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Delta Region Community Health Systems Development (DRCHSD) Program

Remote Patient Monitoring (RPM) – New Changes Effective in the 2021 Physician Fee Schedule Final Rule

Forvis

September 1, 2022

Delta Region Community Health Systems Development (DRCHSD) Program



Delta Regional Authority

U.S. Department of Health & Human Services



This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$10,000,000 with 100% funded by HRSA/HHS and \$0 amount and 0% funded by non-government sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by HRSA/HHS, or the U.S. Government.



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Building a culture where difference is valued.

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

[Read more at ruralcenter.org/DEI](https://ruralcenter.org/DEI)



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Agenda

- 1) CCM, TCM & RPM
- 2) RPM Codes
- 3) RPM Guidelines (RHC/ FQHC)
- 4) Frequently Asked Questions

CCM, TCM & RPM

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Chronic Care Management (CCM)

- CCM is considered critical primary care service that contributes to better patient health and care
- Eligible if the patient has 2 or more chronic conditions
- Chronic conditions are defined by CMS
- Services are NOT typically face-to-face
- Allows eligible practitioners to bill at least 20 minutes of care coordination services per month (Physicians, Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners and Certified Nurse Midwives)
- Can help reduce geographic and racial/ ethnic health care disparities

[Chronic Care Healthcare Resources | CMS](#)

21 CMS Chronic Conditions

- Alcohol Abuse
- Alzheimer's Disease/ Related Dementia
- Arthritis (Osteoarthritis/ Rheumatoid)
- Asthma
- Atrial Fibrillation
- Autism Spectrum Disorder
- Cancer (Breast, Colorectal, Lung, Prostate)
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes

- Drug Abuse/ Substance Abuse
- Heart Failure
- Hepatitis (Chronic Viral B & C)
- HIV/ AIDS
- Hyperlipidemia (High Cholesterol)
- Hypertension (High Blood Pressure)
- Ischemic Heart Disease
- Osteoporosis
- Schizophrenia & Other Psychotic Disorders
- Stroke

[Chronic Conditions | CMS](#)

Who Can Bill What

CPT Codes	Description	Who Can Perform
99487	Complex chronic care management services, first 60 minutes of clinical staff time directed by a physician	Physician & Clinical Staff
99489	Complex chronic care management services, additional 30 minutes of clinical staff time directed by a physician	Physician & Clinical Staff
99490	Chronic care management services, first 20 minutes of clinical staff time directed by a physician	Physician & Clinical Staff
99439	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician	Physician & Clinical Staff

Who Can Bill What continued

CPT Codes	Description	Who Can Perform
99491	Chronic care management services; at least 30 minutes of physician time	Physician
G0506	Comprehensive assessment of and care planning by physician for patients needing CCM	Physician

[Chronic Care Management Frequently Asked Questions \(cms.gov\)](#)

Transition Care Management (TCM)

- TCM is the management of transition from acute care or certain outpatient stays to a community setting with face-to-face visits, once per patient with 30 days post-discharge.
 - 99495
 - + Communication within 2 business days (email, phone, direct contact)
 - + MDM of at least **Moderate** Complexity
 - + Face to face within **14** calendar days from discharge
 - 99496
 - + Communication within 2 business days (email, phone, direct contact)
 - + MDM of at **High** Complexity
 - + Face to face within **7** calendar days from discharge

Remote Patient Monitoring (RPM)

- Per CMS, RPM stands for Remote Physiologic Monitoring, however Remote Patient Monitoring has been used interchangeably
- RPM is the development and management of a plan of treatment based upon patient physiologic data
- The service involves the collection and analysis of the patient's physiologic data that is obtained from devices
- Treatment plans are developed and managed for chronic and/ or acute health illness or conditions

RPM Codes

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CPT 99453

- Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; setup and patient education on use of equipment.
 - This code is used to report the initial setup and patient education of device(s)
 - This code can only be billed once per episode of care
 - Episode of care is defined as “beginning when the RPM service is initiated and ends with attainment of targeted treatment goals”
 - This code can only be billed once regardless of the number of devices
 - Do not report this code if monitoring is less than 16 days
 - Do not report this code when these services are included in other codes (i.e., 95250)
 - This code may be billed in the same month with CCM and TCM codes

CPT 99454

- Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
 - This code is used to report remote physiologic monitoring services and to report the supply of the device for daily recording or programmed alert transmission.
 - This code can be billed once every 30 days even when multiple devices are provided to the patient.
 - Do not report this code if monitoring is less than 16 days
 - Do not report this code when these services are included in other codes (i.e. 95250)
 - This code may be billed in the same month with CCM and TCM codes.

CPT 99457 & 99458

- 99457: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time per calendar month requiring interactive communication with the patient/caregiver during the month, first 20 minutes
- Reported once each 30-day period, regardless of the number of physiologic monitoring modalities performed in the given month
- 99458 each additional 20 minutes; add-on code
- Both codes require a live interactive communication with the patient/ caregiver
- This code may be billed in the same month with CCM and TCM codes

CPT 99091

- Collection and interpretation of physiologic data digitally stored and/ or transmitted by the patient/ caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days.
- This code is valued to include a total of 40 minutes of billing provider (physician, nurse practitioner or physician assistant) work broken down as follow:
 - 5 minutes of pre-service work (chart review)
 - 30 minutes of intra-service work (data analysis/ interpretation)
 - 5 minutes of post-service work (EMR documentation)

CPT 99091 continued

- Documented time included in 99091 may NOT be performed by clinical staff, but rather must be directly performed by the billing provider.
- The treatment plan should be documented in EMR and include:
 - Substantiated diagnosis(es);
 - Short and long-term goals;
 - Specific devices and amount/types of modalities being utilized; and
 - Responsibilities of the care team members
- This code does not require any communication between patient and provider.
- This code cannot be billed in the same month with CCM or TCM codes.

Who Can Bill What final

CPT Codes	Description	Who Can Perform
99453	Initial set-up and patient education on use of equipment	Physician & Clinical Staff
99454	Device(s) supply with daily recording and transmission of data for each 30 days	Physician & Clinical Staff
99457	20 minutes a month of monitoring and interactive communication;	Physician & Clinical Staff
99458	Add-on code for an additional 20 minutes of RPM services in a given month	Physician & Clinical Staff
99091	Collection and interpretation of remote physiologic data by qualified healthcare professional	Physician

RPM Guidelines for RHC/ FQHC

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HCPCS G0511

- G0511 - Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month
- FY 2022 rate for G0511 is \$79.25

RHC/ FQHC Guidelines

- RHC and FQHC cannot bill for the newly added RPM codes
- G0511 was added to cover these services.
 - 20 minutes or more of time, per month, coordinating a patient's chronic care management services or behavioral health integration services
 - Is NOT a telehealth service
 - Billable for Physicians, Nurse Practitioners, Physician Assistants & Certified Nurse Midwife

Frequently Asked Questions

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How are patients tracked?

- Patients use an FDA approved telemonitoring device
- Allows for continuous collection of physiologic data
- Bluetooth & cellular available, cellular is better long term
 - For cellular, irregularities will alert the patient & provider
- Third Party providers can be used to monitor data
- Programs can include subscriptions to monitor admit/ discharge services to alert provider of hospitalizations

Does RPM integrate to my EMR?

- Devices can easily and automatically integrate into an EMR
- Integration can reduce staff training cost and solution adoption
- Device communication to the EMR can have a constant connection (cellular) or a scheduled communication (Bluetooth)

What specialties benefit most from RPM?

- All specialties can benefit but the ones that utilize the service are:
 - Cardiology
 - Pulmonary
 - Endocrinology
 - Gastroenterology
 - Bariatrics
 - Internal Medicine
 - Primary Care

What disease states benefit most from RPM?

- Some disease states that can benefit are:
 - Hypertension
 - Obesity
 - Congestive Heart Failure
 - Chronic Obstructive Pulmonary Disease
 - Diabetes

What are some benefits from using RPM?

- Some benefits are:
 - Improved management of acute and chronic conditions
 - Reduced hospitalizations and readmissions
 - Reduced hospital lengths of stay
 - Lowered overall healthcare costs
 - Increased patient adherence and engagement
 - RPM enables older and at-risk individuals to remain at home longer and delay or avoid moving into skilled nursing facilities
 - RPM helps reduce the risk of infectious disease exposure such as COVID-19 for patients, providers and healthcare workers.

Questions

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