



CMS Signals Support for Remote Patient Monitoring with New Reimbursement Incentives

Carrie Nixon, Esq.¹ and Rebecca E. Gwilt, Esq.²

Authors: ¹Managing Partner, Nixon Law Group PLLC, ²Partner, Nixon Law Group PLLC

Corresponding author: Carrie Nixon (carrie.nixon@nixonlawgroup.com)

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Two final rules issued by The Centers for Medicare & Medicaid Services (CMS) in November 2017 gave physicians and other healthcare providers ringing in the New Year another reason to celebrate. The Centers for Medicare & Medicaid Services has opened entirely new avenues for reimbursement of Remote Patient Monitoring (RPM) services in 2018, creating the potential for better patient outcomes and a boost to a healthcare providers' bottom lines.

As described in the Center for Connected Health Policy's Telehealth Definition Framework,¹ Remote Patient Monitoring (RPM) entails the use of digital technologies to collect personal health and medical data from an individual in one location via electronic communication technologies, which is transmitted to a provider in a different

location for use in care and related support. Remote patient monitoring has been around for decades (e.g., cardiac, glucose, blood pressure

monitoring). Traditionally, RPM has been considered a subcategory of telehealth, which Medicare defines broadly in Section 1834(m)(4)(F)(i) of the Social Security Act. However, CMS is signaling that it views RPM differently from telehealth services.

The CPT Code 99091 for RPM was created in 2002 to describe an interaction whereby patients use a home monitoring device (at that point in time, a glucose monitor) to collect their health information and transmit it to their doctor. Since that time, CMS has considered the work of the practitioner in reviewing and interpreting that data to be covered by the management services codes already billed by the practice—meaning, CPT Code 99091 was "bundled" with other management services codes and not separately reimbursable as a standalone service. The changes to the 2018 Medicare Physician Fee Schedule (MPFS) not only allow practitioners to seek separate Medicare reimbursement for the use of RPM, but this reimbursement is available without many of the barriers in place for

reimbursement of Medicare telehealth services. In addition, CMS specifically decided to allow practitioners to use RPM to boost their Merit-based Incentive Payment System (MIPS) score.

CMS “UNBUNDLING,” AND GETTING PAID FOR REMOTE PATIENT MONITORING

New Standalone Reimbursement for CPT Code 99091 Under the 2018 Medicare Physician Fee Schedule

In 2018, the reimbursement landscape for RPM will change dramatically, as CPT Code 99091 is "unbundled" and separate payment for RPM services by practitioners becomes a reality. As of January 1, 2018, CMS will pay \$59 per patient beneficiary per service period (subject to geographic variations) for RPM services as defined in the MPFS.

Whether commercial payers will follow suit remains to be seen, but if the recent past is any indication, the likelihood is high. Payers in general are trending towards reimbursing for services shown to improve patient care and reduce costs, and over the past several years, commercial payers have adapted delivery and payment programs similar to those implemented by CMS and taken them to the next level.

What is “Remote Patient Monitoring” Under The 2018 Physician Fee Schedule?

The 2018 Medicare Physician Fee Schedule Final Rule² describes CPT Code 99091 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." Although CMS imposed a number of requirements with respect to CPT Code 99091, it is important to

note that RPM is NOT subject to the same restrictions that currently govern reimbursement of general telehealth services under Medicare. For purposes of Medicare reimbursement for telehealth services, CMS imposes geographic restrictions that limit reimbursement to rural or underserved areas, while requiring that patients receiving services be physically located at a designated medical facility “originating site.” This excludes reimbursement for direct to consumer care, and care delivered to patients living in urban and suburban areas. None of these barriers exist for RPM in 2018. Specifically, reimbursement for RPM services is not limited by geography to rural or medically underserved areas, nor is there any "originating site" restriction for RPM services. In fact, RPM services can be provided anywhere the patient is located, including at the patient's home!

Specific guidance as to what exactly constitutes “physiologic data,” which kinds of devices are permissible, who the “other qualified health professionals” may be, and how the “minimum of 30 minutes of time” may be aggregated will be forthcoming over the next few months, as CMS considers the recommendations of the American Medical Association’s Digital Medicine Payment Advisory Group (DMPAG). However, early indications are that “physiologic data” will be interpreted broadly, such that any data deemed by a qualified health professional to provide useful information in the monitoring of a patient’s condition is appropriate for collection and interpretation under CPT Code 99091. Furthermore, the device used to collect the data will not need to be an FDA-approved Medical Device. In theory, this could mean that a patient could collect number of steps taken via her FitBit and, upon her physician’s (or other qualified health professional/billing practitioner’s) recommendation, transmit that as a measure of her activity levels post hip replacement surgery.

Key Requirements for Billing CPT Code 99091

Table 1 lists RPM services required for reimbursement under Medicare, CMS.

CPT Code 99091 in Practice

What might all of this look like from a practical perspective? Let's use a Medicare patient with diabetes as an example. During a face-to-face visit with the patient, the monitoring practitioner—likely in this case to be from a primary care or endocrinology practice—must

have a workflow in place to advise the patient regarding RPM services and to clearly document consent to these services in the patient's medical record. The billing practitioner should also document what type of physiologic data (e.g. glucose levels, blood pressure, weight, and/or circulation to the feet) will be collected by the remote device(s) to be used. The practitioner can then monitor aggregated readings—for this patient and the fifty others in the practice with a diabetes diagnosis—on a dashboard, on a daily or otherwise appropriate basis.

Table 1. Remote Patient Monitoring services required for reimbursement under Medicare, CMS

Requirement	Defined
Advance Beneficiary Consent	Practitioner should obtain beneficiary consent prior to initiating RPM services and document this consent in the beneficiary's medical record.
Face-to-Face Visit	For new patients or patients who have not seen the billing practitioner within one year, RPM services must be initiated during an initial face-to-face visit with the billing practitioner, such as a Preventive Physical Exam or an exam included in Transitional Care Management.
30-Day Period, 30 Minutes of Time	RPM services may be billed under CPT Code 99091 <i>once per patient per contiguous thirty days</i> . The services should be billed at such time when a practitioner in the practice has accrued thirty minutes of time reviewing, interpreting, and responding to the RPM data. This may include, for example, communicating with the patient/caregivers, modifying the patient's care plan, and documenting recommended interventions. (Note: Interpretation of data from hospital or clinical lab computers is NOT to be included as time attributable to CPT Code 99091.)
Physician or Other Qualified Health Professional	CPT Code 99091 encompasses time spent by a <i>physician or other qualified health professional</i> on RPM services as described above. Note: this is distinguishable from time spent by Chronic Care Management staff furnishing care management services.
Use with Other Care/Monitoring Services/Codes	CPT code 99091 can be billed once per patient during the same service period as Chronic Care Management (CPT codes 99487, 99489, and 99490), Transitional Care Management (CPT codes 99495 and 99496), and Behavioral Health Integration (BHI) (CPT codes 99492, 99493, 99494, and 99484).

The dashboard will flag patients needing attention, stratifying situations that need urgent attention by the practitioner as top priority and directing patients with lower needs to the

appropriate care provider. At such point when the billing practitioner has spent an aggregate of 30 minutes of time during a 30-day period reviewing and analyzing the data provided on a

patient via the dashboard, the practice can bill CPT code 99091 for that patient. The same holds true for each of the other fifty patients. The DMPAG is still developing guidelines for application of 99091, including more specific guidelines that would apply in the situation where a practitioner is reviewing a dashboard containing RPM data for a panel of patients.

To reduce the potential for allegations of false claims, practices should document the RPM vendors with whom they have relationships. And vendors of RPM technologies should consider incorporating an audit trail into their platforms that tracks time spent by a practitioner reviewing the dashboard or otherwise interacting with the patient-generated health data.

Importantly, CMS has indicated that standalone reimbursement under CPT code 99091 is an interim measure until new/additional codes specific to a variety of types of RPM services are approved, hopefully by 2019.

MACRA'S QUALITY PAYMENT PROGRAM AND REMOTE PATIENT MONITORING

There is more good news in the 2018 Quality Payment Program (QPP) Final Rule³ for practices implementing RPM services. The Rule, which implements the 2015 Medicare Access and CHIP Reauthorization Act (“MACRA”), determines reimbursement levels for practices serving Medicare patients and sets forth parameters for Year 2 of MACRA's QPP. Year 2 includes changes to the Clinical Practice Improvement Activities performance category and the Advancing Care Information performance category that incentivize the use of RPM services. Clinical Practice Improvement Activities and Advancing Care Information are two of the four performance categories that determine reimbursement rates for a physician/practice—meaning, practices will

want to do all that they can to improve their scores in these categories.

Clinical Practice Improvement Activities Performance Category

Physicians and other eligible practitioners participating in the Merit-based Incentive Payment System (“MIPS”) under MACRA must attest to participation in up to four Clinical Practice Improvement Activities: 2 “high-weighted” activities, 4 “medium-weighted” activities, or a combination thereof, to obtain the maximum performance score in this category. In 2018, CMS is emphasizing the use of technologies that facilitate collection and exchange of Patient Generated Health Data (“PGHD”). For example, the Clinical Improvement Activity called “Engage Patients and Families to Guide Improvement in the System of Care” is now classified as a “high-weighted” activity. This is an added incentive to use RPM technologies to engage patients, and to provide real-time feedback to patients and their care team. Another Improvement Activity called “Use of CEHRT (‘Certified Electronic Health Record Technology’) to Capture Patient Reported Outcomes” remains from Year 1 as a “medium-weighted” activity and involves use of digital tools to capture health data from patients.

Advancing Care Information Performance Category

Under MIPS, participating practitioners must also report their use of Certified Electronic Health Record Technology for the secure exchange of health information to support patient engagement and improve quality of care. In Year 2 of the QPP, practitioners are eligible for a 10% bonus on their performance score in this category if they use CEHRT to complete at least one of several specified Clinical Practice Improvement Activities. Both Improvement Activities discussed above qualify for this bonus. So, practitioners who use RPM to collect

real-time PGHD and (1) allow patients to access and/or transmit their data in or to the CEHRT, or (2) incorporate PGHD into their CEHRT, can increase their performance scores in both the Advancing Care Information category and the Improvement Activities category.

IMPLEMENTING RPM SERVICES IN YOUR PRACTICE

As is always the case in the healthcare industry, the devil is in the details. First, it's important that arrangements between technology vendors and practitioners for RPM services be evaluated by a healthcare attorney for any potential Anti-Kickback and/or Stark Law implications. Second, be vigilant about any HIPAA privacy and security vulnerabilities introduced to your practice by the use of new digital RPM technologies. Further, the way in which you implement RPM technology for patients in your practice combined with the method by which you bill for and report these services matters when it comes to 1) being reimbursed for specific services, and 2) the potential for enhanced performance scores under MIPS. Please consult a qualified healthcare attorney for guidance in establishing a compliant RPM program for your practice. For additional information on RPM and telehealth services, visit the Connected Health Initiative⁴ and the Center for Connected Health Policy.⁵

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Contributors

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