

Remote Physiologic Monitoring (RPM)

Opportunities to reduce inappropriate billing in Medicare and ensure high-quality care delivery

As national leaders in remote patient monitoring (RPM), we have committed to a [shared set of principles](#) to ensure the delivery of high-quality, patient-centered care and to shape the future of our industry. Recognizing the critical role RPM plays in the future of health care, we endorsed these shared principles to define and uphold standards of excellence.

Building upon our efforts to uphold standards of excellence in RPM, we have collected a list of specific practices that we do not believe reflect the spirit or intent of the RPM CPT codes, or appropriate patient care.

99454 Data- Within billing for CPT 99454, we are aware of organizations that have misinterpreted what constitutes a data transmission by counting:

- a device status indication as a data reading.
- a ping to a cell tower.
- SMS interactions with a patient as a reading under 99454, even if no patient data is transmitted.
- a “null data point” as a reading (e.g., counting the absence of data as a data point - even if the patient did not transmit anything).

Recommendation: CMS should clarify that only a transmission of physiologic data captured by an FDA-cleared or approved medical device meets requirements for billing 99454.

99454 Relevance– Within billing for CPT 99454, we are aware of situations in which the monitoring is not clinically indicated or sufficiently directed by the provider. Such situations include:

- organizations tracking physiologic data unrelated to or not clinically indicated for the patient’s diagnosed medical condition. (e.g., a device does not support requirements for condition and there is no clear clinical indication for RPM).

Recommendation: CMS should direct the ordering provider to document the condition(s) being monitored with appropriate ICD-10 codes and the device that is relevant and appropriate for monitoring the condition(s) as part of the demonstration of medical necessity.

CPT 99457/8- Within billing for CPT 99457/8, we are aware of organizations that have adopted an inadequately rigorous tracking of time spent on care, such as:

- intentionally rounding the time (e.g., a provider meets 18 minutes for CPT 99457, but rounds up to 20 minutes).
- operationalizing potentially inflated assumptions for how long a service/condition may take to perform/treat and billing that time rather than documenting actual time spent (e.g.,

assuming review of vitals readings for a heart failure patient takes 3 minutes and billing as such rather tracking and billing actual time spent).

- double counting time spent providing RPM services alongside time spent providing chronic care management services.
- exploiting unclear definitions/understanding of roles that constitute clinical staff. This includes the inappropriate use of staff outside of the United States.
- tracking time that does not result in the occurrence of any clinically meaningful activity (e.g., staff counts time during which they were not documenting the patient visit, or counts time attempting to contact a patient they never spoke with).

Recommendations:

- *CMS should clarify that providers must use auditable, accurate electronic time tracking methodologies and should bill based on actual time spent delivering services.*
- *CMS should clarify that providers must separate and distinguish time to prevent double counting of time spent performing RPM versus other care management services such as chronic care management.*
- *CMS should reinforce existing guidance on the use of appropriate clinical staff for RPM.*
- *CMS should reaffirm that 99457 and 99458 require “interactive communication”, which CMS has [defined as](#) “a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission.”*

RPM plan of care – As the RMLC has previously communicated to CMS, we are aware of concerns around the appropriate clinical duration for RPM services, including situations such as:

- organizations in which a vendor organization drives patient selection without appropriate provider direction and oversight.
- the delivery of RPM outside of a care plan that is regularly re-evaluated by the supervising clinician and patient based on progress. We believe RPM should exist as part of a plan of care with goals or benchmarks for the conditions upon which medical necessity should be re-evaluated.

Recommendation: *CMS should require providers not enrolled in risk-based models to re-evaluate medical necessity for patients’ continued use of remote monitoring on an annual basis.*