Quick reference guide

Assisting healthcare professionals with information about remote patient monitoring billing codes

Medicare and commercial payers are beginning to recognize how advances in communication technologies have changed the ways patients and providers interact. The quantity and quality of health information now conveyed through communication technologies are changing healthcare delivery. This guide is to provide information about understanding remote physiologic monitoring treatment management service codes, payment requirements and coverage associated with remote patient monitoring (RPM verification is always the responsibility of the billing provider).

Non-face-to-face services for remote patient monitoring – CPT codes

- Between 2018 and 2020, CPT codes were established (99091, 99453, 99454, 99457, 99458) to describe the work providers perform through digital monitoring services. These codes pay for practice expense (PE) such as set-up, supply of equipment and provider work when furnishing RPM services.
  - CPT code 99091: collection and interpretation of physiologic data digitally stored and/or transmitted.
  - CPT code 99453: set-up, patient instructions and education regarding the use of RPM equipment.
  - CPT code 99454: device(s) supply with daily recording or programmed-alert transmissions.
  - CPT code 99457: remote physiologic monitoring treatment management services that require 20 minutes of live (non-face-to-face), interactive communication (e.g. monitoring, etc.) between the patient/caregiver and the clinical staff/ physician/other qualified healthcare professionals (QHCP) in a calendar month.
  - CPT code 99458: reported in conjunction with 99457 to report each additional 20 minutes of time.
- These codes are billable to Medicare by physicians or QHCP (or either when providing general supervision of clinical staff or auxiliary personnel performing the service) but not payable to durable medical equipment (DME) suppliers. See page 42-43 of the 2020 CPT Professional Code Book for additional guidance and restrictions.
- Eligibility for payment, as well as coverage policy, is determined by each individual public or private payer. Providers should directly contact their payers for proper billing guidance.

CPT coding for healthcare professionals

Physicians and qualified healthcare professionals use current procedural terminology (CPT) codes for billing services and procedures.

CPT code	Description	2020 Medicare Physician Fee Schedule (MPFS) national payment amount[1]	
		Non-facility price	Facility price
99091	Collection and interpretation of physiologic data (e.g. ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days	$59.19	$59.19
99453	Remote monitoring of physiologic parameter(s) (e.g. weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	$18.77	$18.77

ResMed

CPT code	Description	2020 Medicare Physician Fee Schedule (MPFS) national payment amount[1]	
		Non-facility price	Facility price
99454	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	$62.44	$62.44
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes	$51.61	$32.84
99458	Each additional 20 minutes (List separately in addition to code for primary procedure)	$42.22	$32.84

Appropriate reporting parameters and criteria for use of remote physiologic monitoring services.*

Parameter/Criteria	99453	99454	99457	99458	99091
Requires the use of a medical device as defined by the Food and Drug Administration (FDA)	✓	✓	✓	✓	
Requires an order from a physician or other QHCP	✓	✓	✓	✓	
May or may not be reported in conjunction with other CPT codes. *Check with payer or AMA CPT professional edition for guidance*	✓	✓	✓	✓	✓
May only be reported for 16 days or more of monitoring	✓	✓			
May be billed only once for each 30-day period		✓	✓		✓
May be reported if initial 20 minutes of time is within 1 calendar month			✓		
May be reported for each additional 20 minutes of time				✓	
Reported once for each episode of care (e.g. begins when monitoring is initiated and ends with attainment of targeted treatment goals)	✓				
Services may be furnished by auxiliary personnel (any individual who is acting under the supervision of a physician)			✓	✓	
May be reported with other management services (i.e. chronic care, transitional, behavioral health integration, and principal care management services)	✓	✓	✓	✓	✓
Service(s) captured in code	**Technical component**		**Physician/QHCP**		
When	Once	Each 30 days	Calendar month		Each 30 days
When	•	•	20 mins	Each additional 20 mins	30+ mins
Is interaction with patient required?	Yes	No	Yes	Yes	No
Requires a treatment plan?	No	No	Yes	Yes	No

* American Medical Association. CPT® *Assistant* January 2019

ResMed

CPT code FAQs

1. **Can certain technology (e.g. software applications, smartphones, etc.) be used to deliver RPM services?**

   The Centers for Medicare & Medicaid Services (CMS) did not offer any specific type of technology in the CMS-1693-F final rule; however, the device used must be a medical device as defined by the FDA. CMS plans to issue future guidance to help inform providers and stakeholders on appropriate qualifying technology.

2. **Who may perform RPM services?**

   CPT code 99457 allows a physician, QHCP and auxiliary personnel (clinical staff under direct supervision of a QHCP) to perform RPM. Under a technical correction to the 2019 Physician Fee Schedule final rule, CMS states that 99457 "may be furnished by auxiliary personnel, incident to the billing practitioner's professional services."[2] CPT code 99091 services may only be performed by physicians and QHCPs.

   Until CMS issues a determination, billing practitioners should check with their payer or healthcare attorney to determine if clinical staff may perform RPM services.

3. **Can multiple physicians provide and bill for RPM services for the same patient during the same month?**

   Having more than one physician bill for different RPM services within the same 30-day period or episode of care may be covered. Providers should verify eligibility with the payer.

4. **Is there patient coinsurance for RPM services?**

   Medicare patients are responsible for cost sharing for RPM services (e.g. deductibles, 20% coinsurance and copayments).

5. **What medical billing code(s) can be used for the initiation and management of CPAP ventilation therapy?**

   CPT code 94660 may be used by physicians and QHCPs to bill for the initial education and long-term patient management of issues related to CPAP ventilation therapy. Code 94660 describes the initiation or the subsequent management of all forms of positive airway pressure (PAP) therapy. Code 94660 includes reviewing medical history performing a physical examination and reviewing diagnostic test results. Discussions with the patient may include various device options and masks available; prior experiences with PAP devices; desensitization therapy to manage side effects; ordering DME items; and addressing any related healthcare needs. A brief chart note to document the service is required. Typically, code 94660 may not be reported with an evaluation and management (E/M) code for the same day. If addressing other issues or diagnoses in addition to sleep apnea in the same patient encounter, an E/M code may be a more appropriate code to select.[3]

RPM billing example*

A 65-year-old female presents to her primary care practice with daytime sleepiness. Following the visit, she has a sleep study, is prescribed an ResMed AirSense™ 10 AutoSet™, and is set up on equipment by her medical supplier. She is enrolled in AirView™ to enable data collection and monitoring to facilitate treatment management.

99453. Per this example, since the DME supplier, not the provider, is providing the AutoSet, billing of this code by the QHCP is not appropriate.

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99457. Based on interpreted data retrieved from AirView, the physician's clinical staff (working under the direct supervision of a physician or QHCP billing Medicare Part B services) uses medical decision making to assess the patient's clinical stability, communicates the results to the patient, and oversees the management and/or coordination of services as needed, spending a minimum of 20 minutes of time in a calendar month. This code cannot be reported in conjunction with 99091.

99458. Clinical staff spends an additional 20 minutes of time overseeing the management and/or coordination of services. Note: This is an add-on code and represents the services performed after 20 minutes of time reported with code 99457.

99091. Instead of clinical staff interacting with the patient and overseeing the management and coordination of services, during the course of the month, physiological data is transmitted to the physician's office via AirView and the data is reviewed by a physician or QHCP billing Part B services. The intraservice work involves the QHCP spending 30 minutes or more during a 30-day period reviewing, interpreting, and reporting based on the data. This code cannot be reported in conjunction with 99457.

*This is a hypothetical scenario. Results will vary based on actual practice.

HCPCS coding for DME suppliers

Durable medical equipment (DME) suppliers use Healthcare Common Procedure Coding System (HCPCS) codes for billing DME.

Code	Description	Applicability to ResMed devices	2019 Reimbursement
A9279	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified.	ResMed technologies that provide RPM and data downloads, such as wireless monitoring devices, internal modems and SD cards, may fall within HCPCS code A9279. Code A9279 is considered all-inclusive and may not be used to bill separately for individual features of the monitoring technology.	No Medicare reimbursement Contact commercial payers for eligibility

HCPCS Codes FAQ

Can a DME supplier bill CPT codes for the collection or monitoring of patient data?

No. DME suppliers cannot bill CPT codes for the collection or monitoring of patient data. However, suppliers may be able to bill HCPCS code A9279 for the remote monitoring technology (e.g. built-in cellular, Bluetooth®, wireless modems, SD card, etc.). Medicare does not currently issue payment for this code, but suppliers may consider billing and/or negotiating payment with commercial payers.

Glossary

Remote patient monitoring (RPM). Involves using digital technologies to electronically collect medical and other forms of health data from individuals.

Current Procedural Terminology (CPT®). CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other qualified healthcare professionals. The code set is owned, managed, and developed under copyright by the American Medical Association.

Qualified healthcare professional (QHCP). An individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. *AMA CPT 2020 Professional Edition, pg. 5.*

Clinical staff. A person who works under the supervision of a physician or other QHCP, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service, but does not individually report that professional service. *AMA CPT 2020 Professional Edition, pg. 5.*

Non-facility price. This is the fee schedule amount when a physician performs a procedure in a non-facility setting such as the office. Non-facility fees are applicable to therapy procedures regardless of whether they are furnished in facility or non-facility settings. Although the terminology might seem confusing at first, the higher payment makes sense because here the facility is responsible for the cost of providing the staff and supplies.[4]

Facility price. This is the fee schedule amount when a physician provides this service in a facility setting, such as a hospital or ambulatory surgical center (ASC).[4] Occasionally, institutions such as hospitals are under the MPFS, so physicians and other QHCPs may be paid at the non-facility (higher) rate.

1 Centers for Medicare & Medicaid Services, Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2020, accessed Jan 1, 2020 from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.

2 U.S. Centers for Medicare & Medicaid Services. Medicare Program; revisions to payment policies under the Physician revisions to payment policies under the Physician Fee Schedule and other Revisions to Part B for CY 2019. Final Rule; correction," accessed Jan 1, 2020, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.

3 American Medical Association CPT Assistant Oct 14:9.

4 U.S. Centers for Medicare & Medicaid Services. How to use the searchable Medicare Physician Fee Schedule (MPFS). ICN 901344 September 2017," accessed January 1, 2020, https://www.cms.gov/apps/physician-fee-schedule/help/How_to_MPFS_Booklet_ICN901344.pdf.

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