Crash Course on Remote Patient Monitoring Program Compliance

On Demand Webinar Presentation

Today's Presenter

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Disclaimer

This presentation is for informational purposes only and does not constitute legal, billing, or other professional advice.

Billing and coding requirements – especially in the telehealth space – can change and be reinterpreted often. You should always consult a medical billing professional prior to submitting claims for services to ensure that all requirements are met.

OIG report to audit RPM in 2025

- December 2024: OIG announced its intent to audit Part B RPM services throughout 2025 to determine whether providers are properly furnishing and billing for these services under Medicare requirements.
- Announcement came on heels of an OIG report calling for additional oversight of RPM with the following key findings:
    1. RPM adoption increased dramatically from 2019-2022
    2. 43% of enrollees have not received all components of RPM (CPT 99453, 99454, 99457/8)
    3. Medicare lacks key information on devices being used and vitals being monitored
    4. OIG and CMS have raised concerns about fraud related to RPM
- New presidential administration has emphasized desire to better combat chronic conditions, while also working to identify fraudulent spending.

OIG and CMS have both emphasized the value of RPM services. However, it is clear that organizations with RPM programs **must prioritize compliance** to avoid potential issues with regulators.

Determining patient eligibility

To determine whether a patient is eligible for an RPM program, the questions to consider:

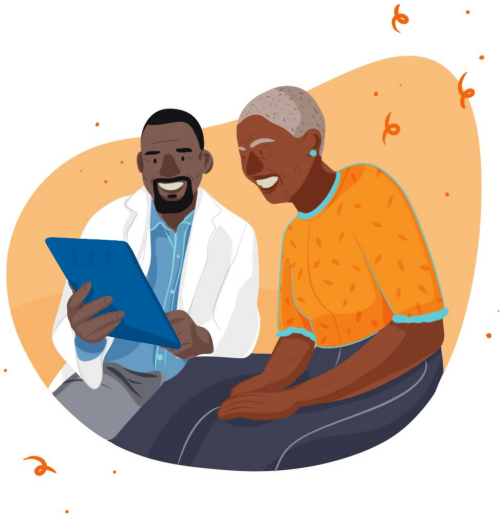
- **Medicare-enrolled? Medicaid? Private payor coverage?** Any Medicare beneficiary has coverage for RPM. Additionally, over half of state Medicaid programs and private payors also cover RPM, though coverage and the requirements vary by payor and plan. This guide focuses on the Medicare requirements (CPT 99454, 99457, et al) which have also been widely adopted by other payors.
- **Target condition?** Patients must have at least 1 documented health condition where the collection of physiologic data will facilitate the treatment plan. If doing CCM and RPM together, patients must have at least 2 chronic conditions.
- **Established with billing provider?** Patients must be “established” with the billing provider, meaning the patient has received professional services from the provider within the past 12 months. If the patient is not established, new patient annual wellness visit (AWV) or other E/M visit should occur to collect necessary documentation prior to RPM enrollment.
- **Not currently receiving RPM services?** Only one provider can bill for RPM services per patient, per month. It’s best practice to ask your patient if they are already receiving RPM services before enrollment.

RPM device selection

- RPM devices must meet FDA's definition of a medical device.
- Depending on device class, acceptable RPM device may have received 510(k) clearance, pre-market approval, or waiver. If they are FDA listed, they meet the definition, but FDA listing is not a requirement.
- Devices must digitally transmit readings to a secure location where data can be available for analysis and interpretation by billing practitioner.
    - Patient self-reported data **does not meet** RPM requirements.
- Device must be reasonable and necessary for the diagnosis or treatment of a patient's illness or injury.
- In order to bill for the RPM supply codes (99453/99454) the device must be supplied to the patient by the provider.
- Debate exists on which functions of consumer wearables fall under the medical device definition. Some functions had to go through FDA review and are clearly medical devices (ECG) while others are less clear (gait, sleep, fall risk, etc).
    - Even when a consumer wearable meets the medical device definition, beware of the "reasonable and necessary for treatment" requirement.

Documenting patient consent

- Obtaining and documenting patient consent is a prerequisite for RPM billing.
- Patients must be made aware of the following:
  1. Availability of RPM services
  2. Possible cost sharing responsibilities
  3. Only one practitioner can provide and bill for RPM services during a calendar month
  4. Patient has right to stop RPM services at any time
- While CMS allows for verbal consent, providers must **document** the details above were explained before consent was obtained.
- Auditors can take issue when providers fail to document the consent process or do not record required conversation details.
- Fast way to get an audit: Send devices out or cold-call patients without fully explaining the service. Complaints to Medicare about unexpected EoBs draws scrutiny.



Key service requirements

Some often-overlooked or misconstrued requirements for compliant RPM billing:

- **Device setup and education:** CPT 99453 covers initial patient device setup and program enrollment. While not required, the OIG has said failure to bill an initial CPT 99453 (while billing for other RPM codes) can indicate to auditors that setup and education was not provided.

- **Interactive communication:** CPT 99457 and 99458 (20 min of clinical staff time communicating with patient or caregiver) require at least 1 documented instance of "interactive communication" with the patient. This must be a real-time, two-way audio or audio-visual interaction. **Text messaging or leaving voicemails do not count**.

- **16 days of readings:** To be billable under CPT 99454, patients must submit 16 *days* worth of RPM device readings (can be one or multiple per day) during the 30-day reporting period. You cannot bill for a patient who, for example, takes 16 readings in a single day.

  Also, **readings must include legitimate physiological data**. Some RPM vendors have programmed "alerts" (containing no physiological data) that transmit daily from devices that are incorrectly counted towards the 16-day requirement.

Additional documentation best practices

Thorough documentation is essential in the event of an OIG audit. Here are some other key things that should be well-documented (or auto-captured) in your RPM platform:

- **Medical necessity** – Although an official “order” is not needed, the provider should clearly outline the chronic condition(s) or exacerbation(s) that are being addressed with RPM when enrolling a patient in the program.
- **Device type and parameters** – Document key information like the device being used and set healthy, caution, and critical reading ranges.
- **Device readings** – Ensure device readings are centrally located and are either being actively monitored or have configured notifications that relate to the patient's condition and treatment plan.
- **Care management notes** – Capture notes on interactive communications and log care management time.

Other common compliance pitfalls

- **Two-day waiver rule** – During the COVID-19 PHE, providers could bill for patients with 2-16 days of RPM readings if they had a suspected or confirmed case of COVID-19. This waiver was lifted at the end of the PHE, yet some providers continue to apply the 2-day requirement.
    - Note: This may change in 2026 with the new 2-day RPM codes proposed by the AMA.
- **Deceased patients** – Repeatedly billing for a deceased patient is quickly flagged by Medicare's system and is a leading trigger for audits. This scenario can arise when providers do not regularly interact with enrolled patients or rely on aforementioned "alerts" without physiological data.
- **Failure to use distinct device codes** – Certain devices (e.g., continuous glucose monitors, holter monitors, pacemakers) have their own codes. If any more specific code applies, you can not use the base RPM codes 99453, 99454, 99457, and 99458.

Maintaining compliance while outsourcing

Two main RPM outsourcing models: agent and independent clinic. In a vacuum, both can be compliant and legitimate. However, the independent clinic model has been flagged by OIG as more prone to fraud. Ensure partners prioritize compliance and make sure to closely review how any money from federal programs are shared!

1 'Vendor as Agent' model

Vendor's care managers act as an extension of practice, engaging patients under general supervision of the provider(s).

Benefits:

- ✓ Maintain ownership of and insight into your patients
- ✓ More collaborative relationship
- ✓ Clear insight into vendor practices

Challenges:

- ✓ Requires some degree of staff and provider involvement
- ✓ Claims are submitted and managed by the provider's staff

2 'Vendor as Billing Clinic' model

Vendor operates as an independent (often virtual) clinic to whom providers refer their patients.

Benefits:

- ✓ Requires no staff or provider involvement after initial referral
- ✓ Claims and billing are done by the vendor

Challenges:

- ✓ Lose control of patients and their care after referral
- ✓ Limited insight into vendor practices
- ✓ Less collaborative relationship

Key takeaways

1. With OIG audits here, it's more important than ever that your RPM program is compliant with payer requirements.

2. There are potential compliance issues throughout the RPM process. Good software, devices, and partner support can help you run an impactful, profitable RPM program that also meets payer requirements.

3. Selecting a trustworthy RPM technology and service partner, especially when outsourcing, can help limit potential exposure during an audit.

4. If you have compliance concerns about your current RPM program, our team of RPM experts would be happy to provide you with a free audit!

Q & A

Thank you