



Providing and Billing Medicare for Remote Patient Monitoring: A How-To Guide



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I. Medicare Reimbursement for Non-Face-to-Face Services

Since 2013, the Centers for Medicare & Medicaid Services (CMS) has been expanding Medicare reimbursement for services furnished to beneficiaries outside the four walls of the clinic or hospital. Relying on evidence from numerous studies and pilot projects, CMS believed its investment in these services would reduce the overall cost of care through patient engagement and improved coordination among providers.

As a part of this expansion, on January 1, 2015, CMS started payment for chronic care management (CCM) services under CPT® 99490,¹ defined as follows:

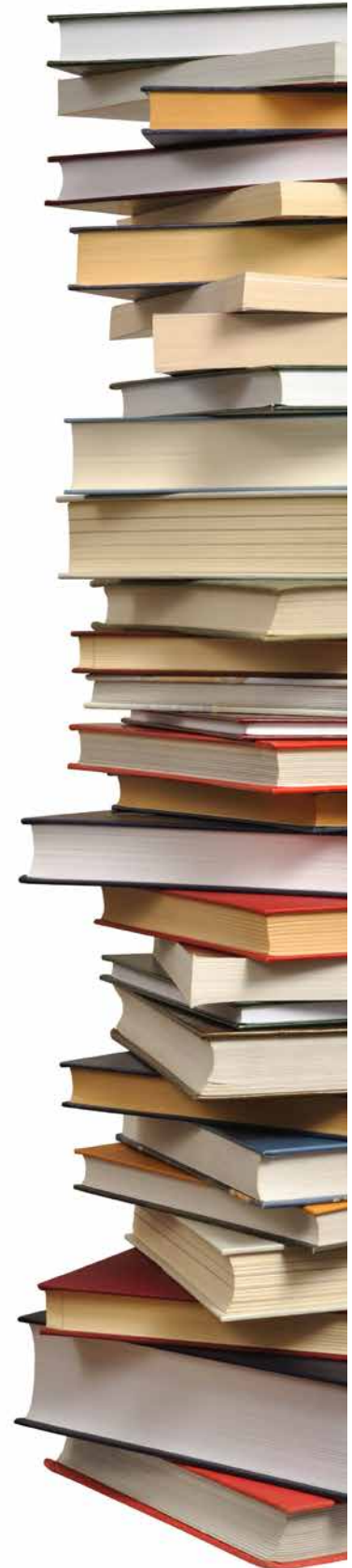
Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements:

- (1) Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- (2) Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- (3) Comprehensive care plan established, implemented, revised, or monitored

Since the initiation of CCM services, CMS has refined its CCM billing rules, eliminating many onerous requirements that practitioners found challenging. The agency has also published extensive guidance addressing the application of these rules in different circumstances. Additionally, CMS has begun reimbursing for related services, including care plan development, advance care planning, and complex CCM.

CMS' investments in these services appears to be paying off. The agency's evaluation contractor, Mathematica, recently published its analysis² of CCM's impact on Medicare spending in 2015 and 2016. The results are impressive: per-beneficiary-per-month (PBPM) expenditures **decreased by \$74** for CCM beneficiaries who received these services for 18 months. Most of these savings were realized in the inpatient and post-acute care settings, while Medicare payments to physicians actually increased.

Success of this magnitude is likely to fuel additional investment in non-face-to-face services, both by CMS and providers. New Medicare reimbursement for remote patient monitoring is the latest example of CMS' willingness to pay physicians more for purposes of reducing other healthcare expenditures.



1 Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association.

2 Schurrer, J. et al. *Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report*. November 2, 2017. Mathematica Policy Research.



II. CMS' Latest Investment: Remote Patient Monitoring

Generally speaking, the term “remote patient monitoring,” or RPM, refers to the use of digital technologies to collect health data from an individual in one location and electronically transmit that information securely to a healthcare provider in a different location for assessment and recommendation. Like CCM, numerous studies and pilot projects have shown that RPM improves health outcomes and reduces total cost of care.³

For years, CMS classified CPT® 99091, the existing CPT® code for RPM, as a “bundled” code, meaning it was considered content of another billable code and thus not separately reimbursable. In the 2018 Medicare Physician Fee Schedule (MPFS) proposed rule released in July 2017, CMS solicited comment on whether it should make separate payment for RPM. Most saw this solicitation as a first step in what would be a long journey to reimbursement for RPM.

When it published the 2018 MPFS Final Rule in November 2017, however, CMS elected to take a shortcut by “unbundling” CPT® 99091. Effective January 1, 2018, practitioners can receive roughly \$60.00 for accessing, reviewing, interpreting, and acting on various physiological data for at least 30 minutes over a 30-day period. The required 30 minutes may include updating the patient’s care plan, or communicating with the patient, caregivers, or other providers regarding the data.

Importantly, CMS noted RPM is not a telehealth service. Thus, RPM is not subject to the limitations that apply to telehealth, namely that the beneficiary must be located in a health professional shortage area (HPSA) or rural area, and that the beneficiary must be physically present at a specific site of service.

RPM shares some of the same billing requirements as CCM. Like CCM, practitioners must obtain and document beneficiary consent in the patient record prior to conducting RPM. An initial face-to-face visit is required prior to initiating RPM for new patients and/or patients not seen within the last 12 months.

Unlike CCM, however, the 30 minutes of service must be performed by a practitioner, not clinical staff under general supervision. Also, CMS did not limit the eligible recipients of RPM in any way; all Medicare beneficiaries are eligible as long as all service requirements are met.

3 See, e.g., Riley, WR et al., *Program Evaluation of Remote Heart Failure Monitoring: Healthcare Utilization Analysis in a Rural Regional Medical Center*, *Telemed J E Health*. 2015 Mar 1; 21(3): 157–162 (available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4365431/>); Hale, TM, et al., *A Remote Medication Monitoring System for Chronic Heart Failure Patients to Reduce Readmissions: A Two-Arm Randomized Pilot Study*, *J Med Internet Res*. 2016 Apr 17 (available at <https://www.ncbi.nlm.nih.gov/pubmed/27154462>).

With CMS giving the green light for RPM, it remains to be seen whether practitioners will rush to provide this service for their patients. It seems unlikely, however, that \$58.68 – the national payment rate for RPM – will be enough to incentivize practitioners to spend the required 30 minutes per month personally performing the service. A physician, for example, could spend the same 30 minutes required for RPM (or even less time) performing a routine office visit and be paid \$74.16 (the national payment rate for CPT® 99213).

As it stands, RPM only makes sense if the service is performed by clinical staff, similar to CCM. However, as noted above, CMS stated in the Final Rule that RPM, unlike CCM, must be performed by a practitioner, as opposed to clinical staff under general supervision.

To make RPM work financially, the service must be provided in compliance with the “incident to” billing rules, which are derived from some of the most confusing and misunderstood Medicare regulations. The following section outlines these rules and presents a clearer pathway for providing and billing for RPM.

III. Medicare Billing Rules

Services billed under the MPFS must be **(1)** personally performed by the individual under whose National Provider Identifier (NPI) the service is billed, or **(2)** furnished by another individual as an integral, although incidental, part of a physician’s personal professional services in the course of diagnosis or treatment of an injury or illness. In the case of the latter, which is called incident to billing, the service is billed under the NPI of the physician or non-physician practitioner who provides direct supervision of the individual furnishing the service (who may or may not be the physician who routinely cares for the patient).⁴

For purposes of incident to billing, CMS defines “direct supervision” to mean the billing physician **(1)** is physically present in the same suite of offices, at the same time, as the individual performing the service; and **(2)** is immediately available to furnish assistance and direction throughout the performance of the service.

CMS has made one exception to the direct supervision requirement for incident to billing. CCM services, CPT® code 99490, require “at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional.” Under CMS billing rules, clinical staff provide these services incident to a physician’s services. However, CMS amended 42 CFR 410.26(b)(5) in 2015, to permit the designated care management services associated with CCM services to be furnished under general supervision.



4 See 42 CFR 410.26.

Unlike direct supervision, general supervision does not require the physician to be physically present at the location or immediately available at the time the services are furnished.⁵

In its November 2017 announcement to “unbundle” CPT® code 99091, and thus provide separate reimbursement for RPM beginning January 1, 2018, CMS “note[d] that under current billing rules, time counted toward the CCM codes generally refers to time spent by clinical staff furnishing care management services; while CPT® code 99091 refers to practitioner time.” 82 Fed. Reg. 52,014 (Nov. 15, 2017).

While incorporating other CCM requirements into RPM requirements,⁶ CMS did not identify RPM as a “designated care management service.” Thus, an RPM service is billable under the incident to rules only if all of the requirements – including direct supervision – are satisfied.

A. Incident to Billing

Requirements for incident to billing include, in part, the following, derived from 42 CFR 410.26 and the Medicare Benefit Policy Manual (Chapter 15, Section 60). A physician or non-physician practitioner may bill for a Part B service furnished by another individual as if the physician or non-physician practitioner personally performed the service if *each* of the following requirements are satisfied:

01

CMS has not stated by regulation, manual provision, or other guidance that the service cannot be billed incident to.

For example, home health and hospice care plan oversight (CPT® codes 99367, 99374, 99375, 99377, and 99378) cannot be billed incident to; only time spent by the billing physician counts toward the 30 minutes of service required for these codes. However, there are several other time-based codes for which CMS has stated incident to billing is permitted.

02

The service is not one for which payment is made under a separate benefit category (e.g., physical therapy, diagnostic tests).

03

The individual furnishing the service qualifies as auxiliary personnel—i.e., he or she is an employee, a leased employee, or an independent contractor of the billing physician (or his or her practice).

Stated another way, the expense of providing the service is an expense to the physician (or physician practice) that bills for the service (i.e., the physician supervising the individual, who is not necessarily the patient’s treating physician).

04

The individual furnishing the service has not been excluded from Medicare, Medicaid, or any other federal health program, or had enrollment revoked at the time the service is provided.

An individual’s status may be checked using the healthcare exclusion databases, accessible at <https://exclusions.oig.hhs.gov/>.

⁵ See 42 CFR [410.32\(b\)\(3\)\(ii\)](#).

⁶ These requirements include the following: (1) a physician must obtain advance beneficiary consent for the service, and document this consent in the patient’s medical record; (2) for a new patient or a patient not seen within one year before the provision of RPM services, the physician must initiate these services in a face-to-face visit; and (3) RPM cannot be billed more than once per patient in a 30-day period.

05

The billing physician determines that **(1) the individual furnishing the service is qualified under state law to perform that service, if the service falls within the scope of practice for a specific state-issued license or certification; and (2) in his or her professional judgment, the individual has the appropriate training and experience to provide the service.**

06

The service is provided for an established patient (seen in the last three years) of the billing physician's practice, and the service relates to an existing medical condition for which the patient previously has been treated by the billing physician's practice.

Per this requirement, the ordering physician (the physician who routinely cares for the patient) and the supervising physician (the physician under whose NPI the incident to service is billed) must be in the same practice. Generally, this means billing under the same TIN, but one can argue a "practice" can be composed of multiple TINs (e.g., hospital-employed physicians), assuming the TINs function as such.

07

The service is furnished under the billing physician's direct supervision (as discussed above).

"Immediately available" means the supervising physician is present in the office suite and is available without delay to assist and to take over care as necessary.

"Office suite" means a dedicated area, or suite, designated by records of ownership, rent, or other agreement with the owner, in which the supervising physician maintains his or her practice or provides his or her services as part of a multi-specialty clinic.

08

The service is not performed in an institutional setting—i.e., hospital inpatient or hospital outpatient department or skilled nursing facility.

However, CMS has clarified that services may be furnished incident to in a provider-based physician clinic.

09

All required elements of the service are performed by the individual, another individual who meets all of the aforementioned requirements, or the billing practitioner.

10

If incident to services are furnished by ancillary staff (e.g., registered nurse), the medical record note must be signed by such staff member and the supervising physician.

NOTE: Certain Medicare Administrative Contractors (MACs) list this incident to billing requirement in educational materials, but CMS has not specifically stated such co-signature is required.

Time spent by ancillary staff on RPM-related activities may count toward the required 30 minutes to bill for RPM. Under no circumstances, however, may the same time be counted for multiple services. For example, while CMS permits both RPM and CCM to be billed for the same patient during the same month, time spent providing RPM cannot be counted toward the required 20 minutes for CCM. (Note, however, the total reimbursement for CCM and RPM [totaling 50 minutes] is nearly \$7.00 more than the reimbursement for complex CCM [requiring 60 minutes]).

B. Counting Toward 30 Minutes

Assuming a practice successfully structures its operations to bill for RPM under the incident to rules, there remains the question of what types of activities can be counted toward the required 30 minutes of service for RPM. Unlike the introduction of other care management services – which included dozens of pages of explanation – CMS devoted only a single page in the Final Rule to the definitions of acceptable activities.

Thus far, CMS has offered only general guidance on this issue: the code includes “time spent accessing the data, reviewing or interpreting the data, and any necessary modifications to the care plan that result, including communication with the patient and/or her caregiver and any associated documentation.”⁷

This general description is broad enough to include the following specific activities (any reference to a “patient” includes his or her caregivers):

- Making arrangements for the delivery of monitoring equipment to the patient
- Educating the patient regarding the use of the monitoring equipment and data transmission
- Responding to any questions received from a patient regarding data collection and transmission
- Engaging in activities related to retrieving, organizing, or compiling the patient’s data for review
- Following up with a patient whose data is not transmitted properly or received in a timely manner
- Validating the data
- Addressing any data quality issue with the patient or third party (e.g., monitoring equipment vendor)
- Reviewing and posting the data
- Comparing the data to the patient’s prior reported data
- Reviewing the patient’s electronic health record
- Comparing the data to established parameters
- Consulting with approved protocols and/or other clinicians to determine whether, and what, action is warranted based on the patient-reported data
- Discussing with the patient possible explanations for results outside established normal ranges
- Communicating specific data to other providers as directed by established protocol or upon request
- Acting on directives from the patient’s physician or other practitioner
- Counseling, educating, and following up with the patient in response to reported results
- Modifying the patient’s care plan based on reported results
- Communicating with the patient’s care manager regarding the reported results
- Documenting any of the aforementioned activities

Time spent on multiple days by multiple individuals may be aggregated to meet the 30 minutes-per-month services requirement. However, if two individuals are performing the same task at the same time (e.g., together analyzing a patient’s reported data) only one individual’s time may be counted.

7 82 Fed. Reg. 52,014 (Nov. 15, 2017).

Keep in mind all of these activities will need to be performed by ancillary staff while a supervising physician (or non-physician practitioner) is present in the same suite of offices. As the service must be billed under the NPI of a physician providing direct supervision (*i.e.*, physically present at the time the services are furnished), the practice will require some mechanism to capture this information.

One of the most important unanswered questions regarding RPM is whether it is permissible to bill for reviewing data for multiple patients at the same time. Many RPM products provide an alert when a patient falls outside defined parameters, permitting a provider to monitor several patients at the same time. If a practitioner can count the same time toward multiple patients – billing for what is referred to as “exception monitoring” – the economics of RPM become significantly more favorable.

In specific circumstances, CMS permits billing for group services—*i.e.*, submitting claims for multiple beneficiaries for services furnished in a group setting. Unless, and until, CMS offers additional guidance regarding this RPM-related matter specifically, however, there will be no clear answer regarding exception monitoring.



C. Documentation for Time-Based Codes

The “gold standard” for documenting time-based codes is to contemporaneously record start and stop times, and include in the documentation the provider’s name and a specific description of the work performed. While auditors prefer this level of documentation, other less demanding methods are sufficient, provided a prudent reviewer of the information is not left with the impression the documentation is generated automatically without regard to the services actually delivered.

For example, a documentation tool that includes a checklist of activities with a space by each to insert total minutes could be utilized. If, however, staff routinely completed the tool without regard to the services actually performed, and thus there was limited variation from one patient to another or from one month to another, it may prove difficult for a practice to demonstrate compliance with all billing requirements. As part of its implementation of an RPM program, a provider should develop a detailed documentation policy and provide staff education.

IV. Conclusion

The addition of Medicare reimbursement for RPM holds great promise for improving care and outcomes for patients requiring ongoing monitoring. An amazing array of technology solutions are already available, and in use, to enable these services, and more are entering the market every day.

While the Medicare billing rules for RPM are challenging, these rules should not be viewed as an absolute barrier to providing this important service. Instead, practitioners should be familiar with, and structure, their service delivery models to meet the requirements. With our experience and expertise, PYA can assist your organization in building a successful ambulatory care management program, including the provision of RPM services.

For more information about providing and billing Medicare for remote patient monitoring, contact:

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