ALLIANCE for CONNECTED CARE

September 24, 2024

Ms. Christi Grimm
Inspector General
U.S. Department of Health and Human Services
Office of Inspector General
330 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Grimm:

We are writing to highlight the inaccuracies and subjective nature of the report your office released on Remote Patient Monitoring (RPM) today. We request that you consider retracting the report, and amending it to accurately reflect the way that RPM services are required to be delivered in Medicare, as well as reducing the bias language.

1. The OIG falsely states that there is no "order" requirement for RPM. There is an order requirement expressly referenced multiple times in the 2021 Physician Fee Schedule[1] and in guidance from the Medicare Administrative Contractors.

2. The OIG falsely states that the device must be "internet connected." CMS has never stated that the devices utilized must be "internet connected." The devices must automatically upload the patient's data, and this can happen in a variety of ways, including through cellular connectivity.[2]

3. The OIG falsely states that to receive RPM services, the patient must transmit their data at least 16 days of vitals every 30 days to their provider. CMS has never adopted this as an express requirement. In fact, they expressly stated in the 2024 Medicare Physician Fee Schedule Final Rule that this was not a requirement to receive the RPM treatment management services billed under the RPM time-based codes (99457 and 99458).[3]

4. The OIG falsely concludes the RPM services are not being used as intended since patients may not have received all three components of monitoring (device set-up and education under 99453, device supply under 99454, and treatment-management services under 99457 and 994458) based on claims reviewed. This is a sweeping inaccurate generalization. There are plenty of reasons a provider may not bill:

[1] See pages 84543, 84545 of the 2021 Medicare Physician Fee Schedule Final Rule)
[2] See page 84543 of the 2021 Medicare Physician Fee Schedule Final Rule: "Beyond acknowledging the CPT specification that the medical device supplied for 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)."
[3] See page 78884 of the 2024 Medicare Physician Fee Schedule Final Rule: "We would like to offer clarification that the 16 day data collection requirement does not apply to CPT codes 99457, 99458, 98980, and 98981. These CPT codes are treatment management codes that account for time spent in a calendar month and do not require 16 days of data collection in a 30-day period."

a) CMS requires that to bill for device set-up and education under 99453, that the patient submit 16 days' worth of data in a 30-day period enabling the provider to bill for device supply under 99454, thus, there are naturally some number of patients who providers set-up and educate on their devices but who the providers are literally prohibited from billing for when the patient does not end up submitting 16 days' worth of vitals in a 30-day period. This is simply an unreimbursed loss for the provider when this happens.

b) As you note in your footnote, "some enrollees may not have a claim for the education and setup of a device because they used a device they owned and, therefore, did not receive one from the provider. According to CMS, in these cases, the provider is not permitted to bill for education and setup."

c) Providers regularly have conversations with their patients that they do not bill or are not allowed to bill. In your own footnote, you say "this analysis is based on analyses of Medicare claims and encounter data. We did not conduct a medical record review." If you did not do a deeper analysis than just looking at claims, you cannot infer that 43% did not get education. These are new codes, and providers may not even know they can bill for the patient education. This inference is wholly unsubstantiated.

d) CMS requires that, to bill for the time-based treatment management codes (99457 and 99458) that, at least 20 minutes of time be spent on those services in a calendar month, and that there is at least one interactive communication between the provider and the patient. There are many instances in which providers offering RPM services simply provide up to as many as 19 minutes of treatment management services, which means that the provider is prohibited from billing for, which also means these services would naturally not show up on claim forms reviewed by the OIG. Additionally, many providers offering RPM services provide exemplary care for their patients by communicating with them via text message or other non-interactive communication mechanisms in a calendar month, however, without the interactive communication with the patient, these services go unbilled, and would also naturally not show up on a claim form reviewed by the OIG.

e) CMS requires that to bill for 99454, the patient submits 16 days' worth of data in a 30-day period. This is a high-bar and many patients who regularly participate in RPM programs may not provide 16 days' worth of data meaning the provider cannot bill for these services and the OIG would not see those on reviewed claim forms, despite the patient providing sometimes up to 15 days' worth of data in a 30-day period which still permits their provider to effectively treat and manage their condition.

5. Your report stated that some enrollees received remote patient monitoring for a diagnosis that did not specify the actual condition being monitored. Providers are not required to include diagnosis codes in their charts. This is not a sign of fraud. Instead, it's emblematic of a charting problem that is widespread in Medicare.

Below are areas we believe demonstrate bias in your report:

1. The growth charts are misleading. Twenty-fold growth sounds significant, but can mean one person grew to 20 people. Without the historical context that RPM was a new program in 2019, and started with minuscule penetration, it appears that RPM has unusually large growth, which is does not for a new program.

2. There is no context about fraud in the Medicare program. In the same year that the entirety of RPM claims were $311 million, the false claims alone in Medicare were $31.2 billion. That tells a different story than the misleading headline and pull-out statements in the report. If we applied the fraud amount in the rest of the program of 3-10%, the fraud in RPM would have been between $9.3 million and $31 million in 2022. That's less than .01% of the fraud in Medicare.

3. The report refers to a consumer alert, which outlines telemarking scams that occur in Medicare. The consumer alert mentions cases of alleged fraud billed as RPM. HHS OIG has previously conflated Medicare fraud with telehealth as well. Your agency has since released clarification between telehealth and telemarketing fraud. We urge you to not repeat the same mistakes again for RPM and future digital health technologies.

4. There is no acknowledgement of the positive findings in the data. First, RPM is helping the people it's meant to -- patients with chronic disease and dual eligibles. RPM is meant as a useful intervention for people with chronic disease, or post-acute or cannot easily travel to manage their conditions. Those are exactly the people receiving the service. Second, RPM is helping to improve health equity. Black and Hispanic populations are more than double as likely to receive these services than white patients.

We would be happy to work with you on designing and recommending tools to address the real fraud that is happening in the Medicare program. Better control of inappropriate Medicare enrollment, solicitation, and prescribing while instituting stronger monitoring and audits to ensure fraudulent providers are caught sooner and weeded out of the system.

We hope you will seriously consider amending, and re-releasing this report.

Sincerely,

Krista Drobac

Krista Drobac
Alliance for Connected Care