ALLIANCE for CONNECTED CARE

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Christopher Jagmin, MD
Chair
CPT Editorial Panel
American Medical Association
330 N. Wabash Ave, Suite 39300
Chicago, IL 60611-5885

Barbara Levy, MD
Vice Chair
CPT Editorial Panel
American Medical Association
330 N. Wabash Ave, Suite 39300
Chicago, IL 60611-5885

RE: Interested Party Comments on Tab 38 – 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") May meeting agenda, which includes Tab 38 – Remote Monitoring. We greatly appreciate the consideration of stakeholder feedback into the revised proposal to ensure coding for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) accurately and appropriately represents the clinical utilization of these services by clinicians and care teams.

We are generally supportive of this revised proposal. We believe that this proposal meets the Panel's CPT application requirements including representing current clinicians who commonly provide RPM and RTM and accurately reflecting how the procedures or services are typically performed.

The Alliance is dedicated to improving access to care through the reduction of policy, legal, and regulatory barriers to the adoption of telemedicine and remote patient monitoring. Our members are leading health care and technology organizations from across the spectrum, representing health systems, healthy 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 appreciates the incorporation of our members' feedback prior to the February meeting. We believe that the revised proposal better represents a clinician's ability to manage care.

Addition of Codes for 2-16 Days of Monitoring

The authors of the proposal create the allowance of monitoring that is performed for 2 days up to 16 days in a 30-day period, and modifies the existing codes to include specific language to denote monitoring used for 16-30 days in a 30-day period. The authors highlight stakeholder feedback that strongly favor maintaining the current codes for 16-30 days and the addition of new device supply codes for 2-15 days.

The Alliance appreciates the consideration of stakeholder feedback. In discussing the new proposal, we are optimistic about the opportunity for innovation that shorter periods of monitoring could bring, as we believe it could be useful for a variety of clinical situations, such as short-term monitoring after an acute

care episode, monitoring patients after a lung transplant, minor chronic obstructive pulmonary disease (COPD), and other situations.

This being said, Alliance members generally viewed the clinical use cases for this lower level of monitoring as being different from the highly-engaged chronic disease management services (often with medication management) that are currently the predominant use case for RPM. Alliance members shared concerns that this proposal could lead to some companies attempting to manage chronic disease with much less data and patient engagement. Generally, we believe that two days of monitoring data would not demonstrate positive clinical outcomes due to lack of patient engagement for many of these chronic disease patients.

With this in mind, we encourage the CPT panel work with the applicant to develop clinical use cases that could be outlined in the code descriptor or through subsequent work. Similarly, we believe treatments for which significant patient engagement is required should likely be differentiated, as there does appear to be compelling evidence supporting the collection of additional patient data for chronic disease interventions that are working to change and support patient behavior and/or adjust medications.

New Codes for Shorter Management Times

The Alliance appreciates the addition of this provision, which we supported in our previous letter to the panel. The proposal requests new codes for shorter management times, as well as modifications to the existing management codes to reflect different professional time spent on patient management related to monitoring services (both RPM and RTM).

We agree that providers sometimes need codes that include shorter times for management services, and that this has been a significant challenge for the broader treatment through remote monitoring when some months that do not meet the minimum billing threshold of 20 minutes are not reportable and billable. The current structure results in approximately 30 percent of care being uncompensated.

In addition to supporting this proposal, we offer that structuring the treatment management codes to resemble primary care services more closely by offering reimbursement for care furnished in a wider range of increments would improve the long-term viability and reach of RPM.

Work of Management of RPM and RTM Codes

The authors of the proposal believe that the work of management of RPM and RTM is the same work, and eventually could be combined into a single code for remote patient monitoring, however believe that stakeholder preference is to maintain these as separate services at this time.

The Alliance appreciates the consideration for stakeholder preference in this revised proposal. As noted in its previous comments, the Alliance and its members believe that current data and clinical use cases support separate RPM and RTM services. The Alliance is appreciative of maintaining separate RPM and RTM codes, as it allows for additional time to build RTM evidence and use cases. Additionally, the Alliance members have reported that they generally do not experience conjoined RPM and RTM programs when providing services to patients – although it is possible that these capabilities will be developed in the future.

Other RPM Issues to Consider for Future Work

The Alliance is appreciative that the panel is working to address concerns of RPM and RTM coding issues. As RPM and RTM develop, we believe there continue to be other barriers to coverage and reimbursement for remote monitoring services. The Alliance recommends the CPT panel to consider addressing these front-facing remote monitoring issues with clear clinical care implications:

- *Incorporate RPM software or cellular and broadband device fees as direct practice expense inputs under current CPT code 99454.* 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.

- *Allow for more than one device to be offered to a patient when clinically appropriate for that patient's condition.* Currently, 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. We believe there are clinical situations in which it is appropriate for a patient to receive multiple devices to manage a high-cost, high-need chronic condition.

- *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.

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
Executive Director
Alliance for Connected Care