

Telehealth and Remote Patient Monitoring: COVID-19 and Beyond

American Congress of Rehabilitation Medicine
March 26, 2020

Presented by Carrie Nixon, Esq.

Telehealth vs RPM: What's the Difference?

Medicare Reimbursement for Telehealth Services in “normal” circumstances

- “Telehealth” is a service provided remotely that otherwise would have been furnished/reimbursed in a face-to-face encounter
- Limited to designated rural or geographically underserved areas
- Patient must be at an “originating site” (e.g. clinic, CAH, SNF)

Medicare Reimbursement for RPM/e-Visits/Virtual Communications

- RPM is NOT the same thing as Telehealth! RPM services are inherently NOT face-to-face and are therefore NOT subject to Medicare’s rural/underserved and originating site restrictions.
- RPM is eligible for standalone reimbursement

Important Changes to Medicare Telehealth during COVID-19 National Emergency



- No geographic/rural or originating site restrictions
- No pre-existing practitioner/patient relationship required
- Providers may opt to waive patient's Medicare Part B copay
- No OIG penalties for using a platform that does not meet HIPAA requirements, e.g. FaceTime, Skype, Facebook video chat
- No need for Business Associate Agreement between practitioner and platform
- Licensed providers may provide care outside of the state in which they are enrolled in Medicare, though state licensure rules apply

General Requirements for Medicare Telehealth

- In order to be reimbursed, telehealth services must be included on the list of allowable telehealth codes established annually by Medicare. Reimbursement is at the same rate as the comparable in-person visit.
 - See <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
- NOTE: MAY CHANGE! Providers eligible to bill Medicare for telehealth visits include:
 - Physicians.
 - Nurse Practitioners.
 - Physician Assistants.
 - Nurse Midwives.
 - Clinical nurse specialists.
 - Clinical Psychologists.
 - Clinical Social Workers.
 - Registered dietitians

Telehealth Services and Other Payers

Medicaid

- All 50 states reimburse for some services provided via live audio/video
- State by state determination as to which services

Commercial Payers

- 40 states have laws governing provision of telehealth; several have “parity” laws requiring same reimbursement as for in-person visit
- Many are waiving copays/deductible requirements, reimbursing at parity rates

What is Remote Patient Monitoring?



“RPM” is the collection of Patient-Generated Health Data (PGHD) by a patient or caregiver outside of a traditional clinical setting that is digitally stored and transmitted to a physician or other qualified healthcare professional for interpretation and, as necessary, intervention.

Use Cases for Remote Patient Monitoring

Managing Patients with Chronic Disease

- Diabetes
- COPD
- Heart Disease

Post-Discharge Care

- Hospital or SNF to home
- Post-surgery
- Rehabilitation therapy

Behavioral Health and Substance Abuse Treatment

- Social/environmental Challenges
- Medication Adherence

Remote Patient Monitoring under CPT Code 9901



- **CPT Code 99091** is for the *collection and interpretation* of physiologic data *digitally stored and/or transmitted* by the patient and/or caregiver to the *physician or other QHCP* qualified by education, training, licensure/regulation requiring a minimum of **30 minutes** of time. Average reimbursement is **\$59**.

Remote Patient Monitoring Codes



- **CPT Code 99453** provides a one-time reimbursement averaging **\$19** for the *initial setup and patient education* on the RPM device(s)/technology.
- **CPT Code 99454** is for the *supply of the device or devices* to be used in monitoring the patient and is reimbursable at an average of **\$63** on a monthly recurring basis for as long as monitoring is in effect.
- **CPT Code 99457** requires that a *physician, QHCP, and/or clinical staff* spend an aggregate of **20 minutes** of time during a calendar month *monitoring and analyzing* patient data, *interacting live* with the patient, and *making treatment changes* as necessary. Average reimbursement is **\$51**
- **CPT Code 99458** is for reimburse for **subsequent 20 minute intervals** of RPM services provided by **clinical staff, physician, or QHCP** spent above and beyond the **initial 20 minutes** in a calendar month indicated for **CPT Code 99457**. **\$42**

“Clinical Staff” for purposes of RPM



CPT Manual

- *“A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.”*

Key Considerations:

- Is the clinical staff member being asked to perform tasks that go beyond his/her scope of practice as defined by the state in which s/he practices or in which the patient is located?
- Do you have the right monitoring/patient interaction protocols in place for the level of clinical staff you are using?

Supervision for Incident-to Billing

“Incident to”
billing

“Incident to” services provided by clinical staff must be an integral part of billing practitioner’s professional services to patient.

Direct
Supervision

Billing practitioner must be physically present in the office suite where services are happening and immediately available to assist clinical staff.

General
Supervision

Billing practitioner need not be physically present in same location where services are happening, but maintains overall direction/control

Requirements for Billing RPM

NOTE: These may change under the National Emergency

- Must be ordered by a physician/QHCP
- Initiating face-to-face visit if patient not seen within last year
- Document patient consent
- Device used must meet FDA definition of a “medical device”
- Must involve interactive communication with patient
- Must be at least 16 days in duration
- May be billed in conjunction with CCM, TCM, and BHI codes, BUT no double-counting of time

Rehab Therapist use cases for RPM

Discussion

Other Virtual/Technology-Based Communication Codes



Standalone reimbursement for interaction via telephone, audio/video, secure text messaging, email, or use of a patient portal if no E/M visit within prior 7 days or within 24 hours:

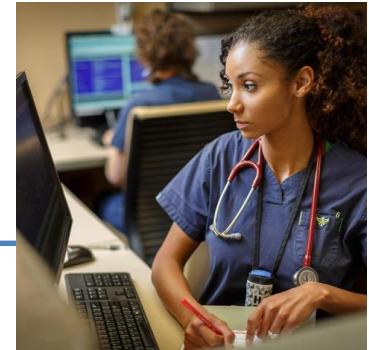
Virtual Check-in (HCPCS Code 2012): \$15

- Patient-initiated 5 to 10-minute virtual consult by MD/QHCP to determine whether an in-person visit is warranted

Remote Evaluation of Pre-recorded Patient Information (HCPCS Code 2010): \$12

- Asynchronous transmission by patient of recorded still or video images for evaluation by MD/QHCP

Online Digital Evaluation Service/“e-Visits”



- Six new non-face-to-face codes to describe and reimburse for “*patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office.*” Usually conducted via patient portal.
- The code descriptors refer to “*online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the 7 days*” and are reimbursed in increments of **5-10 minutes, 11-20 minutes, and 21 or more minutes.**
- Three of the codes (**CPT Codes 99421, 99422, 99423**) can be reported by *practitioners who can independently bill E/M services*, while the other three will apply to *non-physician healthcare professionals* who cannot independently bill these services (**HCSPCS Codes G2061, G2062, G2063**)

2020 Medicare Reimbursement Rates

Category	Code	Brief Descriptor	Approx. 2020 Non-Facility Reimbursement	Approx. 2020 Facility Reimbursement
e-Visits (e-Consults)	HCPCS G2061	Qual nonmd est pt 5-10 min	\$12.27	\$12.27
	HCPCS G2062	Qual nonmd est pt 11-20 min	\$21.65	\$21.65
	HCPCS G2063	Qual nonmd est pt 21+ min	\$33.92	\$33.56
	CPT 99421	Ol dig e/m svc 5-10 min	\$15.52	\$13.35
	CPT 99422	Ol dig e/m svc 11-20 min	\$31.04	\$27.43
	CPT 99423	Ol dig e/m svc 21+ min	\$50.16	\$43.67
Remote Patient Monitoring	CPT 99091	Coll & Interp data ea 30 d	\$59.19	\$59.19
	CPT 99453	Rem mntr physiol param setup	\$18.77	N/A
	CPT 99454	Rem mntr physiol param dev	\$62.44	N/A
	CPT 99457	Rem physiol mntr 1 st 20 min	\$51.61	\$32.84
	CPT 99458	Rem physiol mntr ea addl 20	\$42.22	\$32.84
Virtual Care Services	HCPCS G2010	Remot image submit by pt	\$12.27	\$9.38
	HCPCS G2012	Brief check in by md/ghp	\$14.80	\$13.35

Carrie Nixon, Esq.

Contact:

(703) 795-9763

Carrie.Nixon@NixonLawGroup.com



Carrie Nixon, Esq. is the Co-Founder and Managing Partner of Nixon Law Group, a healthcare innovation law firm. She also serves as Special Advisor to Empactful Capital, a healthcare venture capital firm based in Silicon Valley, and is an Ambassador for Digital Health Today. Carrie is an expert in healthcare law and policy issues relating to healthcare innovation, including Remote Patient Monitoring, telehealth, mHealth apps, healthcare predictive analytics, personalized medicine, and value-based delivery/reimbursement models such as Accountable Care Organizations (ACOs) and other Alternative Payment Models (APMs). She provides counseling in healthcare regulatory compliance matters and strategy advice regarding business models and healthcare transactions. Carrie represents health tech companies and healthcare startups, along with hospitals and health systems, individual practitioners and large medical groups, pharmacies, and post-acute care providers. Prior to starting her own firm, Carrie began her legal career as an attorney at Mintz Levin, an AmLaw 250 firm. She practiced in the firm's DC office as part of the Health Law section. Carrie later joined the DC office of Reed Smith, another AmLaw 250 firm, practicing in the litigation section with an emphasis on healthcare litigation. She received her J.D. from the University of Virginia School of Law.