CALIFORNIA TELEHEALTH RESOURCE CENTER
Part of **OCHIN**

California Health Care Foundation

Remote Patient Monitoring Event

Learn, Engage, Advance

February 9, 2023

Zoom Tips

CALIFORNIA TELEHEALTH RESOURCE CENTER
Part of OCHIN

| Unmute | Stop Video | Security | Participants 1 | Polls | Chat | Share Screen | Record |
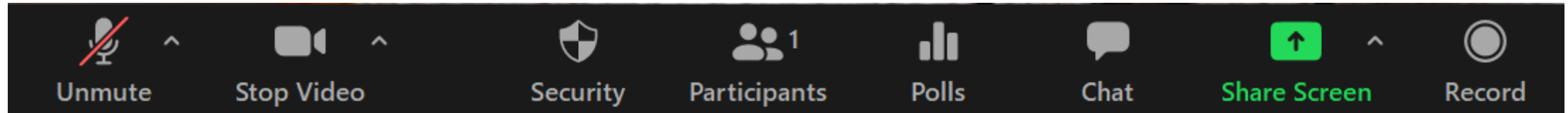
Muted on Entry

You are muted on entry. If you wish to comment or ask a question, you can unmute yourself.

Use Your Video

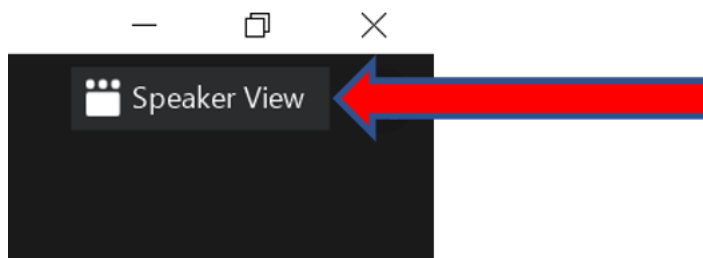Please turn on the video for a more collaborative and engaging experience.

Open the Chat

Please open the chat and use it liberally; we want to hear from you!

Send questions and feedback to **"Everyone"**

Video Recording

The presenter will indicate if the meeting is being recorded and where to find the recording after the presentation is complete.

Speaker View

Speaker View vs Gallery View

At the top right of your screen you can change the video panel to just show the main speaker, or to gallery view to see the speaker and other participants, depending on your preference.

Before We Get Started

Today's session is purely for informational purposes.

CTRC does not provide legal advice. CTRC has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services mentioned in this session.

This event is being recorded. By attending you consent to be included.

Agenda

01 Event Welcome & Kick-Off 12:00 - 1:00 pm PT
  • Hear from CHCF, CTRC, and HRSA!

02 Policy Panel 1:00 – 2:00 pm PT
  • Get expert insight into the policy challenges and implications for RPM.

03 **BREAK!** 2:00 – 2:15 pm PT

04 Expert Program Highlights 2:15 – 3:15 pm PT
  • Gain real knowledge from the clinical SMEs who offer RPM services

Break-out Room Discussion & Final Reflections 3:15 – 4:00 pm PT
  • Discuss what matters to you, and let us know what we can do next to support success!
05

About **CTRC**

Established in 2006, the California Telehealth Resource Center (CTRC) exists to share **unbiased, no-cost telehealth resources and consultative support services** with providers and patients located across all 58 California counties and beyond.

CTRC became part of OCHIN in 2017 and serves as OCHIN's dedicated telehealth consulting arm. CTRC is also part of a coast-to-coast, federally designated consortium that includes two national and 12 regional telehealth resource centers (TRCs). Our knowledgeable CTRC team teaches others to employ innovative technologies in ways that **enhance connected care and advance health equity**. CTRC insights reflect OCHIN's 22 years of practice-based solutions expertise.

CTN & CTRC
Your solution for telehealth training and Infrastructure

- **CTN (California Telehealth Network) began in 2007** when a coalition of California healthcare, technology, and governmental agencies collaborated to request funding from the Federal Communications Commission (FCC) for the expansion of broadband throughout California's rural and underserved areas.

➢ A state-wide broadband network dedicated to expanding health care access in rural and medically underserved communities with a goal to improve clinical outcomes and reduce costs.

- **CTN is California's leading consortium** of organizations focusing on increasing access to health care through innovative use of technology which includes telehealth, telemedicine, and health information exchange.

- **CTRC is housed within the California Telehealth Network**. In May 2017, CTN & CTRC became part of the OCHIN family of organizations. OCHIN is a nonprofit health care innovation center designed to provide knowledge solutions that promote quality, affordable health care for all.

Meet the CTRC Team

Kim Klupenger
President, CA Telehealth Network

Lindsey Haase
Executive Director

Shubha Devadoss
Manager, CTRC Program

Aislynn Taylor
CTRC Program Specialist

Mariah Getch
CTRC Content Intern

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CTRC **Services & Impact**

CTRC has served **over 17,000 individuals since 2019**

CTRC provides support to patients and providers in all **58 counties of California +**

CTRC creates numerous resources: **workshops, monthly office hours, toolkits and educational materials**

Provided over **2500 hours of Training and Technical Assistance** since December 2019

Is seeing a **sustained increase in the demand** for virtual health services

CALIFORNIA TELEHEALTH RESOURCE CENTER
Part of **OCHIN**

CTRC's RPM Webpage

Our comprehensive library of no-cost, unbiased telehealth resources can save you time, while helping your program grow and thrive.

Check out CTRC's new webpage with guidelines, toolkits, reimbursement information, webinars, and more, all focused to Remote Patient Monitoring!

www.caltrc.org

Remote Patient Monitoring Toolkit

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Why Should I Offer RPM? Benefits, Tools, Policy, & More

"Remote patient monitoring (RPM) technology allows health care providers to use devices that gather and analyze health information without a face-to-face appointment or in-person testing. RPM is not a new practice, but it continues to grow in popularity for the convenience it provides patients and the opportunities it offers to improve patient care." – Telehealth.HHS.Gov

Learn More About
Remote Patient Monitoring & Telehealth

Remote Patient Monitoring (RPM) represents a form of telemedicine where clinicians monitor patients while they are at a location other than a physician's office, typically at home. RPM involves the collection, evaluation, and communication of individual health data from a patient to their healthcare providers. Remote Patient Monitoring supports ongoing condition monitoring and chronic disease.

- RPM and **Remote Therapeutic Monitoring (RTM)** are closely related. One of the primary differences between RPM and RTM is the **type of patient data** being monitored.
- **Chronic Care Management** refers to the management and care coordination for patients with **two or more complex** conditions between regular office visits.
- **Principle Care Management** similarly refers to the management and care coordination for patients with **one complex** condition between regular office visits.

Let Us **Serve You!**

If you're starting, expanding, or considering a program, **talk with us today.**

The work we do is fueled by our organizational values, our combined industry expertise, and our non-stop dedication to providing quality health care for all. **At CTRC, we're your unbiased resource for telehealth success.**

Contact CTRC

Call us: **(877) 590 - 8144**

Visit us: **CalTRC.org/contact/**
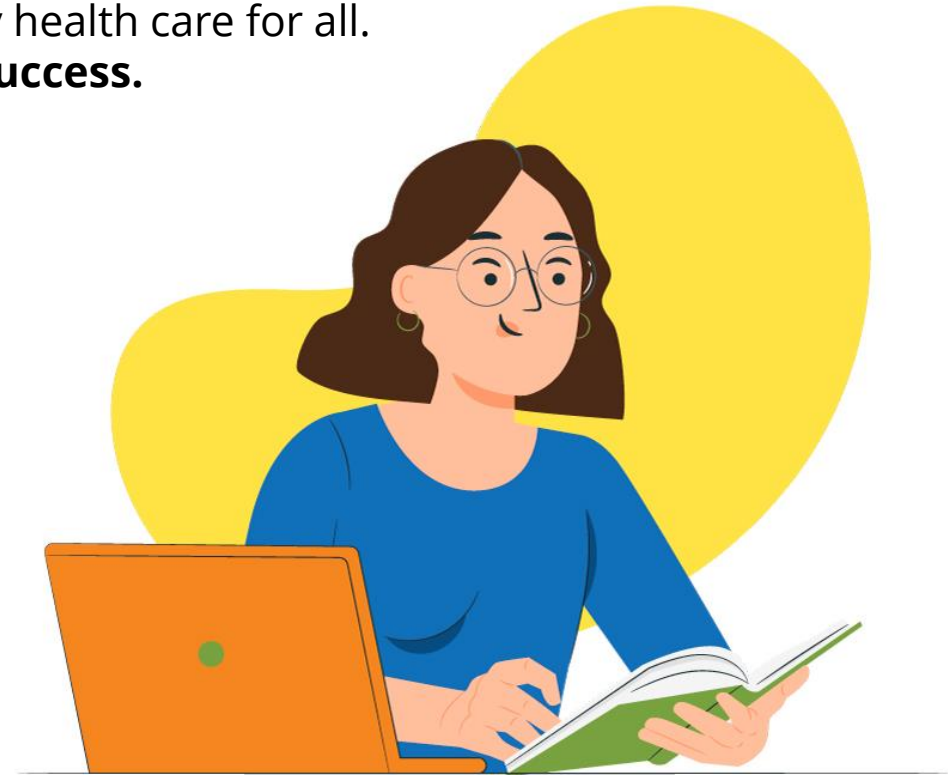
William England

William England is senior advisor and former director of the Office for the Advancement of Telehealth (OAT) at HRSA. Before coming to HRSA, he was Director and Vice President of the FCC/Universal Service Rural Health Care Program. He is a Fellow of the American Telemedicine Association. His career started as an assistant professor of Industrial Engineering and Preventive Medicine at the University of Wisconsin. After a Robert Wood Johnson Foundation Healthcare Financing Fellowship at Johns Hopkins in Baltimore, he joined CMS to work on Prospective Payment policy and then started the original Medicare Telemedicine Demonstration. He has a BS and MS in Electrical Engineering and a PhD in Industrial Engineering from Purdue University. His law degree is from the University of Maryland.

Senior Advisor, HRSA Office for the Advancement of Telehealth

CTRC Remote Patient Monitoring Event: Learn, Engage, Advance

February 9, 2023

William England, PhD, JD
Senior Advisor, Office for the Advancement of Telehealth
Health Resources and Services Administration (HRSA)

Vision: Healthy Communities, Healthy People

Office for the Advancement of Telehealth

- Serves across HHS and coordinates with key federal partners to leverage telehealth to improve access, enhance outcomes, and support clinicians and patients

- Promotes the use of telehealth technologies for health care delivery, education, and health information services

- Provides telehealth funding for direct services, research, and technical assistance

- Promote HRSA's Telehealth Strategic Plan focus on:
  - ✓ Clinical telehealth services
  - ✓ Telementoring and distance learning
  - ✓ Research and evaluation
  - ✓ Telehealth business strategy
  - ✓ Broadband resources
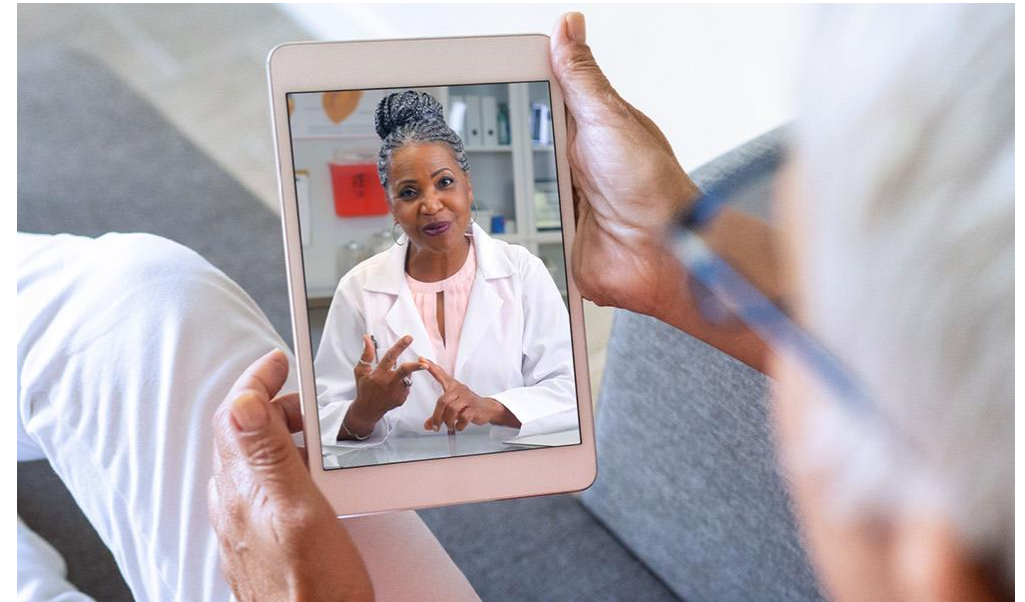
What is Telehealth?

Telehealth is the use of electronic information and telecommunication technologies to support and promote long-distance health care; patient and professional health-related education; public health; and health administration.

Telehealth Technologies:

- Video conferencing
- The internet
- Store-and-forward imaging
- Streaming media
- Terrestrial and wireless communications
- Mobile phone use

Telehealth Resource Center Program

The **Telehealth Resource Center Program** supports the delivery of telehealth technical assistance.

The Telehealth Resource Centers served more than **6,800 technical assistance** clients by direct consultation and had more than **60,000 webinar attendees** in Fiscal Year 2022. That is a slight decrease from 2021, but almost 5 times pre-pandemic levels.
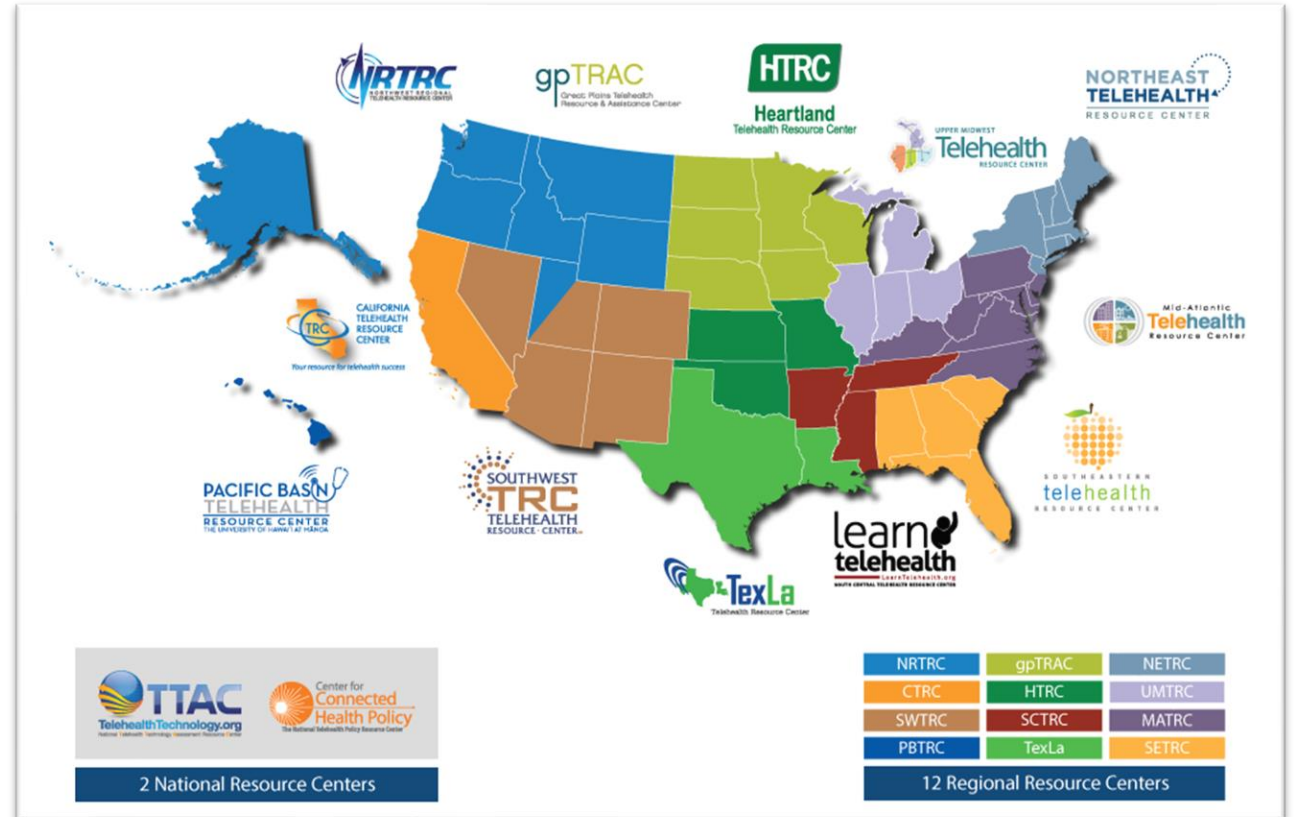
Center for Connected Health Policy (CCHP)

Judge gavel and stethoscope , close-up view

CCHP is a program under the Public Health Institute and is dedicated to integrating telehealth virtual technologies into the health care system through advancing sound policy based on objective research and informed practices. CCHP's mission is to advance state and national telehealth policies that promote better systems of care, improved health outcomes, and provide greater health equity of access to quality, affordable care and services.

CCHP actively researches and analyzes important telehealth policy issues, engages influential public and private sectors through analyses and reports, and provides key telehealth policy resources nationwide. CCHP acts as a catalyst for change by providing non-partisan, unbiased, research-based policy analyses and bringing policy makers together with the private health care sector, health plans, academic researchers, and consumer health advocates to create successful models of connected care, that lead to more transparent systems of communication between providers and patients which can lead to better health outcomes and greater efficiencies in the delivery system.

We've transitioned our twice-yearly *State Telehealth Laws and Reimbursement Policies* report into The Policy Finder, a consistently updated digital database of all 50 states and the District of Columbia. Don't worry, you can still view our findings through our executive summary, infographic, and state summary chart.

TAKE ME TO THE POLICY FINDER

Office for the Advancement of Telehealth

Evidence-Based Telehealth Network Program

The **Evidence-Based Telehealth Network Program** demonstrates how health care systems can increase access to health care services utilizing **direct-to-consumer telehealth technologies** and conducts evaluations of those efforts to assess effectiveness.

In Fiscal Year 2022, OAT funded approximately **$3.8 million to 11 organizations in 11 states** to participate in the program.

Evidence for Remote Patient Monitoring Benefit

Telehealth.HHS.gov

Telehealth.HHS.gov is a one-stop resource for patients, providers, and researchers for everything they need to know about telehealth including:

- Best practice guides
- Funding opportunities
- Events
- Tip sheets
- Videos

Telehealth.HHS.gov - Events & Funding Opportunities

Telehealth.HHS.gov Search for RPM

TELEHEALTH.HHS.GOV

For patients ⌄ | For providers ⌄ | For researchers | Funding opportunities | Events | About ⌄

For providers

Getting started

Planning your telehealth workflow

Health equity in telehealth

Preparing patients for telehealth

Announcing the availability of telehealth

Introducing patients to telehealth

Obtaining informed consent

Getting patients set up with telehealth technology

Helping patients prepare for their telehealth appointment

Conduct a telehealth physical exam

Creating an

For providers › Preparing patients for telehealth

Telehealth and remote patient monitoring

The ability to monitor certain aspects of a patient's health from their own home has become an increasingly popular telehealth option. Remote patient monitoring lets providers manage acute and chronic conditions. And it cuts down on patients' travel costs and infection risk.

On this page:
- How to use remote patient monitoring with telehealth
- How to help patients use at-home health monitors
- Billing and payment for remote physiologic monitoring

How to use remote patient monitoring with telehealth

Remote patient monitoring pairs well with telehealth when patients need to be monitored for certain health conditions. It can also prevent health complications in patients who aren't able to easily travel.

There are many symptoms and conditions that can be tracked through remote patient monitoring, including:

- High blood pressure

Billing and payment for remote physiologic monitoring

Billing for Medicare

While private insurance companies set their own terms, Medicare has its own payment policies.

They include:

- An established patient-physician relationship is required. But there does not have to be an established relationship between the patient and physician for the duration of the public health emergency
- Consent to receive remote physiologic monitoring services at the time services are furnished is allowed
- Physicians and non-physician practitioners who are eligible to furnish evaluation and management services (E/M) may bill for remote physiologic monitoring services

Guidelines for remote physiologic monitoring services billed to CPT codes 99453 and 99454

- Physiologic data must be electronically collected and automatically uploaded to the secure location where the data can available for analysis and interpretation by the billing practitioner
- The device used to collect and transmit the data must meet the definition of a medical device as defined by the FDA
- Remote physiologic monitoring data must be collected for at least 16 days out of 30 days. During the public health emergency for COVID-19, if a patient is suspected or diagnosed with COVID-19, data can be collected over as few as two days
- Remote physiologic monitoring services must monitor an acute care or chronic condition
- The services may be provided by auxiliary personnel under the general supervision of the billing practitioner

For specific codes and requirements for Medicare's remote physiologic monitoring coverage, visit the billing and coding page from the Centers of Medicare & Medicaid Services.

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CCHP Remote Patient Monitoring Guides

RPM Medicaid Reimbursement

Some Useful References on RPM Policy

- American Telemedicine Association 2/10/2022 prefilling submission on CY2023 Physician Fee Schedule https://www.americantelemed.org/wp-content/uploads/2022/02/Prefiling-FY23-PFS-RPM-and-RTM-final-final.pdf

- American Telemedicine Association 4/14/2022 prefilling submission on CY2023 Physician Fee Schedule (follow-up to February 10, 2022 prefiling submission and subsequent discussion regarding Remote Monitoring services in the CY23 Physician Fee Schedule https://www.americantelemed.org/wp-content/uploads/2022/04/Follow-up-letter-to-CMS-RPM-RTM-4.14.22.pdf

- American Telemedicine Association 8/24/2022 Comments on proposed CY2023 Physician Fee Schedule https://www.americantelemed.org/wp-content/uploads/2022/08/CY23-PFS-Comments_ATA_FINAL.pdf

- RPM 101 https://mhealthintelligence.com/features/rpm-101-what-is-remote-patient-monitoring-its-benefits-and-uses

- 2023 changes to remote monitoring and preventive care. https://www.medicaleconomics.com/view/2023-changes-to-remote-monitoring-and-preventive-care

- Multi-Jurisdictional RPM/RTM for Non-Implantable Devices Contractor Advisory Committee Meeting: February 28, 2023 https://www.palmettogba.com/palmetto/jjb.nsf/DID/SF52UW8AZ4. Public invited (virtual only) as observers.

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Common Uses of RPM

- Diabetes and nephrology assessment
- Fertility management
- COPD
- Hypertension
- Gastrointestinal Stromal Tumor diagnosis
- Chronic heart disease
- Post-operative care and follow-up
- Addiction care
- Can also include acute conditions

Projected Growth of RPM

US Remote Patient Monitoring Users, 2020-2025
millions and % change

- 2020: 29.1 (34.4%)
- 2021: 39.3 (35.3%)
- 2022: 45.1 (14.6%)
- 2023: 53.1 (17.8%)
- 2024: 60.6 (14.2%)
- 2025: 70.6 (16.4%)

■ Remote patient monitoring users   ■ % change
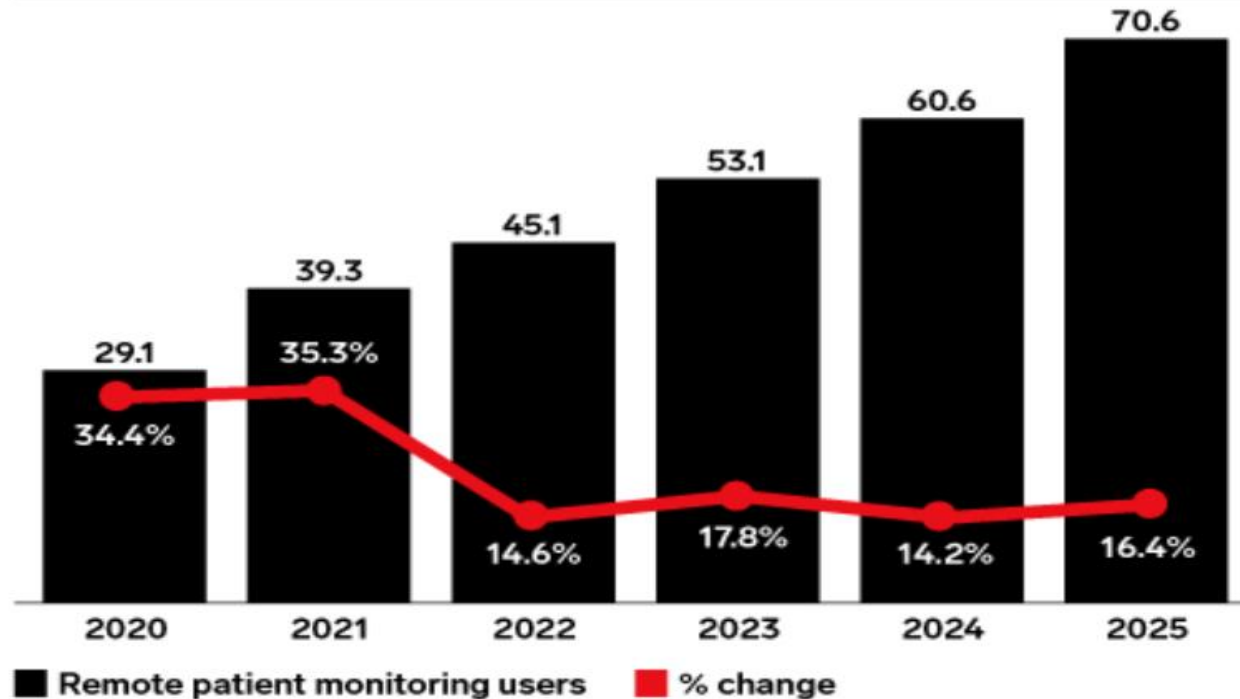
Note: individuals of any age who use wired or wireless devices that remotely track or collect well-being or medical data from the user outside a traditional healthcare setting at least once per month, and exchange it via the internet with electronic health records accessed by a medical professional or healthcare provider; includes wearable devices, home health devices, and sensors
Source: Insider Intelligence, Aug 2021

RPM in the News

- A clinical-grade wireless cardiac monitor similar to a bandage strip promises to analyze the ECG signal of every heartbeat with four to five times more detail than that provided by a wired ECG monitor. Aug. 11, 2011

- New 'smart bandage' contains a sensor that can accurately measure moisture levels and transmit the data to a smartphone. Nov 8, 2021

- Continuous Glucose Monitoring (CGM) systems that enable continuous subcutaneous monitoring of the interstitial fluid, help people manage diabetes at home without frequent finger pricks. CGMs are the standard of care for type 1 diabetes and increasingly being used for control of type 2 or gestational diabetes with timely, actionable information.

- Alongside remote technologies and 5G, AI is emerging as a key technology in the tech-powered healthcare armory.

RPM in the News (con't)

- McKinsey & Company survey reports that 51% of respondents were interested in using digital technology to track health information and share the data with their doctors.
- Seniors are driving positive ROI from RPM largely due to the cohort's high incidence of multiple chronic diseases. A KLAS Research report surveying 25 healthcare organizations found 38% have RPM programs focused on chronic care management and report reduced admissions and cost reductions.
- The University of Pittsburgh Medical Center reduced the risk of hospital readmissions by 76% — and held patient satisfaction scores over 90% — by equipping patients with tablets and RPM equipment.
- The excitement in RPM technology is miniaturization. Device makers are making their solutions smaller and less invasive while partnering with new players to expand their market share, for example, implantable diabetes sensors that transmit health data to smartphones via Bluetooth.
- Venture capital may be slowing. A significant wearable device maker just filed for bankruptcy – 1/27/23

Office for the Advancement of Telehealth

Remote Patient Monitoring (RPM)
Remote Therapeutic Monitoring (RTM)

- RPM billing codes were introduced PFS 2019 while RTM codes were introduced in PFS 2022.
- The main difference between RPM and RTM is the type and amount of data collected. RPM codes only cover physiologic data (e.g., heart rate, blood pressure, body temperature), while RTM codes monitor and collect non-physiological data, such as "pain tolerance" and "medication adherence."
- New RTM coding was created to allow practitioners who cannot bill …(RPM) codes to furnish and bill for services that look similar to RPM.
- See more detail at https://telehealth.hhs.gov/providers/telehealth-for-physical-therapy/physical-therapy-and-remote-patient-monitoring/
- There is nuance with respect to how the new RTM codes function versus how the existing RPM codes are implemented. For example, the AMA CPT Codebook states that providers cannot bill both RPM and RTM codes for the same patient(s) within the same month.
- RPM codes allow clinical staff to provide service under general supervision of billing practitioner.
- RTM codes required direct supervision, meaning supervising practitioner and clinical staff providing service must be co-located in the same office suite while rendering services BUT PFS 2023 changed to general supervision (including non-NPP providers?)

RPM, RTM, CCM, PCM

	RPM	RTM	CCM	PCM
Objective	Monitoring of specific physiological parameters between office visits	Monitoring of specific therapeutic or non-physiological (including self-reported data), parameters between office visits	Chronic care management and coordination for patients with two or more complex conditions between regular office visits	Chronic care management and coordination for patients with one complex condition between regular office visits
Device and Reading Requirements	Requires use of FDA-defined device with a minimum 16 of days of readings per 30 days	Requires use of FDA-defined device with a minimum 16 of days of readings per 30 days	None	None
Diagnosis Requirement	No specific diagnosis requirement but RPM must be medically necessary	No specific diagnosis requirement but RTM must be medically necessary	Multiple chronic conditions (2+) lasting 12+ months	Single high-risk disease lasting 3+ months
Ordered by:	Physician or Qualified Health Care Professional (QHCP), who can bill for E/M services	Physician or Qualified Health Care Professional (QHCP), who can bill general medicine codes, including PTs, OTs, dieticians, psychologists.	Physician or Qualified Health Care Professional (QHCP)	Physician or Qualified Health Care Professional (QHCP)
Clinical Care Team Requirement	Requires minimum of 20 minutes by clinical staff per month	Requires minimum of 20 minutes by clinical staff per month	Requires minimum of 20 minutes by clinical staff per month Or Requires minimum of 30 minutes personally by the physician or QHCP	Requires minimum of 30 minutes by clinical staff, physician or QHCP per month
Monitoring Provided Incident to the Billing Practitioner	QHCP or clinical staff, including nurses under the general supervision of the billing practitioner	QHCP or clinical staff under the direct supervision of the billing practitioner	QHCP or clinical staff under the general supervision of the billing practitioner	QHCP or clinical staff under the general supervision of the billing practitioner
CPT® Codes	CPT® Codes 99453/99454/99457/99458	CPT® Codes 98975/98976/98977/98980/98981	CPT® Codes 99490/99491/99439/99437	CPT® Codes 99424/99425/99426/99427

A patient can billed for both a monitoring program (RPM or RTM) and a chronic care management program (CCM or PCM) but time providing care for each must be distinct and not double-counted. See https://blog.optimize.health/rpm-rtm-ccm-pcm

RPM Billing Guides Are Helpful

- Check "date" in web searches to ensure information is current in the evolving RPM/RTM reimbursement field.
- Consult counsel or experts before billing starting or billing for RPM/TRM
- Medicare and Medicaid details may differ
- Some of the confusion is general supervision vs direct supervision and who can perform RPM/RTN services.
- In 2019, the HHS/OIG allowed a virtual care company and pharmaceutical manufacturer to loan patients free smartphones to track drug therapy adherence via a digital health app. It was the sixth favorable telemedicine/ digital health advisory opinion issued by OIG.
- In 2022, the OIG issued a Special Fraud Alert for Practitioners To Exercise Caution Entering Into Arrangements With Purported Telemedicine Companies

RPM - Remote Physiologic Monitoring (PFS 2019)

CPT Code	Approx Reimbursement	Description	
			Physiologic data automeasured (not patient input): Established patients (waived for PHE) but E&M new patient (99201-99205) could be telehealth. These are E&M Codes only for Physicians and Non-Physician Practitioners (NPP). General supervision ok. Acute or chronic conditions. Only one practitioner can bill per patient per month, even if patient has different devices from different practitioners. Must meet FDA definition of a medical device, but not necessary be prescribed.
99453	$22	Setup	Initial set up and delivery of RPM devices plus patient education. Can be non-clinical staff. Only once per episode.
99454	$49	Monitoring	Continuous monitoring of patient health data as well as ongoing maintenance of RPM devices. This code requires patients submit data at least 16 days/month. Can be non-clinical staff. Only bill once/month.
99457	$52	Treatment management	20 minutes of data review plus conversation with the patient or caregiver over the course of 30 days. Requires the conversations be specific to the data transmitted by the RPM device. Does not need 16 days…can bill 99457 without 99454 and vice versa.
99458	$41	Treatment management, add'l 20 min	Additional 20 minutes (up to 40 minutes) reviewing and communicating with patient or caregiver over the course of 30 days. Medicare allows 2x use of this code/month (previously unlimited?)
99091	$56	Original RPM	Originally created in 2002 but little use until 2017. Reimbursement for interpretation of health data by qualified medical professional. Requires practitioners spend at least 30 minutes per month evaluating and analyzing data. Newer RMP codes unbundled from 99091 but has also been called "newest" RPM code(?)

and many not accurately summarize current rules or policy.

Other RPM Codes

CPT Code	Approx Reimbursement	Description	Explanation
99473	$11	Blood pressure device training	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
99474	$15	Blood pressure device, at least 12/month	Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and communication of a treatment plan to the patient
95249	$60	Ambulatory continuous glucose monitoring	Ambulatory continuous glucose monitoring (CGM) of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training and printout of recording.
95250	$152	Ambulatory continuous glucose monitoring- equipment placement	Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor and printout of recording.
95251	$36	Ambulatory continuous glucose monitoring, interpreting results	Analysis and interpretation of CGM data. This analysis does not need to be performed face-to-face with the patient. However, CPT 95251 is a professional code that is only billable by a physician or midlevel provider (i.e., nurse practitioner or physician assistant).

This chart is for discussion purposes only and many not accurately summarize current rules or policy.

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RTM – Remote Therapeutic Monitoring (PFS 2022)

CPT Code	Approx Reimbursement	Description	Non-physiologic data, allows patient input or counts, like how often medication bottle opened. Not E&M. RTM codes cannot be reported in combination with the RPM codes.
98975	$19	Device setup	Remote therapeutic monitoring (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment. Must be at least 16 days/month
98976	$54	Respiratory system	Remote therapeutic monitoring (respiratory system status), therapy adherence, therapy response); device(s) supply with scheduled (e.g. daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days. Must be at least 16 days/month.
98977	$54	Musculoskeletal system	Remote therapeutic monitoring (musculoskeletal system status), therapy adherence, therapy response); device(s) supply with scheduled (e.g. daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days. Must be at least 16 days/month.
98980	49	Treatment mgt, first 20 min	Remote therapeutic monitoring treatment, physician or NPP time per month requiring at least one interactive communication with patient/caregiver during the month; first 20 min. Required direct supervision but 2023 PFS said general supervision ok. Unclear if that applies to non-physicians. 16 days (98976) was required for proposed G codes but was not required for 98980 in 2022, so presume 16 days not required.
98981	31	Treatment mgt, add'l 20 min. Must bill 98980 before 98981	Remote therapeutic monitoring treatment, physician or NPP time per month requiring at least one interactive communication with patient/caregiver during the month; each additional 20 min. Required direct supervision but 2023 PFS said general supervision ok. Unclear if that applies to non-physicians.
98978	Priced by MACs	Cognitive Behavioral Therapy, needs 16 days	Remote therapeutic monitoring (e.g., therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavior therapy, each 30 days. New for 2023. Priced by MACs…payment may vary while CMS collects data.

This chart is for discussion purposes only and many not accurately summarize current rules or policy.

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RTM Not Enacted (PFS 2023)

CPT Code	Approx Reimbursement	Description	Proposed to replace 98980 and 98981 for physicians and practitioners (GRTM1 & 2) and other clinicians (GRTM3 &4) such as PT, OT, Speech Path. Also clarified general supervision is allowed. Unclear if that applied to 3&4 since they don't have general supervision
GRTM1	NA	Treatment mgt, first 20 min	Remote therapeutic monitoring treatment management services, physician or NPP time per month requiring at least one interactive communication with the patient during month; first 20 minutes of evaluation and management services
GRTM2	NA	Treatment mgt, add'l 20 min	Remote therapeutic monitoring treatment management services, physician or NPP time over a calendar month requiring at least one interactive communication with patient/month; each additional 20 minutes of E &M services during month (List separately in additional to code for primary procedure)
GRTM3	NA	Treatment mgt, first 20 min	Remote therapeutic monitoring treatment assessment services, first 20 minutes furnished personally/directly by a nonphysician qualified health care professional over a calendar month requiring at least one interactive communication with the patient/caregiver during the month
GRTM4	NA	Treatment mgt, add'l 20 min	Remote therapeutic monitoring treatment assessment services, additional 20 minutes furnished personally/directly by a nonphysician qualified health care professional over a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month (List separately in addition to code for primary procedure)

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Pain Management and Home Health

CPT Code	Approx Reimbursement	Description	
Pain Management			
G3002	New	Pain management, 30 min	Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of validated pain rating tool; development, implementation, revision, and/or maintenance of a person-centered care plan; overall treatment management; medication management; pain counseling; chronic pain crisis care; and ongoing care coordination between relevant practitioners, e.g. behavioral health, PT, OT and community-based care. Initial face-to-face visit at least 30 minutes provided by physician or NPP per month. Must be provider, not auxiliary staff.
G3003	New	Pain management, next 15 min	Same as G3002, each additional 15 minutes by physician or NPP per month. Can bill for multiple additional 15 minutes. Must be provider, not auxiliary staff.
Home Health			Not reimbursed, optional reporting 1/1/23, mandatory 7/1/23. Has been anticipated/needed since chronic care management codes first started in 2015.
G0320	0		Home health services furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system
G0321	0		Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system
G0322	0		The collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (for example, remote patient monitoring)

This chart is for discussion purposes only and many not accurately summarize current rules or policy.

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The FDA Relaxed RPM Device Regs for PHE

FDA Guidance on RPM in March 2020

The U.S. Food and Drug Administration (FDA) issued guidance to expand the availability and capability of non-invasive RPM devices to facilitate patient monitoring while reducing patient and healthcare provider contact and exposure during the pandemic. Several devices are included in the guidance, such as FDA-cleared non-invasive blood pressure devices, pulse oximeters, cardiac monitors, and electrocardiograph (ECG) devices. The FDA's policy, which is limited to the duration of the public health emergency, details how the FDA does not intend to object to companies making modifications in product indications, claims, functionality, or limited modifications to hardware and software.

https://www.fda.gov/media/136290/download

Contains Nonbinding Recommendations

Enforcement Policy for Non-Invasive Remote Monitoring Devices Used to Support Patient Monitoring During the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (Revised)

Guidance for Industry and Food and Drug Administration Staff

June 2020
Updated October 2020

This document supersedes "Enforcement Policy for Non-Invasive Remote Monitoring Devices Used to Support Patient Monitoring During the Coronavirus Disease 2019 (COVID-19) Public Health Emergency" issued in March 2020 and updated June 2020.

U.S. Department of Health and Human Services
Food and Drug Administration
Center for Devices and Radiological Health (CDRH)
Office of Product Evaluation and Quality (OPEQ)

HRSA
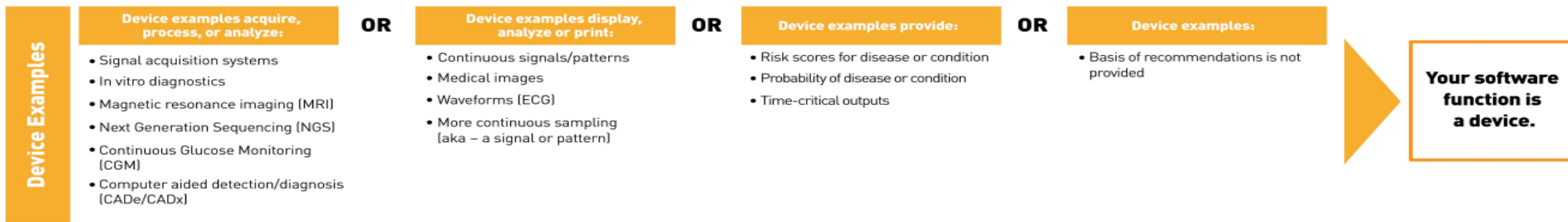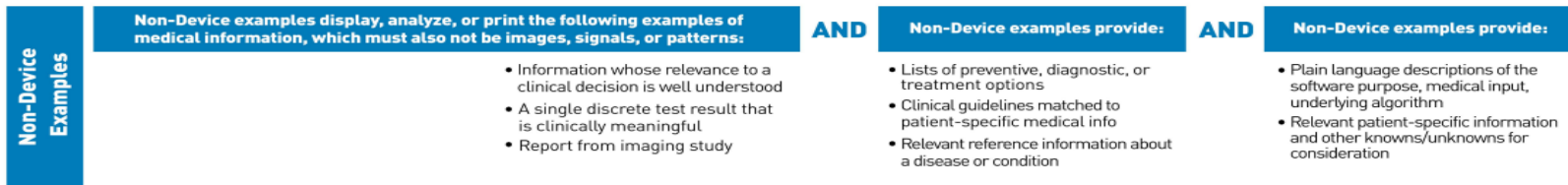Office for the Advancement of Telehealth

Clinical Decision Support Software as a Device (SaMD)

OIG Opinions and Guidance on Telehealth and RPM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201

[*We redact certain identifying information and certain potentially privileged, confidential, or proprietary information, unless otherwise approved by the requestor(s).*]

Issued: April 22, 2022

Posted: April 27, 2022

[Name and address redacted]

Re: OIG Advisory Opinion No. 22-08

Dear [Name redacted]:

The Office of Inspector General ("OIG") is writing in response to your request for an advisory opinion on behalf of [Name redacted] ("Requestor"), regarding an arrangement whereby certain existing patients of Requestor use limited-use smartphones that Requestor loaned to such patients to facilitate access to telehealth services (the "Arrangement"). Specifically, you have inquired whether the Arrangement constitutes grounds for the imposition of sanctions under: the civil monetary penalty provision at section 1128A(a)(7) of the Social Security Act (the "Act"), as that section relates to the commission of acts described in section 1128B(b) of the Act (the "Federal anti-kickback statute"); the civil monetary penalty provision prohibiting inducements to beneficiaries, section 1128A(a)(5) of the Act (the "Beneficiary Inducements CMP"); or the exclusion authority at section 1128(b)(7) of the Act, as that section relates to the commission of acts described in the Federal anti-kickback statute and the Beneficiary Inducements CMP.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201

Special Fraud Alert: OIG Alerts Practitioners To Exercise Caution When Entering Into Arrangements With Purported Telemedicine Companies

July 20, 2022

I. Introduction

The Office of Inspector General (OIG) has conducted dozens of investigations of fraud schemes involving companies that purported to provide telehealth, telemedicine, or telemarketing services (collectively, Telemedicine Companies) and exploited the growing acceptance and use of telehealth. For example, in some of these fraud schemes Telemedicine Companies intentionally paid physicians and nonphysician practitioners (collectively, Practitioners) kickbacks to generate orders or prescriptions for medically unnecessary durable medical equipment, genetic testing, wound care items, or prescription medications, resulting in submissions of fraudulent claims to Medicare, Medicaid, and other Federal health care programs. These fraud schemes vary in design and operation, and they have involved a wide range of different individuals and types of entities, including international and domestic telemarketing call centers, staffing companies, Practitioners, marketers, brokers, and others.

HRSA
Office for the Advancement of Telehealth

Contact Information

William L England, PhD, JD

Senior Advisor

Office for the Advancement of Telehealth

wengland@hrsa.gov

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Policy Panel

RPM Event: Learn, Engage, Advance
February 9, 2023

Sylvia Trujillo

Sylvia J. Trujillo is the Senior Director of Policy for OCHIN where she works closely with OCHIN's leadership to champion public policies that drive equity in healthcare. Prior to joining OCHIN, Sylvia was a member of the American Medical Association's Federal Advocacy team based in DC for over a decade where she served as a Senior Washington Counsel. Sylvia's portfolio covered rapid innovations in medicine such as telehealth, genomics, and artificial intelligence/augmented intelligence. She also served as an Assistant Regional Counsel and Litigation Attorney for the U.S. Department of Health & Human Services. Sylvia earned her B.A. from Bryn Mawr College, a M.P.P from Harvard University's John F. Kennedy School of Government and J.D. from University of California's Berkley School of Law. She serves on HIMSS' Social Determinant of Health Committee.

Senior Director of Policy and Advocacy, OCHIN

Carol Yarbrough

Telehealth-vangelist and UCSF employee Carol Yarbrough, MBA CCA CPC OCS CHC is an ardent advocate of supporting, teaching and shaping virtual policy and interpretation.

Telehealth Business Operations Manager, UCSF

Andy Molnar

CALIFORNIA TELEHEALTH RESOURCE CENTER
Part of OCHIN

Andy Molnar is the CEO of the Digital Therapeutics Alliance (DTA), a trade organization focused on the needs of the clinically validated digital therapeutics industry. Before joining DTA, Andy worked in leadership roles with industry companies Cognoa and Pear Therapeutics, focusing on how to commercialize software as a medical device (SaMD) products, generating meaningful evidence for payors, commercial planning, and working with various government agencies and trade organizations to update policy for reimbursement.

CEO, DTX Alliance

Robert Jarrin

Robert Jarrin is a strategic advisor on digital health and medicine to various companies, associations, and medical organizations. He formerly served for nearly 20 years as a Senior Director, Government Affairs for Qualcomm Incorporated. Jarrin's areas of expertise include CMS coding, coverage, and payment of digital medical services, FDA regulation of digital health, and ONC policies on Health IT interoperability. Jarrin has served on several Federal Advisory Committees covering innovation, safety, health IT standards, and consumer advocacy. He has testified numerous times before the U.S. House of Representatives providing expert testimony on innovation, mobile medical apps, and the 21st Century Cures Act. He currently serves as a member of the American Medical Association (AMA) Digital Medicine Payment Advisory Group (DMPAG). Jarrin has a BA in Government and Politics from the University of Maryland at College Park, and a JD from Northeastern University School of Law.

Digital Health Strategic Advisor

Vimal Mishra

Vimal Mishra is a nationally recognized leader in digital medicine, award-winning practicing physician, clinical leader, educator, researcher, and digital health innovator. Dr. Mishra serves on several national committees, advocacy groups, and business entities. He has been peer-nominated every year since 2017 as a "Top Doctor" in Richmond, Virginia, and has been awarded for excellence in clinical leadership, administration, and research. Dr. Mishra is board-certified in internal medicine and clinical informatics, is a Duke University School of Business graduate, and holds invention disclosures for digital health tools. Read more at: https://health.ucdavis.edu/news/headlines/vimal-mishra-joins-uc-davis-health-to-lead-digital-transformation/2022/09

Director of Digital Health, AMA & Digital Transformation Lead, UC Davis

James Marcin

Dr. James is Professor in the Department of Pediatrics at the UC Davis School of Medicine and Director of the Center for Health and Technology at UC Davis Health. In addition to his clinical work in the Pediatric ICU, he conducts research and advocacy in telehealth related to access and quality of care, particularly as it relates to children with special healthcare needs and acutely ill and injured children in rural communities.

Professor, Pediatric Critical Care
Director, Center for Health and Technology & UC Davis

CHALLENGES AND POLICY IMPLICATIONS

Infrastructure

Practice Integration

Payment Requirements

Equity

What is in a Name?

CALIFORNIA
TELEHEALTH
RESOURCE
CENTER
Part of OCHIN

Remote Patient Monitoring

Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate)

Remote Therapeutic Monitoring

Remote monitoring of respiratory system status, musculoskeletal system status, cognitive behavioral therapy, therapy adherence, therapy response

Infrastructure

Do practices and their patients have the connectivity needed to support RPM?

- Has broadband funding been prioritized to areas that have no connectivity?

Practice Integration

Do practices have staffing to support RPM adoption?

- Do we need to train more community clinic and provider operational and support staff to support adoption?
- Do payment models need to account for community health workers and others in set-up and provision of services?

Practice Integration

Are there compliance challenges, particularly after COVID-19 flexibilities sunset?

- Waivers to Permit Provision of Additional Digital Tools and Support as Needed
- Co-payments
- Patient consent when service is provided (versus when set-up)

Payment Requirements

Whether a provider is paid (and how much) depends on:

CPT | Billing Code Descriptors and Limitations

Payor | Coverage Requirements

Payor | Reimbursement Amount

Caveat

Federal and State Health Care Program Coverage Requirements Differ from Each other and Differ from Commercial Health Insurance

- Medicare
- Medi-Cal
- Medi-Cal (FQHC + RHC)
- Commercial Plans

Caveat

The coding system that describes the services:

Current Procedural Terminology (CPT)

Payment Requirements

Is there coding and coverage clarity?

- What are the coding differences between RPM and RTM?
  - Who can deliver the service?
  - What kind of supervision required?
- What are the differences in payment based on site of service?
- What are specific challenges faced by FQHCS and RHCs?

What is in a Name?

California Telehealth Resource Center
Part of OCHIN

Remote Patient Monitoring

Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate)

Range of Conditions

Limited Practitioners

General Supervision

Remote Therapeutic Monitoring

Remote monitoring of respiratory system status, musculoskeletal system status, cognitive behavioral therapy, therapy adherence, therapy response

| Respiratory | Musculoskeletal | Cognitive Behavioral |

Expanded Practitioners

Direct Supervision

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What is in a name (or code descriptor)?
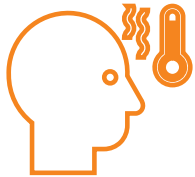
Remote Patient Management

- "CPT Descriptor: "…physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate)…"
- FDA CDS Guidance: "We generally consider the term physiological signals to include….A signal acquisition system that measures a parameter from within, attached to, or external to the body for a medical purpose and often includes: use of sensors (e.g., electrocardiogram (ECG) leads) along with electronics and software function that is used for signal generation (e.g., ECG)"

Remote Therapeutic Monitoring

- CPT Online Assistant: "…recognizes that there are some medical conditions (eg, musculoskeletal and respiratory conditions) for which non-physiological, therapeutic data, such as pain, functional status, and adherence to exercise therapy, are the key data points needed to evaluate patient status and oversee treatment."

No formal definition of Physiologic or Therapeutic by CPT, RUC, or CMS

Equity

What are barriers to equitable access to RPM and RTM services?

Audience Questions?

Recommendations

- Payment
  - Coding Clarity
  - Rational Payment Based on Site of Service (between hospital, ambulatory)
  - Payment Equity for FQHCS and RHCs (separate from existing payment)

- Compliance Challenges
  - Waivers to Permit Provision of Additional Digital Tools and Support as Needed
  - Co-payments
  - Patient consent when service is provided (versus when set-up)

- Connectivity
  - Prioritize broadband for unserved communities (as opposed to enhancing already connected areas)

- Staffing
  - Operational and support staff
  - Community health workers

Medi-Cal RTM Billing Chart Based on Place of Service and Who Performs

11 (non-facility)

- Reimbursement all pro fee (all on CMS 1500)
  - 98975: .57 RVU
  - 98976 (resp): 1.48 RVU
  - 98977 (MSK): 1.48 RVU
  - 98978 (BH): MAC priced
  - $ figures vary based on GPCI

19, 22

(facility, on or off-campus)

- Reimbursement
  - Facility:
    - 98975 – one time; bill after 16 data pts rec'd: $120.86
    - 98976/77 – every thirty days w 16 data collections met: $35.00
    - 98978: unknown

Direct Supervision Remains for PTAs and OTAs

- All other providers require no level of supervision as these codes are located in the "Medicine" Section of the AMA CPT book

Medi-Cal RPM Billing Chart Based on Place of Service and Who Performs

11 (non-facility)

- Incident-to allowed
- Reimbursement all pro fee (all on CMS 1500)
  - 99453: .57 RVU
  - 99454: 1.48 RVU
  - 99457: .89 RVU
  - 99458: .89 RVU
  - $ figures vary based on GPCI

19, 22 (facility, on or off-campus)

- No incident-to
- Reimbursement
  - Facility:
    - 99453 – one time; bill after 16 data pts rec'd: $120.86
    - 99454 – every thirty days w 16 data collections met: $35.00
  - Professional:
    - 99457/99458 – see box to the left

19, 22 – ALL pt work performed by MD, DO, NP

- No incident-to
- Reimbursement
  - 99453 – provider performs education/training bill after 16 data pts rec'd
    - .57 RVU
  - [99454 – device – bill via UB-04]
  - 99457, 99458 – provider performs all tasks contributing to 20 min total time increment(s) required for billing

Multi-jurisdictional MAC Meeting: Feb 28

Meeting Details/Topic/Host	Agenda	Bibliography	Discussion questions	Registration
Date/Time: Tuesday, February 28, 6:00-8:00 p.m. ET **Topic:** Remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) for non-implantable devices **Host:** Meeting to be led by Novitas Solutions (Jurisdictions H and L) and First Coast Service Options (Jurisdiction N)	Available at least two (2) weeks prior to the meeting	Available at least two (2) weeks prior to the meeting	Available at least two (2) weeks prior to the meeting	Webinar link for registration will be available two (2) weeks prior to the meeting

Meta-Analysis of RPM on Hospital Outcomes

- Does RPM reduce acute hospital use (all conditions)

- From 2,050 studies, 91 studies included.

  - Reduce admissions in 49% of studies (n=44/90)

  - Reduce length of stay in 49% of studies (n=23/47)

  - Reduce ED presentations in 41% of studies (n=13/32)

  - **Four studies reported RPM increased acute care use**

Taylor ML, et al: **Does remote patient monitoring reduce acute care use?** A systematic review. *BMJ Open* 2021

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HEALTH

Making RPM More Effective

- Data from 91 studies in systematic review 2015–2020

- 31 factors emerged that impact the effectiveness of RPM.

- Synthesized into six theories of intervention success:

  1. Targeting populations at high risk

  2. Accurately detecting a decline in health

  3. Providing responsive and timely care

  4. Personalizing care

  5. Enhancing self-management

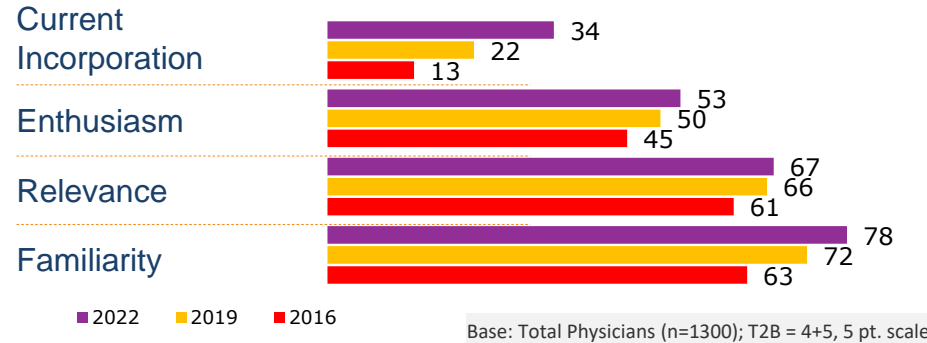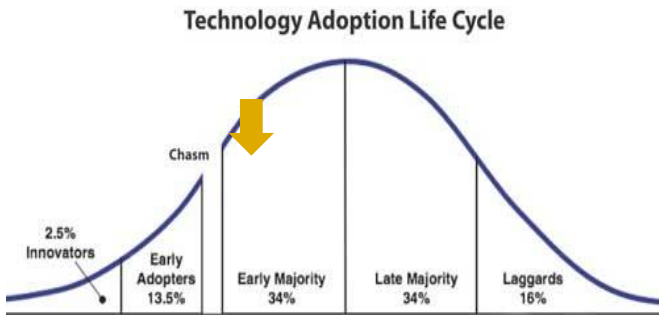 6. Ensuring collaborative and coordinated care

Thomas EE, et al: **Factors influencing the effectiveness of remote patient monitoring interventions: a realist review**. *BMJ Open* 2021

UC DAVIS HEALTH

Remote Monitoring for Improved Care

Apps and devices for use by chronic disease patients for daily measurement of vital signs such as weight, blood pressure, blood glucose, etc. Readings are visible to patients and transmitted to the physician's office. Alerts are generated as appropriate for missing or out of range readings.
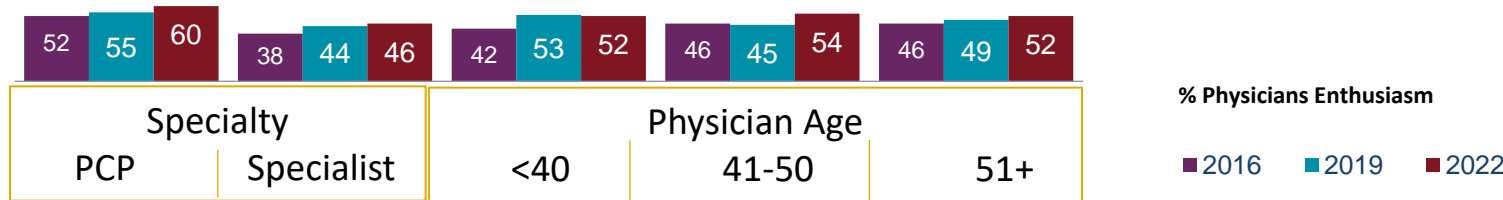
Evaluation among Total Physicians

Current State

Technology Adoption Life Cycle

- 2.5% Innovators
- Early Adopters 13.5%
- Chasm
- Early Majority 34%
- Late Majority 34%
- Laggards 16%

	2022	2019	2016
Current Incorporation	34	22	13
Enthusiasm	53	50	45
Relevance	67	66	61
Familiarity	78	72	63

■ 2022 ■ 2019 ■ 2016

Base: Total Physicians (n=1300); T2B = 4+5, 5 pt. scale

Drivers among physicians where tool is relevant, but not yet used

Most Attractive Elements
Above average importance & ranking

1. Improves health outcomes
2. Improves diagnostic ability
3. Improves work efficiency
4. Increases patient adherence
5. Improves patient safety

Enthusiasm

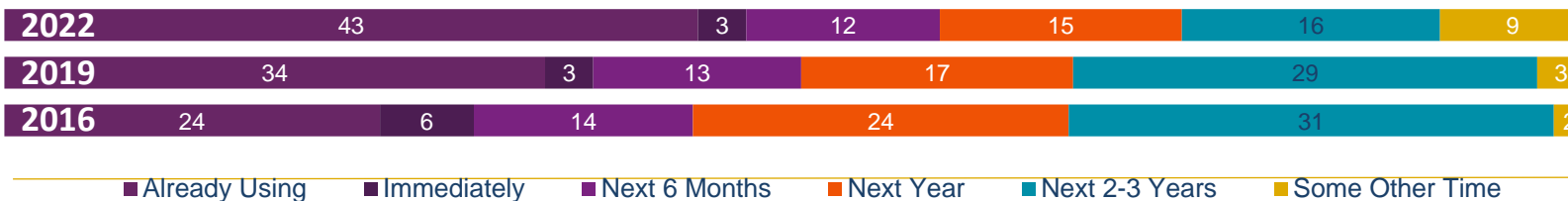|	Specialty		Physician Age		
	PCP	Specialist	<40	41-50	51+
2016	52	38	42	46	46
2019	55	44	53	45	49
2022	60	46	52	54	52

% Physicians Enthusiasm

■ 2016 ■ 2019 ■ 2022

Key Functional Requirements
Above average importance & ranking

1. As good as traditional care
2. Well integrated with EHR
3. Can be reimbursed for time
4. Requires no special training
5. Covered by standard malpractice insurance

Timeline of Adoption Among Enthusiastic

	Already Using	Immediately	Next 6 Months	Next Year	Next 2-3 Years	Some Other Time
2022	43	3	12	15	16	9
2019	34	3	13	17	29	3
2016	24	6	14	24	31	2

■ Already Using ■ Immediately ■ Next 6 Months ■ Next Year ■ Next 2-3 Years ■ Some Other Time

Base: Total Physicians, Excited About Solution: Remote Monitoring for Improved Care (n=684)

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James Marcin, MD, MPH

71

Time for a Break!

Thank You

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We Reconvene @ 2:15 PM PT

RPM Program Highlights

RPM Event: Learn, Engage, Advance
February 9, 2023
2:15 PT

Break-Out Rooms

RPM Event: Learn, Engage, Advance
February 9, 2023

Final Reflections & Polls

RPM Event: Learn, Engage, Advance

February 9, 2023

Thank You

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