

Fact Sheet:

Top Coding Challenges for Remote Physiologic Monitoring (RPM) Providers

A PROVIDER CANNOT IMPLEMENT AN RPM PROGRAM USING A SINGLE MEDICAL DEVICE.

A single medical device cannot be used to furnish RPM without the following:

- Cellular, Wi-Fi, or Bluetooth connectivity and transmission service for the device
- Secure and HIPAA compliant software capable of ingesting and processing patient vitals
- Integration with the provider’s electronic medical record
- Two-way patient engagement support software (via SMS, audio, video, or email)
- Compliant time tracking and billing software
- Technical support, device replacement, and battery replacement



The list above is non-exhaustive as there are other requirements that significantly increase the costs of delivering RPM, such as insurance and administrative costs (e.g., shipping devices to patients). Further, it is not possible to simply purchase an individual medical device without such features given Medicare’s requirement that, in order to report CPT code 99454, the device must automatically upload a patient’s data, which necessarily means the inclusion of software that must be created and maintained in various ways. See 85 FR 84472, 84543 (“CPT code 99454 must meet the FDA definition of a medical device, we clarified in the proposed rule that the medical device should digitally (that is, automatically) upload patient physiologic data (that is, data are not patient self-recorded and/or self-reported).”).

CMS DOES NOT INCORPORATE RPM SOFTWARE OR CELLULAR AND WI-FI DEVICE FEES AS DIRECT PRACTICE EXPENSE INPUTS IN VALUING RPM DEVICE SUPPLY CPT CODE 99454.

CMS’s current valuation of 99454 (monthly remote monitoring, device supply) in the Physician Fee Schedule accounts only for a medical device as a direct practice expense (PE) input. It does not account



for the cost of RPM software as a direct PE input. CMS acknowledged at the time it established 99454 that it might consider adding software as a direct PE input in the future, noting “as the PE data age, these issues involving the use of software and other forms of digital tools become more complex.” Medicare incorporates software costs into the direct PE inputs for a variety of other codes throughout the Physician Fee Schedule (e.g., CAD software, imaging software, incision programming software); CMS should similarly reflect the software input for RPM in the valuation of 99454.

CMS has also resisted payment for cellular and Wi-Fi fees associated with the devices. CMS should reconsider this position as such fees are a cost allocated to each patient’s device and are more appropriately characterized as a direct PE. Compare 83 FR 59452, 59575 (“[W]e continue to believe that the monthly cellular and licensing service fee constitutes a form of indirect PE [for CPT code 99454]. We believe that licensing and data costs are administrative costs that are not unique to individual procedures, in the same fashion that we do not assign separate direct PE for higher electricity costs to diagnostic imaging procedures as compared to cognitive evaluation procedures. We continue to believe that these data costs are appropriately captured via the indirect PE methodology as opposed to being included as a separate direct PE input.”).

RPM PROVIDERS FACE ADDITIONAL CODING BARRIERS.

- **The 20-minute threshold for reimbursement under 99457 and 99458 results in approximately 30% of care being uncompensated.** For example, there are situations in the delivery of RPM – e.g., receipt of a patient vital or phone call requiring immediate intervention – that result in a significant amount of uncompensated care by providers because services do not meet this time threshold. Structuring the treatment management codes to resemble primary care services by offering reimbursement for care furnished in smaller increments, as opposed to the 20-minute rule, would improve the long-term viability and reach of RPM. 95% of the practitioners ordering our RPM services are primary care physicians, and the services are often utilized similarly to telephonic, non-face-to-face E/M codes. RPM treatment management services codes should be modernized to have comparable flexibility.
- **99453 and 99454 may only be reported once per patient during a 30-day period, even if multiple medical devices are provided to a patient for their condition(s).** Due to the CPT codebook’s instructions, CMS does not permit reporting of multiple instances of 99453 and 99454 when multiple devices are provided to a patient, even when medically necessary (e.g., in the case of a patient with type 2 diabetes requiring a blood glucometer and hypertension requiring a blood pressure monitor). 85 FR 50074, 50118.
- **The work RVUs associated with 99457 and 99458 do not accurately reflect the work associated with providing RPM services.** The work RVU of 0.61 associated with 99457 and 99458 should be increased to at least match the work RVU associated with chronic care management (CCM) service codes 99490 and 99439, which are 1.0 and 0.70, respectively. The AMA’s RUC recommended raising the work RVU of the CCM codes to their current value, in part “due to the sicker patient population receiving CCM services, having two or more chronic conditions and the [qualified healthcare practitioner] is using a care plan to manage the patient”). AMA/Specialty Society RVS Update Committee January 13-16, 2021 Meeting Minutes, page 52.



The work RVUs associated with RPM codes 99457 and 99458 should increase for the same reasons. Our members who provide RPM services report that the vast majority of their patients have at least two chronic conditions.

Additionally, like CCM, all RPM patients are managed under a treatment plan as required by the CPT codebook descriptions and Medicare requirements. 2024 CPT Codebook instructions, page 42 (“[r]emote 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”); see also 85 FR 84472, 84544 (“[i]t is at this point that the physician or NPP develops a treatment plan with the patient and/or caregiver (that is, develops a patient-centered plan of care) and then manages the plan until the targeted goals of the treatment plan are attained, which signals the end of the episode of care.”).

CMS also permits time spent providing RPM activities typically reported under 99457 and 99458 to be reported under CCM codes 99490 and 99439, further demonstrating the similarities of work involved in providing these services and that they should be valued the same. See “FAQ about Billing Medicare for Chronic Care Management Services,” Mar. 7, 2016 (“as discussed in the CY 2015 PFS final rule (79 FR 67727), analysis of patient-generated health data and other activities described by CPT 99091 or similar codes may be within the scope of CCM services, in which case these activities would count towards the minimum 20 minutes of qualifying care per month that are required to bill CPT 99490”). 99091 is part of the RPM family of codes and is described, in part, as the “[c]ollection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring)” which may involve preservice work of chart review, intra-service work of data analysis and interpretation, a report based upon the physiologic data, as well as a possible phone call to the patient, and post-service work of chart documentation. 85 FR 84472, 84543. Accordingly, RPM services under 99457 and 99458 mirror services that may be reported under CCM codes 99490 and 99439 and should be valued accordingly.

- **CMS does not reimburse 99457 and 99458 under the Hospital Outpatient Prospective Payment System (OPPS).** This is at odds with CMS’ reimbursement of the first time-based CCM code 99490 under the OPPS. The lack of reimbursement for 99457 and 99458 means that providers practicing in hospital outpatient department settings (Place of Service 19 and 22) are unable to offer RPM services to their patients. Yet, as described above, the services involved in furnishing 99457 and 99458 closely mirror the services provided under the time-based CCM code 99490. Just like 99490, 99457 and 99458 describe services that are furnished to a specific patient by clinical staff under the general supervision of a physician or other qualified healthcare provider in 20 minute increments. 80 FR 70298, 70450 (“[t]he current code descriptor for CPT code 99490 is ‘Chronic care management services (CCM), at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month’... As a physician-directed service, payment under the OPPS for services described by CPT code 99490 is made to the hospital when the hospital’s clinical staff furnishes the service at the direction of the physician (or other appropriate nonphysician practitioner) who meets all the requirements to bill for services described by CPT code 99490 under the MPFS.”). Even though the codes describe nearly identical care management services, under the OPPS, 99490 is assigned to Status Indicator “S” and APC 5822, which permits reimbursement, while 99457 and 99458 are assigned to Status Indicator “B,” which does not allow reimbursement. CMS, Hospital Outpatient PPS, Addendum B (Jan. 2023 Update).



CMS has repeatedly received comments in support of reassessment of the classification of 99457 and 99458 and their corresponding payments, and has stated it plans to revisit these issues. See, e.g., 87 FR 71748, 71875. To date, CMS has not done so.