMS representative also included the following table:

General Care Management Services	HCPCS/CPT Codes
CCM	99487, 99490, 99491
PCM	99424, 99426
CPM	G3002
General BHI	99484
RPM	99453, 99454, 99457, 99091
RTM	98975, 98976, 98977, 98980
CHI	G0019
PIN	G0023

The answers received by the author of this paper; Don Self (Telecare-USA) were identical from the CMS RHC representative.

Discussion and Analysis

- RPM service coverage by Medicare and its implications.
- Statistical data on RPM's effectiveness and patient outcomes.
- Review of Medicare Spending Per Beneficiary data in relation to RPM.

As we already discussed earlier, we do not generally recommend billing the 99091, so using the other three units of G0511 (with an expected 2024 Medicare Allowable of $72.98), results in a very favorable and profitable service for RHCs and FQHCs.

The introduction of this paper assured the reader to disclose why the Centers for Medicare & Medicaid Services and others are not only eagerly paying for it, but also expanding the coverage for it. The answer, as so often is the case, is financial as much as beneficial to the patient's long-term care, as shown in this report from the KLAS study (8) on Remote Patient Monitoring.

The top 8 results from the study were:

1. Reduced hospital admissions: 38%

2. Improved patient satisfaction: 25%

3. Reduced readmissions: 25%

4. Reduced emergency room visits: 25%

5. Quantified cost reductions: 17%

6. Improved medication compliance: 13%

7. Improved patient health: 13%

8. Decreased A1c levels: 8%

The percentages shown indicate the percentile of respondents reporting the results achieved or viewed by the RPM company personnel on the patients involved in the study.

CMS is like any other insurance payer in that they realize it is less expensive to pay for RPM than it is to finance a hospital stay or emergency room visit. CMS publishes the Medicare (8) Spending Per Beneficiary (MSPB) which shows the average at $24,299 for hospital stays. If Medicare can save one hospital stay, by paying for RPM (at a typical $145.96 allowed for 2 units of G0511), they can finance 166 patients rpm months. If they can achieve a reduction in the number of hospital stays on 38% of patients, that is a huge savings.

Unfortunately, many medical providers have not climbed aboard the RPM participation train within the first 3 years of expanded RPM coverage, based on the 2021 Medicare Provider Utilization Data (9). In reviewing this data, we found that in 2021 (most recent year released by the publication of this paper), approximately 1% of Medicare Part B Primary Care Providers were performing and billing RPM services, while less than 2% of Cardiologists participated in billing Part B for these same services. We have also found that most commercial insurance payers are paying for RPM as well.

Conclusion

- Summary of RPM's evolution and future prospects.
- Emphasis on the importance of RPM in improving patient care and reducing healthcare costs.

CMS has received requests to cover RPM services at 100% payment (like Medicare Annual Wellness Visits) claiming that the low number of patients receiving RPM services is somehow linked to the financial conditions of the patient populations. Yet, the number of Medicare Part B patients who are refusing to participate with the RPM due to the 20% co-insurance is probably less than 1 in 10 since about 90% of Part B patients have some kind of secondary or supplemental coverage after Medicare as shown at KFF Report (10) . The following numbers reflect the percentage of traditional Medicare patients with additional coverage is approximately:

- 41% Medicare plus Medigap
- 32% Medicare plus employer coverage
- 16% Medicare plus Medicaid
- 1% Medicare with other coverage

This leads us to believe that the primary reason more patients are not involved in RPM is simply due to the fact their medical provider has not suggested it. With more than 1,000 FQHCs and 500 RHCs in the country, perhaps this new coverage of G0511 for RPM in 2024 will result in more patients getting the remote patient monitoring they need.

We hope you have found *RPM: A Game Changer for Medicare and Patient Care* helpful and informative. You now have a detailed understanding RPM as well as the overall telehealth landscape.

About the Author

Don Self, CPC, CMCS, is a healthcare reimbursement specialist and consultant with over 30 years of experience in medical billing, coding, and practice management. Known for his expertise in Medicare compliance and revenue optimization, he provides training and consulting services to healthcare providers across the U.S. Don specializes in maximizing reimbursement through accurate coding, including CPT, ICD-10, and HCPCS codes, and frequently speaks at national conferences on topics related to medical billing, chronic care management, and value-based care. He is also the founder of Don Self & Associates, a consulting firm dedicated to helping practices improve their financial performance and navigate complex reimbursement challenges.

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