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What providers need to know before billing for RPM services

by Rachael T. Price, RN, BSN, COC, CIC, CDIP, HCS-H, RAC-CT

In 2018, the Centers for Medicare & Medicaid Services (CMS) started reimbursing remote patient monitoring (RPM), a subset of telehealth, with the creation of the Current Procedural Terminology (CPT) code 99091. This allowed physicians to bill for interpretation and monitoring of physiologic data such as blood pressure and glucose monitoring from the patient's home. Since then, RPM services have evolved, and the CPT codes have expanded from one to five. Using these codes allows for reimbursement of the device's setup, ongoing monitoring, and interactive real-time communication between the patient and their healthcare provider. RPM allows providers to better manage their patients' acute and chronic conditions, improving quality and access to care. With the COVID-19 public health emergency, the use of RPM services—like other telehealth services—saw rapid growth. The increase in the use of RPM services can be cause for concern with respect to possible compliance issues; thus, the announcement by the U.S. Department of Health and Human Services Office of Inspector General (OIG) in 2021 that audits would be conducted in two phases and that RPM services would be included in phase two was not surprising.

Phase two audits will include additional audits of Medicare Part B telehealth services related to distant and originating site locations, virtual check-in services, electronic visits, remote patient monitoring, use of telehealth technology, and annual wellness visits to determine whether Medicare requirements are met.[1]

This article will focus on the potential billing and coding compliance issues that healthcare providers and compliance officers should be aware of to avoid denials.

Understanding the RPM CPT codes is important to billing compliance

Although the first RPM CPT service became billable in 2018 with CPT code 99091, the current RPM codes under the Physician Fee Schedule were implemented on January 1, 2019. The code expansion was necessary to reflect what is involved in the delivery of RPM services. "In this final rule for CY 2021, we continue our work to improve payment for care management services through code refinements related to remote physiologic monitoring (RPM), transitional care management (TCM), and psychiatric collaborative care model (CoCM) services."[2] There are two codes to report physiologic monitoring: 99453 and 99454. The first code, 99453, is for the initial setup and patient device education, and the second code, 99494, is for device daily recording(s) or programmed alerts transmission. Additionally, two codes can be used for remote physiologic monitoring treatment management services—99457 and 99458. Both RPM treatment management codes are timed CPT codes. The use of these codes requires live, interactive communication between the healthcare provider and the patient or caregiver. The time spent on care management services for the patient can also include the time spent, as clarified by CMS in 2021.

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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 [Healthcare Common Procedure Coding System] 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.[3]

CPT code 99457 is used for the first 20 completed minutes of clinical staff/physician or other qualified healthcare professional time in a calendar month spent with the patient, and 99458 is for each additional, fully completed 20 minutes. A thorough understanding of each CPT code for RPM services is key to properly billing this code set.

Understanding the coding and billing guidelines is critical

A provider should have a good understanding of the billing and coding guidelines for RPM before billing for these services. CPT codes 99454, 99457, and 99458 can be billed once per month. First, to bill for the RPM monitoring services in a 30-day period (CPT code 99454), there must be at least 16 days of data recorded and documented. This code can only be billed by one of the patient's providers and only once per month. Regardless of the number of devices a patient may have for monitoring, the CPT code 99454 can only be billed once a month. The CPT codes assigned for the RPM treatment management—99457 and 99458—are timed codes and require full 20-minute increments of interactive communication and care management between provider and patient. 99457 is used for the first 20 minutes, and 99458 is used for additional 20-minute increments. If the 20-minute threshold is not met for either code, it cannot be billed. Activities that can be counted toward the 20 minutes per month include analysis of the physiologic data by the physician or qualified healthcare provider (QHCP), time spent updating or making changes to the patient's care plan based on the data collected, and phone calls and/or video calls with the patient. These activities can all count towards the time total time for the month. Billing for 99457 and 99458 can be challenging and should be monitored closely and continuously to ensure the billing guidelines are being followed.

Understanding the documentation guidelines before billing is essential

As with other Medicare services, a physician's or other QHCP's order for RPM is required. Additionally, the physician is required to obtain consent from the patient prior to billing for RPM services. Beneficiaries must understand and agree to the monitoring and the cost-sharing involved. Depending on the beneficiary's coverage, RPM services are subject to copayments and coinsurance. Consent can be written or verbal and should be clearly documented to avoid denials during an audit. The patient's condition(s) that require monitoring must be documented in the medical record, as well as the device(s) that will be used. Finally, the device(s) must be approved by the U.S. Food and Drug Administration (FDA) and should digitally upload the patient's physiologic data. Specifically, the data should automatically upload the data and the data should not be self-recorded or reported by the patient.[4] The dates the patient was trained to use the device(s) should be documented in the medical record. Good and thorough documentation is essential to a compliant, strong RPM program.

Knowing your vendor is vital

Knowing the vendor's level of experience with respect to RPM services is vital. With the growth of RPM services, many companies are deciding to enter this new rapidly growing industry, so practices should do their homework before choosing a vendor. With the many coding and billing, and documentation requirements, engaging a company with a strong, solid compliant program is necessary to ensure success. The practice should:

- Talk with the staff to get a sense of their knowledge of the many CMS billing and coding rules and regulations to ensure correct reimbursement.

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- Ensure the FDA approves the company's devices.
- Know the equipment options available. Find out what RPM technology is being used (for example, cellular or Bluetooth) and how the data is transmitted.
- Consider the RPM platform they offer and how easy integrating it into the providers' electronic medical record is.
- Make sure the vendor is a good fit for your practice. It is an excellent idea to ask for sample cases so the provider can see the documentation's quality and the coding and billing process to assess if it is a good fit for the practice.
- Finally, see if the vendor includes any RPM training and ongoing technical support to the patients, physicians, and staff.

Accessing RPM data: Why is it crucial and challenging

Once the RPM data is gathered, it must be easily accessible to the provider, helping them monitor the patient's condition. A provider's easy access to the RPM data and documentation is imperative for accurate billing. Additionally, the documentation needs to be readily available in the event of a government audit. If the provider is billing these CPT codes, they should review the data and documentation, to bill the proper CPT codes before billing. If this process is difficult, it could cause delays and errors with the billing. Finally, if there is a government audit, the data and documentation need to be collected in a timely manner; therefore, being able to access all RPM record documentation easily and efficiently is critical. Since the billing provider is ultimately responsible for the billing, it is in their best interest to ensure the RPM information can be easily entered.

Conclusion

RPM is here to stay, and with its rapid growth in recent years, the likelihood of scrutiny from CMS has increased. Therefore, healthcare organizations must be aware of the challenges and potential risk areas of RPM services. Physicians, compliance officers, and billing staff should have a good understanding of the coding and billing and documentation guidelines for RPM services. Practices should take the time to research and find the right vendor, making sure that it is a good fit to ensure a successful partnership. Ongoing monitoring is important to identify risk areas and weaknesses in the RPM program to avoid errors and possible denials.

Takeaways

- A good understanding of Remote Patient Monitoring (RPM) coding and billing rules is a must.
- Rock solid documentation is key to supporting RPM services.
- Patient consent is required before billing for RPM services.
- Devices used to provide RPM services must be approved by the U.S. Food and Drug Administration.
- Choosing the right vendor partner can make all the difference.

1 U.S. Department of Health and Human Services, Office of Inspector General, "Audits of Medicare Part B Telehealth Services During the Covid-19 Public Health Emergency," accessed January 24, 2024, https://www.oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000556.asp.
2 Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B

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Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/ Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID–19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID–19, 85 Fed. Reg. 84,472 (Dec. 28, 2020), https://www.federalregister.gov/d/2020-26815/p-631.
3 Centers of Medicare & Medicaid Services, "Final Policy Payment and Quality Provisions Changes Medicare Physician Fee Schedule Calendar Year 2021," fact sheet, December 1, 2020, https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1.
4 Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements, 85 Fed. Reg. 84,472 (Dec. 28, 2020), https://www.federalregister.gov/d/2020-26815/p-636.

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