Care Management Codes: Remote Physiologic Monitoring (RPM)

AACVPR Interpretation of Utilization of RPM Codes

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The current CPT codes for remote patient monitoring (RPM) do not meet the qualifying criteria for use under the guise of cardiac or pulmonary rehabilitation services. RPM codes are intended to provide chronic care management (CCM) or transitional care management (TCM) over a 30-day period. Claims are submitted to Medicare under the Physician Fee Schedule payment system by an MD or Qualified Healthcare Professional (NP, PA, CNS). Billing for Medicare telehealth services is limited to these professionals. Please note that registered nurses do not qualify as QHPs, but may be part of clinical staff under the direction/license of an MD/QHP.

The term RPM indicates a code that allows only one claim submission per month by one user in that 30-day period. The clinician, whether cardiologist office clinical staff or internal medicine office clinical staff, or other, coordinate and track a patient’s metrics, often in the first month after hospital discharge, but not limited to that time frame. For example, some will focus on managing a patient’s diabetes and use one device to track blood sugars and another tool to track dietary habits. Some offices will track weight, BP, and exercise records. A pulmonologist office will track asthma symptomatology over the month, using various apps to gather clinical information on that patient for optimal management of that disease, like inhaler data, medication compliance, etc. Most practices, in fact, use multiple metrics to track patient progress over each 30-day period. In fact, among MD offices, there can be “competition” of sorts over which office uses the RPM or CCM code after the patient is discharged for care management.

One tool or app does not equal RPM. Rather, RPM is a term that allows remote surveillance for disease management by incorporating current devices, tools, apps, and other software increasingly available to track and communicate with patients in medicine today. An app, for example, is just one tool of numerous tools for the physician’s toolbox to help manage that patient’s disease over the 30-day period.

Because CR is a comprehensive (“bundled”) payment code, all services that would be a typical part of care assessment in a CR program are under the two CPT codes that Medicare allows to bill for CR. A separately billable code is not an option for CR or PR programs.

CMS regulations for CR and PR clearly state that there are currently only two settings covered for these services-hospital outpatient or MD office. Until this delivery model changes, CR and PR remain center-based services under Medicare regulations. Some private payers and health systems like the VA, understand the value of remote and home-based treatments to complement CR and PR. Stronger evidence of
comparable outcomes is needed before CMS also recognizes the role that home-based strategies have to offer center-based CR and PR.

Per the CMS regulation, 42 CFR § 410.26(b)(5), designated care management services can be furnished under the general supervision of the ‘physician or other qualified health care professional (who is qualified by education, training, licensure/regulation and facility privileging)’ when these services or supplies are provided ‘incident to’ the services of a physician or other qualified healthcare professional. As of January 1, 2020, RPM services reported with CPT codes 99457 and 99458 may be billed ‘incident to’ under general supervision. The physician or other qualified healthcare professional supervising the auxiliary personnel need not be the same individual treating the patient more broadly. However, only the supervising physician or other qualified healthcare professional may bill Medicare for ‘incident to’ services.”