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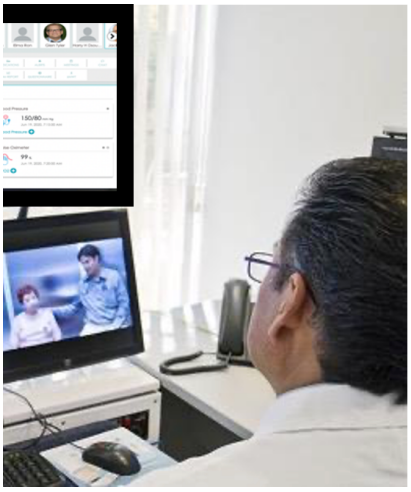
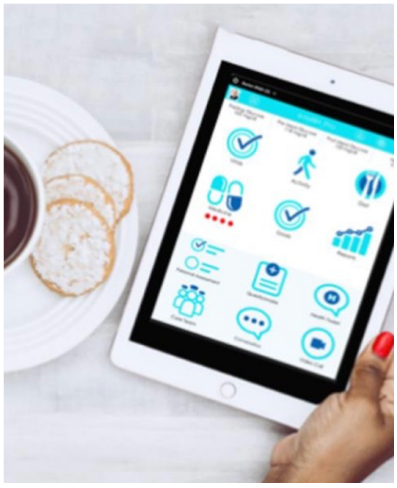
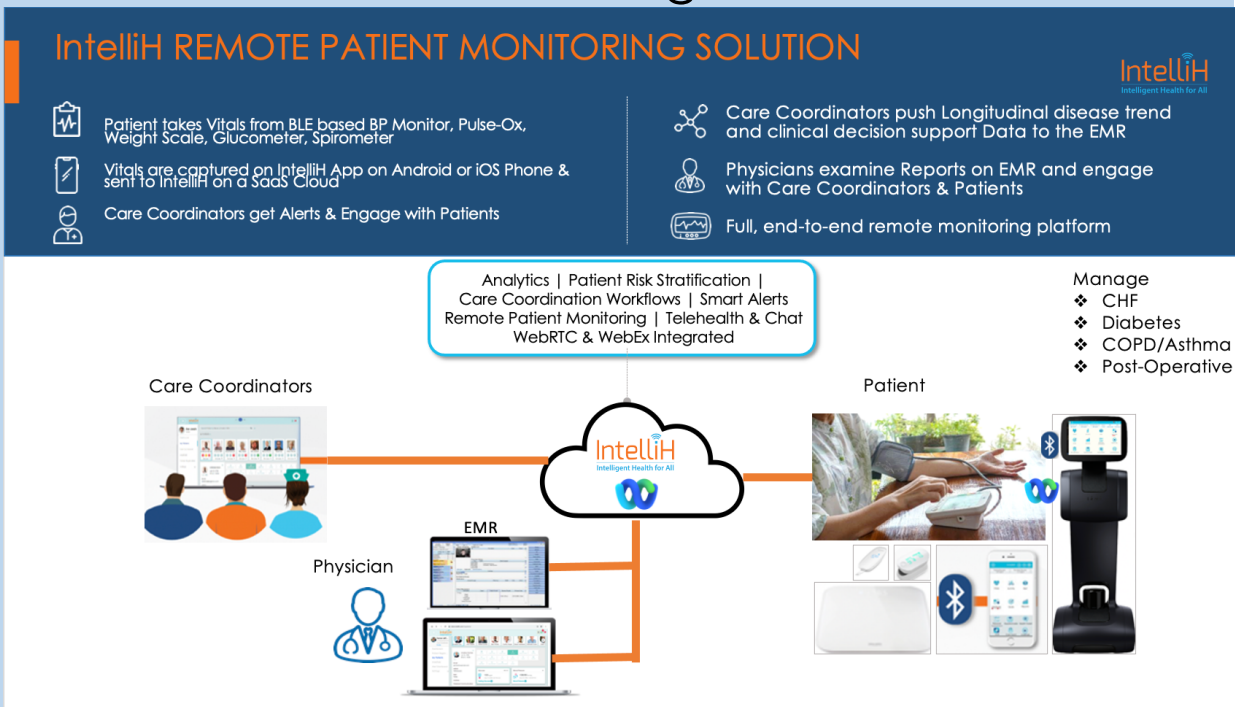


# WHITE PAPER

## A Guide to help providers leverage Remote Patient Monitoring to improve revenue, patient outcomes and patient experience under the CMS RPM reimbursement guidelines





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# 1 EXECUTIVE SUMMARY

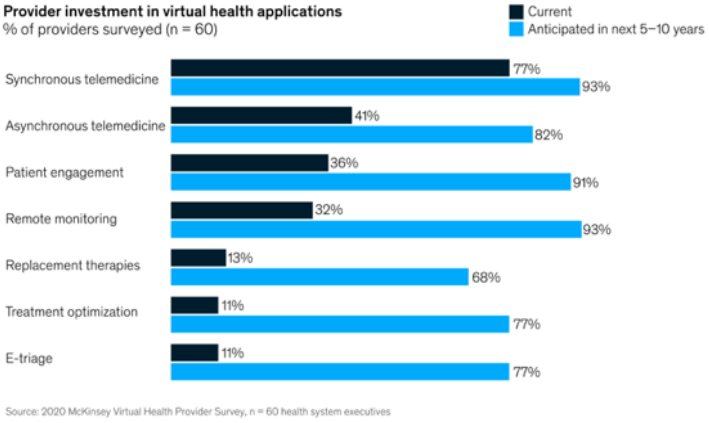
Telemedicine services have for long been reimbursable with geographical and site restrictions found in Section 1834(m) of the Social Security Act. With Covid these restrictions have been kept in abeyance.

Long before Covid impacts, the Center of Medicare and Medicaid Services (CMS) recognized the benefits of **Remote Patient Monitoring (RPM)** to manage chronic and co-morbid patients, improve patient outcomes and lower costs. In 2018 CMS began reimbursing for Remote Patient Monitoring ensuring that these services should **not** be constrained by geographical, or site restrictions imposed under Section 1834(m).

This flexibility paved the way for adoption of Remote Patient Monitoring by Healthcare providers.

McKinsey estimates that in five years over 93% of providers will make substantial investments in a very active Remote Patient Monitoring Program.

**Provider adoption: Pre-COVID-19, most also reported that they would be making substantial future investments.**




# 2 REMOTE PATIENT MONITORING SERVICES

As in any new program the uptake on Remote Patient monitoring services started slow. This was due to the confusion with some of the reimbursement rules. This whitepaper intends to demystify some of the Remote Patient Monitoring services and associated rules.

There is increased evidence that Remote Patient Monitoring helps improve patient outcomes and provides a valuable lifeline to patients from their care teams thus strengthening the patient-provider relationship as well as improving patient experience and satisfaction.

Remote Patient Monitoring is not just one service but a group of services that incorporate physiological monitoring devices that transmit vitals as required by their care plan, as well as rich Video collaboration between patients and care teams.

There are a variety of services now reimbursed for virtual Remote Patient Monitoring and management. These are:

- Remote patient (or Physiological) monitoring (RPM)
    - CPT Codes: 99453, 99454, 99457, 99458
- Chronic care management (CCM)
    - CPT Codes: 99487, 99489, 99490, 99491, G 0506, G 2058
- Transition care management (TCM)
    - CPT Codes: 99495, 99496
- Annual wellness visits
    - CPT Codes: G0438, G0439
- Principal care management (PCM)
    - CPT Codes: G2064, G2065
- Patient self-measurement (PSM)
    - CPT Codes: 99473, 99474
- Virtual check in
    - CPT Codes G2012

**IntelliH implements a support for all of these services**. A review of these services follows.

## 2.1 Remote Patient Monitoring (RPM)

In 2018 CMS initiated reimbursement of RPM under an existing CPT code 99091. However, the requirement that services under this code be provided by a Physician as opposed to a clinical resource and the financial incentive being low, there was little enthusiasm to adopt this service.

### 2.1.1 Medical Necessity for RPM

RPM is required to be ordered by a Physician or a non-physician practitioner- as of now there are no specific requirements from CMS addressing medical necessity other than that the patient should have a chronic condition. The physician should document a justification for prescribing RPM in the patient's medical record.

### 2.1.2 Technology Requirements

CMS requires devices to be a medical device approved by the FDA and the solution supply daily recordings and generate alerts if the vitals fall outside a specified range. FQHC's and Rural Health clinics may not bill for RPM

### 2.1.3 RPM CPT Codes and services

In 2019 CMS provided four new CPT codes that did away the challenges of the earlier CPT 99091.

| CPT CODE | NON-FACILITY RATE | FACILITY RATE |
|---|---|---|
| **99453** | $18.77 | Similar |
| **99454** | $62.44 | Similar |
| **99457** | $51.61 | $32.84 |
| **99458** | $42.22 | $32.84 |

The new CPT codes were:

- CPT 99453
    - Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
    - According to the CPT Guidelines, CPT 99453 "*is reported for each episode of care. For coding remote monitoring of physiologic parameters, an episode of care is defined as beginning when the remote monitoring physiologic service is initiated and ends with attainment of targeted treatment goals*."
    - The CPT guidelines also states that the CPT 99453 should not be reported if the monitoring is less than 16 days. Simply put, providing devices and educating patients on the use of devices is not adequate for billing CPT 99453- a minimum 16 days of vitals should also be sent by the patient before reporting CPT 99453 for billing purposes
    - The date of service should be the date a device is provided to a patient or when the patient has been trained whichever is later.
    - The place of service could be the location of the billing physician's office
    - While billing CMS the provider should include their order for RPM, the chronic condition for which the patient is being monitored, the device type that is being used to monitor the patient, the date of delivery of device, the date the training was initiated and the date the first vital was captured from the patient

- CPT 99454
    - Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial each 30 days.
    - The service can be billed every 30-day period in a month as long as the patient's physiologic monitoring device sends data and any Alerts for at least 16 days in the month.
    - In the first month of service if a patient generates 16 days of Vitals the provider can bill for 99453 and 99454 in the same month
    - CPT 99453 and 99454 cannot be billed if a patient is also being monitored under other CPT codes such as Patient self-measurement or Principal care management or under a CPT code for continuous glucose monitoring (CPT 95250)

  - In any month the billing should record the last day the vital was sent in the month

- CPT 99457 and CPT 99458
  - These services (99457 and 99458) can be provided under general supervision of a physician or practitioner. The billing of these services should be done by the practitioner's NPI under whose supervision the clinical staff is delivering this service.
  - The CPT requirement is for "remote physiologic monitoring treatment management services are provided when clinical staff/physician/other qualified health care professional use the results of remote physiological monitoring to manage a patient under a specific treatment plan. CPT 99457 requires a **live, interactive communication** with the patient/caregiver"
  - If a healthcare professional spends 20 minutes that are qualified for CPT 99457 this can be billed even if the patient has not sent 16 days of data from their device in that month
  - RPM services can work concurrently with Chronic Care Management (CCM- 99487, 99489, 99490 and G2058), Transition care management (99495, 99496) and Behavioral Health Integration (99484, 99492, 99493, 99494) as long as the services delivered are separate with no double counting of time for any individual encounter.
  - These services should not be recorded on days where there is a regular Evaluation and Management (E&M) service, domiciliary rest home service (99324, 99328 and 99334-99337) or home services (99341-99345 and 99347-99350)
  - Time spent on different days or by different care team members in the month can be combined to qualify for the 20 minutes
  - If two care team members are delivering the service at the same time the time spent by one care team member should be counted
  - Time spent should be 20 minutes or more
  - No restrictions are imposed on 99458 in a month so a facility can bill for 2 instances of 20 minutes in a month for 99458 if required. However, there should be only one instance for 99457 in a given month
  - 99457 and 99458 requires a **"live interactive communication"** between the patient and the care team member. This interactive communication can be a Video virtual interaction as well as text message. The practice should be prepared to provide documentation that supports the time spent.

## 2.2 CHRONIC CARE MANAGEMENT (CCM) CPT Codes and services

Chronic Care Management services have been in prevalence since 2015. Patients qualified for CCM services must have **two or more** chronic diseases.

| CPT CODE | RATE PPPM |
|---|---|
| **99487** | $92 |
| **99489** | $45 |
| **99490** | $42 |
| **99491** | $84 |
| **G2058** | $38 |
| **G0506 (ONE TIME)** | $64 |

**Rural Health Clinics and FQHC's are now permitted to bill for CCM.**

Physicians and the following non-physician practitioners may bill CCM services:

- Certified Nurse Midwives
- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants
    - The clinical staff are either employees or working under contract to the billing practitioner (under general supervision) whom Medicare directly pays for CCM

### 2.2.1 PATIENT ELIGIBILITY

- Patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, are eligible for CCM services.
- Billing practitioners may consider identifying patients who require CCM services using criteria suggested in CPT guidance (such as number of illnesses, number of medications, or repeat admissions or emergency department visits) or the profile of typical patients in the CPT prefatory language
- For new patients or those that have not been seen face to face in the preceding 12 months Medicare requires initiation of services during a face-to-face visit with the billing practitioner. The initiating visit is not part of the CCM service and is separately billed.
- Practitioners who furnish a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill **one-time** HCPCS code **G0506** (Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services [billed separately from monthly care management services]
- A patient consent is required for these (RPM and CCM) services
- The patient's health information should be recorded in a certified Electronic Health Record system

- Provide patients a 24 hour a day, 7 days a week (24/7) access to physicians or other qualified healthcare professionals or clinical staff

### 2.2.2 CCM CPT CODES AND SERVICES

CCM may be billed by Primary Care Practitioners although in special circumstances specialty practitioners may provide and bill for CCM.

**NON-COMPLEX CCM**

- CPT 99490
  - Chronic care management services for at least 20 minutes delivered by a Clinical staff (NP) directed by a PHYSICIAN per Calendar month
  - The patient should have two or more conditions expected to last 12 months or until the death of the patient
  - Chronic condition places the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - Comprehensive care plan established, implemented, revised or monitored
  - Assumes 15 minutes of work by the billing practitioner every month

- CPT 99491
  - CPT code 99491 includes only time that is spent personally by the billing practitioner. Clinical staff time is not counted towards the required time threshold for reporting this code
  - Chronic care management services for at least 30 minutes delivered by a Clinical staff (NP) directed by a PHYSICIAN per Calendar month
  - The patient should have two or more conditions expected to last 12 months or until the death of the patient
  - Chronic condition places the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - Comprehensive care plan established, implemented, revised or monitored
  - Assumes 15 minutes of work by the billing practitioner every month

- G2058
  - CCM Clinical time, additional 20 minutes, maximum 60 minutes in total per month unless complex delivered by the clinical staff

**COMPLEX CCM**

- CPT 99487
  - Chronic care management services for at least 60 minutes delivered by a Clinical staff directed by a PHYSICIAN per Calendar month

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Establishment or substantial revision of a comprehensive care plan
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

- CPT 99489
  - Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).
  - Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately.
  - Report 99489 in conjunction with 99487.
  - Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.

## 2.3 TRANSITION CARE MANAGEMENT (TCM)

CMS now enables Transition care for 30 days to patients that have been discharged from Hospitals. The services cover:

- Coordination of services to patients for any medical condition
- Management of psycho-social needs and activities of daily living
- Can work concurrently with RPM and CCM

| CPT | SERVICE | AMOUNT |
|---|---|---|
| **99495** | **One Time**. Moderate Medical complexity within 14 days of discharge to be delivered by a Physician or a Qualified Health professional | $188 |
| **99496** | **One Time**. High Medical complexity within 7 days of discharge to be delivered by a Physician or a Qualified Health professional | $248 |

## 2.4 ANNUAL WELLNESS VISIT

| CPT CODE | SERVICE | REIMBURSEMENT |
|---|---|---|
| **G0438** | Initial AWV | $173 |
| **G0439** | Subsequent AWV | $117 |

There are two services:

- Initial Preventive Physical Exam
  - This is for patients that are new to Medicare within the last 12 months
  - An IPPE can be performed using code G0402
- Annual Wellness Visit
  - There are two situations here:
    - Those who have been in Medicare but have not had an Annual Wellness visit in the last 12 months- use code G0438
    - Those who are eligible for their AWV having had one a year earlier- use Code 0439
- Elements of an AWV
  - Health Risk Assessment (HRA)
  - Record patients medical/family history
  - Review patient's potential risk factors for depression (current/ past) and other mood disorders
  - Review patient's functional ability and safety level
  - List of current providers and suppliers
  - Assess cognitive impairment
  - Examination of height, weight, Blood Pressure, BMI and any other vital as appropriate
  - Education, counseling and referral for preventive services – written plan or checklist
  - List of factors with intervention
- Elements of Subsequent AWV
  - Update all elements of AWV except:
    - Obtain new limited "exam"
    - Reassess for cognitive impairment
    - Furnish new/updated plan for advice and preventive services
  - Use AWV findings to close care gaps and engage patients
    - Medication reconciliation
    - Care Coordination
    - Effectively managing complex patients
      - Update charting
      - Identify hospital and ER encounters
    - Identify high risk behaviors
    - Patient education
    - Assess health confidence

## 2.5 PRINCIPAL CARE MANAGEMENT (PCM)

| CPT/BILLABLE CODE | FACILITY PAYMENT | NON FACILITY PAYMENT |
|---|---|---|
| **G2064** | $79 | $92 |
| **G2065** | $40 | $40 |

In 2020 CMS introduced a Principal Care Management Service (PCM) for patients with **ONE** complex chronic condition as opposed to CCM which was for patients with 2 or more chronic conditions.

- Patient's condition may be expected to last between 3 months to one year or the death of the patient.
- A trigger for this service is an exacerbation of the condition or a recent hospitalization
- The patient's primary care physician will manage the overall condition, but a specialist will manage services for the specific chronic condition

There are two codes G2064 and G2065.

G2064

- Comprehensive care management services for a single high-risk disease,
- At least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements:
    - One complex chronic condition lasting at least 3 months, which is the focus of the care plan,
    - The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization,
    - The condition requires development or revision of disease-specific care plan,
    - The condition requires frequent adjustments in the medication regimen, and/or
    - The management of the condition is unusually complex due to comorbidities
    -

G2065

- Comprehensive care management for a single high-risk disease services
- At least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements:
    - One complex chronic condition lasting at least 3 months, which is the focus of the care plan,
    - The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization,

- The condition requires development or revision of disease-specific care plan,
- The condition requires frequent adjustments in the medication regimen, and/or
- The management of the condition is unusually complex due to comorbidities

## 2.6 PATIENT SELF MEASUREMENT

| CPT CODE | DESCRIPTION | AMOUNT |
|---|---|---|
| **99473** | Hypertension patient onboarding and training on how to take a Blood Pressure reading | $11 |
| **99474** | Hypertension Patient self-measurement – 2 readings separated by a minute twice a day over 30 days with report of average SYS/DIA with a minimum of 12 readings | $15 PPPM |

This service was introduced in 2020 to enable patients to play a more active role in a self-care program.

- Patients should **not be** on RPM or CCM
- Patients should be Hypertensive
- Collection of Blood pressure from a monitoring device at home- sent to a physician
- Patient is required to take 2 readings 1 minute apart twice daily
- The data should be reviewed by the clinical staff every month by their care team
- A minimum of 12 readings are required to qualify for billing in the month
- The system should report Average Systolic/Diastolic blood pressure
- The physician/clinical staff should prepare and communicate to the patient a treatment plan

# 3 INTELLIH THE MOST COMPREHENSIVE RPM SOLUTION

The IntelliH Remote Patient Monitoring and Care coordination solution:

- HIPAA compliant SaaS based solution on Azure
- Provides an iOS and Android Apps on Phone and Tablets as well as an autonomous robot
- Structured intuitive workflows for care coordination and patient management
- Patient 360- enabled care teams across the care continuum
- Supports the following Chronic conditions:
    - CHF
    - Hypertension
    - Diabetes
    - COPD
    - And Post-Operative
- BLE based monitoring devices such as Blood Pressure Monitor, Weight Scale, Glucometer, Pulse Oximeter, Spirometer and Thermometer
- Integrates with Apple Health and Google Fit
- Stratifies patients by Risk
- Workflows for care coordinators and case managers improve oversight and management and provide a lifeline to engaged patients and their care givers
- Provides comprehensive longitudinal single button click reports on disease
- Provides a decision support correlation charts to facilitate and titrate medication
- Generate a Care plan and track adherence to medications and care plan
- Helps maintain a diet diary
- Severe, elevated and boundary condition alerts
- CPT based billing reports
- Management reports in overall patient and care coordination performance
- Immersive High-Definition Video based collaboration along with Secure Text and patient tweets
- Assign Subjective disease specific questionnaires and Quality of life surveys to patients
- Integrated to a variety of EMR's such as EPIC, CERNER, AllScripts, Athena, Dr. Chrono and Kinnser

IntelliH Provides Business Value

- Helps improve patient outcomes
    - Physiological context supplemented by Alerts, extensive analytics and decision support tools allows proactive outreach and patient management before a patient decompensates

- Track patient adherence to care plan

Help Reduce costs

- Manage patients before they decompensate
- Helps avoid rehospitalization or ER visits through proactive interventions
- Generate billing reports

Transformed Patient and Care Team experience

- Care teams spend more time with patients as system generates documentations with single click
- Intuitive workflows embedded in solution wherever needed
- Smart alerts implementation reducing care team alert fatigue and enabling proactive patient oversight
- Immersive collaboration between patients, care teams and care givers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