COSMOS
Navigate the Compliance Universe

Report on Medicare Compliance Volume 31, Number 6. February 14, 2022
CMS: RPM's PHE Flexibilities Don't Extend to RTM; Number of Days Required Is Still Iffy

By Nina Youngstrom

Medicare has given providers a pretty wide berth for remote physiologic monitoring (RPM) services delivered during the COVID-19 public health emergency (PHE), but apparently this doesn't apply to remote therapeutic monitoring (RTM), a new, companion set of services—for the most part.

Medicare allows physicians to bill for RPM delivered two to 15 days a month during the COVID-19 PHE to patients with actual or suspected cases of COVID-19. Patients with other conditions must have 16 or more days of monitoring. Another important PHE flexibility is providing RPM to new patients, regardless of the number of days of monitoring or the condition being monitored, but that goes away after the PHE, when Medicare requires providers to deliver the services to established patients. Whether these and other flexibilities extend to RTM, which went live Jan. 1, has been a source of confusion for providers. Now a CMS official says the answer is no, although there still isn't absolute certainty about the number of days that RTM must be provided every month to bill Medicare.

"The RPM flexibilities were not extended to the RTM codes," Liane Grayson, a health policy analyst with the Division of Practitioner Services at CMS's Hospital and Ambulatory Policy Group, wrote in an email to Richelle Marting, an attorney and certified coder in Olathe, Kansas, which was shared with *RMC*. Grayson added, "As an aside, given the therapeutic nature of the RTM codes, it seems unclear whether fewer days of monitoring would be appropriate."

Drawing the distinction between RPM and RTM in terms of the flexibilities is surprising, Marting said. "There are many clinical scenarios where monitoring under 16 days would make a lot of sense," she said.

The overlapping rules may invite risk. "During the pandemic, there is a recognition that two days is enough" for patients with COVID-19, said attorney Rick Hindmand, with McDonald Hopkins in Chicago, who spoke at a Feb. 1 webinar sponsored by Strafford.[1] "A lot of people have been interpreting" the RPM flexibility "to apply to everyone."

Those are the kinds of details for providers to keep in mind as they navigate RPM and RTM because eventually auditors may come knocking and will expect to see that documentation is consistent with coding and other requirements, Hindmand said. The documentation will have a before-and-after-the-PHE quality to it because CMS suspended certain RPM requirements during the PHE. Also, while RPM services originally were intended to manage chronic conditions, CMS said during the PHE they may be used for patients with acute and chronic conditions, and then made this a permanent change in the 2021 Medicare Physician Fee Schedule rule, Marting said.

Meanwhile, some Medicaid programs may be willing to pay for RPM because CMS isn't requiring plan amendments to cover RPM as a modality of service, Marting said at a webinar sponsored by the Heartland Telehealth Resource Center.[2]

RPM is the collection of physiologic data, such as blood pressure, glucose levels, heart rate and oxygen saturation levels, which can be transmitted to providers using software applications on the patient's smartphone, tablet or other device when patients are not in the office. RTM is the use of patient data, self-reported or digitally uploaded, to manage respiratory status, musculoskeletal conditions, medication response or therapy adherence. The data for both RPM and RTM must be collected through a medical device as defined by the Food and Drug Administration (FDA), although it doesn't have to be cleared or approved by the FDA. "This is where privacy and security concerns come in and concerns about the integrity of the data," said attorney Iliana Peters, with Polsinelli, who spoke at the Strafford webinar. It's better to build in security controls on the front end, but "you'd be surprised how many times I hear from patients and clients there is not really a good understanding of basic level security controls for this type of device or tool," Peters said.

RPM and RTM are not telehealth services in Medicare's eyes, Marting noted. As a result, they don't require audiovisual equipment, and there are no geographic or other telehealth-related restrictions on where the services can be performed. "That means the patient can be at home while they are monitoring and collecting physiologic data," she noted. Because RPM and RTM aren't considered preventive services, patients fork over copays, and providers must get patient consent before enrolling them and inform them of their cost-sharing obligations, she said. Consent can be provided at the time of service during the PHE, and there's flexibility to reduce cost sharing (for RPM), Hindmand said.

Coding for RPM and RTM Is Similar

Coding-wise, RPM and RTM have similarities, but RPM has a convoluted history. When Medicare introduced RPM in 2018, there was one evaluation and management (E/M) code (CPT 99091), and it was classified as a care management service. Because it was an E/M service, RPM could only be provided by physicians and qualified health professionals, such as nonphysician practitioners (NPPs), and CMS left no room for incident-to billing. CPT 99091 required 30 minutes of time, and Medicare didn't reimburse enough to make it worthwhile for physicians, Marting said.

But RPM codes didn't stop at 99091. CMS opened it up with specific codes (CPT 99453, 99454 and 99457) that allow physicians, NPPs and clinical staff (e.g., registered nurses, licensed practical nurses) to perform the services under physician supervision and did the same for RTM this year. The newer codes require 20 minutes, not 30 minutes, of time monitoring the patient's data per 30 days or calendar month, depending on the code. In addition to live, interactive communications, the time that clinicians spend on data review and care management counts toward the 20-minute time requirement. The newer codes require a physician order, Marting said.

When the newer series of RPM codes were introduced, providers complained about the inconsistency in refusing to allow the services to be provided incident to, when the new codes by definition involve clinical staff work, Marting said. CMS subsequently allowed incident-to billing, but was silent on the level of supervision, which defaulted to direct supervision—which wasn't enough of a carrot because physicians and clinical staff have to be in the same office suite when services are performed. Again CMS relented and changed it to general supervision, allowing clinical staff to monitor patient data from a different location than the supervising physician/NPP.

According to Marting's slides, the codes describe the setup of the device, recording of the data and management of the patient, with an add-on for an additional 20 minutes:

- **CPT code 99453**: "Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment."
- **CPT code 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."

- **CPT code 99457**: "Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month."
- **CPT code 99458**: "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)."

New RTM codes for 2022 follow a similar formula:

- **98980** "Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes."
- **98981** "Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes."
- **98975 "**Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment."
- **98976** "Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days."
- **98977** "Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days."

CMS expects nurses and physical therapists to be the primary providers of RTM, Marting said. Because the codes are medicine codes, they don't fall under care management and general supervision doesn't apply, she noted.

No Rounding Up the Minutes

RPM and RTM offer opportunities for providing better care, but there are risks, Hindmand said. Other codes can't be billed at the same time as RPM and RTM, although some of the time may overlap with chronic care management or other services. "If there's a day when the physician is billing an E/M code, typically the physician or NPP is not allowed to use it for RPM as well," he said.

There's also no rounding up minutes with RPM and RTM, Hindmand said. "You can't say, 'We got to 19 minutes and that's good enough.' You have to be up to the minute." Marting agreed, and noted the rounding prohibition runs counter to the "default coding rule in CPT that if you pass the mid-point, it's sufficient. It's confusing and almost contradictory because the number of days of monitoring described by the code (30 days, calendar month) is subject to the mid-point rule, but the amount of time spent in monitoring in 99457 is a minimum threshold that is not subject to the mid-point rule."

Hindmand recommended documenting start and stop times. It's not a Medicare requirement to have exact start and stop times of the RPM and RTM services, but they're more convincing to an auditor than a general entry in

the medical records, Hindmand said.

Supervision is another potential vulnerability, he said. Physicians may contract with a vendor for a turnkey RPM and/or RTM operation, but the responsibility to supervise clinical staff still rests with the physician. "It doesn't have to be a high level of supervision, but the billing practitioner has to have some involvement in supervising," he said. From what Marting understands, general supervision of RTM won't suffice for Medicare billing.

There are also risks around the accuracy of the data, Peters said. For example, if the device is not set with the correct time zone, the readings from a blood glucose monitor may be skewed. "Similarly, the availability of the data is key. We want to make sure in any case where we have a remote tool, the data is available on demand."

Adverse events are another concern, Peters said. "'That's where the FDA comes in. What if the device goes offline? We can't monitor patients and it affects the safety? What if the device transmits inaccurate data? How will we be prepared to respond? What does that look like from an FDA reporting perspective?" She said it depends on the device and how the patient interacts with the tool.

Contact Hindmand at rhindmand@mcdonaldhopkins.com, Peters at ipeters@polsinelli.com and Marting at rmarting@richellemarting.com.

1 Rick Hindmand and Ilana Peters, "Remote Patient Monitoring: Contract Structures, Medicare Coverage, and Regulatory Compliance," webinar, Strafford, February 1, 2022, https://bit.ly/33dONqb.
2 Richelle Marting, "HTRC Education Series: A Deeper Dive Into Remote Patient Monitoring," webinar, Heartland Telehealth Resource Center, December 9, 2021, https://youtu.be/OyuPI-Yiv4k