Medicare's Evolving Remote Physiologic Monitoring Payments Extend Non-face-to-face Care Opportunities

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Traditional Medicare (Medicare Fee-for-Service) now includes an opportunity for physicians and other qualified clinicians to provide care and bill for monitoring patients' health status without requiring a visit to the clinic.

Sharing attributes with Medicare's existing Chronic Care Management (CCM) program, the new rules for Remote Physiologic Monitoring (RPM) enable physicians and their onsite clinic teams to build processes that are more satisfying for patients and more effective in their impacts on important outcomes. Read on to explore the background, requirements and some implementation suggestions for starting RPM under Medicare's new rules.

Background

The coding system that is used to quantify clinical work and its reimbursement has historically been structured around the idea of a clinic visit or hospital stay. The patient came face-to-face with the clinician, who billed by choosing from a menu of service codes, covering most anything that could be performed in an encounter. Any services that did not have a code, and all the work that physicians and staff did before or after the patient spent time in the clinic, were either deemed to be part of that face-to-face service or were considered "good marketing," that kept the patients attached and coming back for more. Where the rationale of marketing left off, the notion of professional duty to the patient kicked in, to justify work that had no mechanism for compensation.

Codes were established for almost everything that a patient experiences, with gradations for the complexity or duration of the care. Most parties were satisfied that sufficient revenue could be generated to cover the expense for non-face-to-face activities, such as phone calls, prescription refills, care coordination, utilization management and other administrative tasks.

The current state of healthcare strains the presumptions of this historical model of care delivery and payment, especially in primary care. The amount of work, particularly administrative "paperwork," required outside of and around the actual delivery of care only increases. Moreover, the costs for that work rises, while payments to clinics compete with the other expenses that go into care today. At the same time, all recognize that we have underappreciated the adverse outcomes attributable to access to care, whether due to simple geography or by social determinants of health. In addition, most now recognize the missed opportunities to improve care in transitions between encounters in hospitals and clinics. In general, clinicians are waking up to the faulty assumption that the most important moments occurred in their clinics, when life really was elsewhere.

This recognition--that "life elsewhere" has underappreciated effects on health outcomes--was not the only driver for change. The advent of global payments and value-based care moved

many planners to think anew about where investments in services or resources could impact either the final cost or overall health outcome. As this kind of thinking spread, even the fee-for-service payment model began to include mechanisms for remote care, exemplified by the Chronic Care Management (CCM) program in Medicare.

Simultaneously, the growing presence of information technologies in daily life lowered barriers for remote monitoring dramatically. The ever-increasing access to the internet, with the connection of smaller and smarter devices everywhere, opened possibilities for easy, sophisticated measurement of patient health outside of the clinic. Smartphones and their computing power enable more nuanced care in the daily lives and homes of patients.

The combination of connectivity and distributed computing provides a foundation for software-as-a-medical-device. Increasingly doctors and nurses can set-up and manage "apps" that can guide patients through decisions in care plans for ongoing chronic disease management. These developments provide new opportunities to work toward the triple aim: population health outcomes, patient satisfaction and per capita costs.

Indeed, not only do these technologies move the focus of care away from the medical centers and into homes and patients' lives, they also present the possibility for action at a smaller scale of care. Through a web browser, staff in a small clinic can access information on their panels of patients and the tools they need to manage the health of these patients in sophisticated ways. Care teams of clinicians and staff don't need support from large institutions when they want to build workflows that take advantage of remote monitoring technologies. Thus, the scene was set for the care of patients beyond the walls of the clinic, as RPM.

Requirements for RPM

Medicare has taken the lead in defining the requirements for an RPM program. To get started in setting the standards for the 2019 RPM codes, CMS built off of the non-face-to-face model found in the Medicare CCM program (see Table 1).

Table 1

CPT Codes Recognized by Medicare for RPM

99453	Remote monitoring of physiologic parameter(s), (for example, weight, blood pressure, pulse oximetry, respiratory flow rate) initial; setup and patient education on equipment use.
99454	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
99457	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.

The first requirement is that the billing provider have an established relationship with the patient. This relationship is demonstrated merely by the occurrence of one face-to-face visit of any kind within the 12 months before starting RPM. This standard is not hard to meet when one considers the care of a patient with a chronic disease warranting RPM. At this time, it is not clear whether this condition can be met through a telemedicine visit, but as such encounters increasingly count as "face-to-face," that issue should become a settled matter.

The second requirement, also reminiscent of CCM, is the need for the Medicare beneficiary's consent. This demand reflects Medicare's constant concern for protecting beneficiaries from exploitation but does not present a difficult burden on the clinician. Indeed, the patient's consent can be obtained orally, so long as it is documented in the medical record.

A third aspect of the RPM program reminiscent of CCM is time-based billing. The RPM service code requires twenty minutes of activity in a calendar month. The scope of activities that count towards the time requirement is broad (see Table 2), but the time spent must be documented in the medical record.

Table 2

Kinds of Activities That Will Count Toward Remote Patient Monitoring Time Required for Billing

✓	Making arrangements for the delivery of monitoring equipment to the patient
✓	Educating the patient regarding the use of the monitoring equipment and data transmission
✓	Responding to any questions received from a patient regarding data collection and transmission
✓	Engaging in activities related to retrieving, organizing, or compiling the patient's data for review
✓	Following up with a patient whose data is not transmitted properly or received in a timely manner
✓	Validating the data
✓	Addressing any data quality issue with the patient or third party (e.g., monitoring equipment vendor)
✓	Reviewing and posting the data
✓	Comparing the data to the patient's prior reported data
✓	Reviewing the patient's electronic health record
✓	Comparing the data to established parameters
✓	Consulting with approved protocols and/or other clinicians to determine whether, and what, action is warranted based on the patient-reported data
✓	Discussing with the patient possible explanations for results outside established normal ranges
✓	Communicating specific data to other providers as directed by established protocol or upon request
✓	Acting on directives from the patient's physician or other practitioner
✓	Counseling, educating, and following up with the patient in response to reported results
✓	Modifying the patient's care plan based on reported results
✓	Communicating with the patient's care manager

Going beyond the CCM program, CMS adds conditions that constrain how RPM can be executed. First, Medicare RPM must use an FDA-approved medical device. Consequently, the vast array of smartphone apps created to measure wellness and other activities in daily life can't be used for RPM that gets billed to Medicare. Only devices that have been vetted for safety and efficacy and meet FDA rules for their health claims are available for use in this program.

Second, while CMS allows staff time spent in RPM activities to count towards the time-based billing, only staff working under the "direct supervision" of the billing clinician can be included. "Direct supervision" is understood to describe a setting in which the staff have immediate access to the billing clinician, working on-site together, in the clinic, at the same time. This model works well for the classic small clinic model in a single site, but less well where a system may share care management staff across billing clinicians at multiple locations.

All-in-all, these requirements are manageable, if less than ideal for diabetes management staff working off-site from the billing clinician—something otherwise entirely reasonable now that system-wide EMR's are becoming the norm.

General Principles of Implementation

Manageable requirements still demand management. Here are some ideas for implementing RPM within a clinic.

First and foremost, as is likely the practice in the clinic, try to have staff working "at the top of their license." Ask non-licensed staff to do as much of the preparation and information gathering work as they can before handing off to licensed nursing staff. Nurses, in turn, will do as much as they can, before involving the clinicians. So long as the "direct supervision" requirement is met, and the work and time spent are documented, it all counts toward the time-based billing. As mentioned, this model suits the classic "doctor and their staff" care team in a small clinic better than geographically distributed networks, with system-wide care management staff. That being said, such staff may be rotating on-site to provide in-person patient education. These staff can perform RPM activity for patients of the billing clinicians from that site when they are visiting that day, and thus meet the current supervision requirements.

Another habit to structure into the workflow is systematic documentation. As EMR's become nearly ubiquitous, staff should leverage EMR tools—visit types, documentation templates, searching—to create "RPM progress notes" and track time through the calendar month. This kind of routine will enable staff to trigger RPM billing when the twenty-minute monthly time threshold is met.

Finally, billing office staff should have a process for finding RPM patients whose care has met the threshold twenty minutes time requirement. When staff via time tracking documentation, note that twenty minutes of work have accumulated in the month, a billing event, such as a visit, should be created. The billing staff can submit a claim to close the RPM event.

Just the Beginning

Responding to the changing tides of healthcare and standing on already existing movement away from strictly face-to-face services, Medicare's RPM program has a definite direction, but the program likely is not in its final form. The efficiencies of disease-specific care management staff supporting billing providers across a network of locations warrants a relaxation of the "direct supervision" rules, especially with network-wide access to EMRs. Such changes are especially important if payors seek to impact outcomes in areas like diabetes, heart failure, COPD and other chronic conditions with avoidable hospitalizations and complications. Indeed, clinics and health systems contemplating RPM services should plan

with the likelihood of such evolution in mind. While significant changes in clinic workflows should perhaps await these developments, using Medicare RPM at smaller scales and in smaller teams could be very useful to prepare for the wider opportunity ahead.

Benefit from the Opportunity

As the changes related to RPM take effect, clinicians should be prepared for a flood of RPM proposals seeking to engage the clinic in multiple channels of activity, directed at a wide range of patients with chronic disease. While it is not entirely fair to view such proposals as merely attempts to tap into new revenue streams, it is appropriate to be skeptical. Does the proposed activity really impact the care of the patient and its outcome? Equally important, does it work in a way that is truly more efficient than bringing the patient into the clinic? Most importantly, will the patient perceive value as a series of bills arrive from your clinic?

If these questions cause concern, then first try RPM in a therapeutic area of substantial clinical intensity for both patient and clinician—one that has limited duration.

Basal insulin titration is a good example and RPM-ready tools are available to address the need, such as Insulia, an FDA-cleared, prescription-only medical device that recommends basal insulin doses for adults with type 2 diabetes based on the treatment plan created by their healthcare provider. In this case, a very busy and sometimes intimidating clinical experience for patients that extends over a number of months can become a diligently managed remote activity with a clear endpoint.

With these final considerations in mind, your clinic is well advised to begin thinking about how RPM works in your setting, for your patients and your staff. Voluntis stands ready to help.

To learn more about remote patient monitoring with Insulia, from Voluntis, visit Insulia.com.