January 18, 2024

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RE: Interested Party Comments on Tab 50 – Remote Monitoring

Dear Dr. Jagmin, Dr. Levy, and members of the CPT Editorial Panel,

The Alliance for Connected Care ("the Alliance") welcomes the opportunity to provide feedback on the American Medical Association's (AMA) February 2024 meeting agenda, which includes Tab 50 – Remote Monitoring. We look forward to working with you to ensure coding for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) accurately and appropriately represent the clinical utilization of these services by clinicians and care teams.

We are concerned that this proposal does not fully meet the panel's CPT application requirements including; 1) representing current clinicians who commonly provide RPM and RTM, 2) accurately reflecting how the procedures or services are typically performed, and 3) including literature that directly addresses the efficacy of the described service.

The Alliance is dedicated to creating a statutory and regulatory environment in which patients can receive and providers can deliver safe, high-quality care using connected care technology. Our members are leading health care and technology organizations from across the spectrum, representing health systems, health payers, technology innovators, and patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth and remote patient monitoring.

As reflected in the comments below, the Alliance is concerned with the proposal to combine remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) in Tab 50 – Remote Monitoring. There are a broad range of chronic conditions for which utilizing RPM and RTM to improve patient care and outcomes are appropriate. We have concerns with potential consolidation of this coding because we do not believe these changes would improve a clinician's ability to manage care and we are concerned with downstream implications of this change – such as the potential exacerbation of concerns with appropriate utilization and practice expense calculations for the relevant device codes.

The Alliance would like to emphasize four overarching themes around which our response is based:

1. The Alliance appreciates the proposal to simplify RPM and RTM coding. However, given the significance of the change, we strongly believe the panel should not finalize this proposal without significant additional input and potential modifications from a wider range of stakeholders.

2. As discussed below, the Alliance believes that RPM and RTM should remain separate for the time being due to different clinical use cases, the evolving nature of the technologies involved, and the relatively new nature of RTM coverage.

3. The Alliance and its members are concerned with current and potential restrictions on overlapping RPM/RTM services across multiple clinicians and different monitoring services and the implications of this change on those concerns. We believe that simplifying coding like the application proposes would make it harder for payers to support multiple clinicians providing clinically distinct services, exacerbating this ongoing challenge.

4. While the Alliance agrees that RPM and RTM coding could be simplified and improved, we believe there are other priorities to consider in this conversation, such as addressing uncompensated care for the 20-minute threshold for reimbursement, changes to the calculation of direct practice expense, and coding to support the reporting of multiple medical devices for different conditions.

Please find below additional comments in response to the proposal under Tab 50 – Remote Monitoring. We look forward to meeting with you to discuss these items in more detail, as needed.

Proposal to Simplify RPM and RTM Coding

The proposal under Tab 50 – Remote Monitoring proposes to consolidate RPM and RTM services into one family of remote monitoring codes in the Medicare section of the CPT code set. The Alliance and its members appreciate the panel's concerns about RPM and RTM coding, however, do not believe the panel has received significant input from stakeholders during the drafting of this proposal – despite clear and widespread interest in engaging in the future of monitoring services among leading clinician voices.

In February 2023, the Alliance led a call for data and convened stakeholders to advocate for continued RPM and RTM coverage in response to a Multi-Jurisdiction Contractor Advisory Committee (CAC) to jointly consider a new local coverage determination (LCD) for RPM and RTM for Non-Implantable Devices. The Medicare Administrative Contractor (MACs) meeting resulted from questions about the utilization of the RPM codes and rapidly growing utilization of those services in Medicare. However, after the Alliance requested more transparency and stakeholder input for the meeting, the MACs held an open meeting and heard from a wide variety of medical specialty societies and health system leaders who testified about their strong clinical outcomes from RPM and support for growing adoption of these services. Particularly notable were cardiologists and primary care clinicians representing at least a dozen leading academic medical centers who testified about how their RPM programs were crucial to improving patient outcomes.

The Alliance requests that the CPT panel consider additional stakeholder input processes to ensure that this proposal represents day-to-day clinical practices of clinicians and payers prior to moving forward. Additionally, the Alliance requests that the CPT panel ensure that changes made in this proposal are specially supported by evidence relating to the coding and billing process used to offer the services.

RPM and RTM Should Remain Separate Based on Current Clinical Evidence

The Alliance and its members are concerned that the proposal may not be fully supported by current data and clinical use cases for RPM and RTM. The Alliance maintains a tracker on RPM studies and data and has found more data and evidence around the use of RPM than RTM given its more established nature. Because of this, the Alliance believes that additional RTM evidence and use cases should be submitted to ensure that any changes made are based on evidence.

Reviewing the attached supporting literature, the Alliance did not see specific evidence supporting the consolidation of RPM and RTM services. Additionally, from our RPM research tracking efforts, the Alliance seldomly found research and data on clinicians utilizing RPM and RTM interchangeably. A recent report

from the Bipartisan Policy Center (BPC) found that "sufficient evidence does not yet exist to support a recommendation consolidating remote physiologic and remote therapeutic monitoring into a single set of payment codes." BPC recommended that the Centers for Medicare and Medicaid Services (CMS) work with the AMA to evaluate the evidence base that could support additional RTM billing codes to allow for use beyond those cases currently available. This recommendation aligned with the input from stakeholders that convened for the MACs meeting, with a majority of clinicians speaking on their experience with RPM or RTM, but with few able to speak to both services concurrently.

Alliance members report that they generally do not experience conjoined RPM and RTM programs when providing services to patients. Speaking to the intent of the proposal – Alliance members do face difficulties starting and expanding RPM programs, and are concerned about the complexity and barriers to executing on RPM and RTM programs. However, we are concerned that the proposal as structured will not resolve many of these challenges.

It's also notable that the AMA requires applications to provide a "typical patient" vignette, however the application does not clearly articulate a patient care example for these services being used interchangeably or consecutively. In lieu of this example, a clearer utilization explanation justifying these changes and explaining how they will strengthen clinical care is needed. The Alliance is concerned that significant changes to coding at this point, while these services are still new or evolving could lead to additional complexity for newly established or growing remote monitoring programs.

Because of this, the Alliance and its members believe that the current code structure preserves the ability to adjust payment and coverage for specific RPM or RTM services based on evidence and outcomes, which are still in the process of being demonstrated for RTM in particular.

<u>Proposal Exacerbates Problems with Current Regulation</u>

The Alliance urges the panel to consider CMS's interpretation of the CPT codebook when considering the proposal.

In the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (PFS) final rule, the Centers for Medicare and Medicaid Services (CMS) clarified that RPM and RTM services could be billed concurrently with other services, but that RPM and RTM codes could not be billed together. In the CY 2024 Medicare PFS final rule, again CMS clarifies that RPM and RTM may not be billed together, so that no time is counted twice by billing for concurrent RPM and RTM services. These decisions have been very concerning, as there are clear, clinically justified patient use cases for the use of both RPM and RTM services concurrently. AMA adoption of the proposal submitted under Tab 50 would make it far more difficult for stakeholders to address concerns with CMS's interpretation and ensure adequate access to care.

Additionally, CMS further clarifies that 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).[1] The proposal submitted under Tab 50 again would undermine regulatory advocacy efforts to ensure adequate patient access when multiple devices for RPM and RTM are clinically justified.

[1] 85 FR 50074, 50118.

<u>Other RPM Issues to Consider for Future Work</u>

The Alliance is appreciative that the panel is working to address concerns of RPM and RTM coding issues, however, the proposal could be improved incorporating changes that address other barriers to coverage and reimbursement for remote monitoring services. The Alliance recommends the CPT panel to consider addressing these front-facing RPM issues with clear clinical care implications:

- *The 20-minute threshold for reimbursement under 99457 and 99458 results in approximately 30 percent of care being uncompensated.* 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.
- *Current CPT code 99454 does not incorporate RPM software or cellular and Wi-Fi device fees as direct practice expense inputs.* A provider cannot implement an RPM program without connectivity for the medical device to be useable. Medicare incorporates software costs into the direct PE inputs for a variety of other codes throughout the PFS (e.g., CAD software, imaging software, incision programming software); CMS should similarly reflect the software input for RPM in the valuation of 99454.
- *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, and the same reasons should be done for the RVUs associated with RPM codes 99457 and 99458.
- *AMA should work to clarify to CMS that 99457 and 99458 should be billable under the Hospital Outpatient Prospective Payment System (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.

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Thank you for the opportunity to provide comments on this important initiative. The Alliance greatly appreciates the AMA's concerns on RPM and RTM issues. The Alliance stands ready to be a resource to the AMA to ensure these issues are addressed with sufficient stakeholder input. Please contact me at cadamec@connectwithcare.org with any questions.

Sincerely,

Chris Adamec
Vice President
Alliance for Connected Care