Published on *The National Law Review* https://www.natlawreview.com

Remote Monitoring and Digital Therapies: CMS Updates Coverage and Payment Policies

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In recent years, the Centers for Medicare & Medicaid Services (CMS) has expanded payment for remote monitoring services in an effort to pay for non-face-to-face services that improve care coordination for Medicare beneficiaries. On November 2, 2023, CMS released the calendar year 2024 final rule for services reimbursed under the Medicare Physician Fee Schedule. In the final rule, CMS clarified certain guidance for remote monitoring services, finalized separate reimbursement for remote monitoring provided by rural health centers and federally qualified health centers, and discussed a recent request for information for digital therapies.

IN DEPTH

BACKGROUND

Over the past several years, CMS has established separate reimbursement for a variety of care management services to recognize and pay for services not appropriately captured by existing codes for in-person patient encounters. Care management services are patient management and support services that are provided by or under the direction of a physician or qualified healthcare professional. Remote monitoring is a type of care management service that uses digital technologies to collect medical and other health data from patients remotely and transmits the information electronically to the patient's healthcare provider for assessment. Remote monitoring is typically used between in-person visits with a healthcare practitioner, and the data collected is used to formulate, update and manage the patient's treatment plan.

There are currently two distinct types of remote monitoring services that are reimbursable under the MPFS. Remote physiological monitoring (RPM) uses medical devices to obtain data, such as blood pressure and weight, and transmits it to healthcare providers for review and assessment. Remote therapeutic monitoring (RTM) uses non-physiological data to monitor a patient's health or response to treatment, such as medication adherence, musculoskeletal activity or respiratory activity. Both services use a series of codes that account for initial setup and patient education on the remote monitoring device, transmission of data, and interpretation and analysis of the data by the patient's healthcare provider.

During the public health emergency (PHE) for the COVID-19 pandemic, CMS issued certain waivers and flexibilities that permitted more patients to receive remote monitoring services.

GENERAL CLARIFICATIONS ON REMOTE MONITORING PAYMENT POLICIES

As previewed by preamble commentary related to the PHE flexibilities for remote monitoring services, CMS did not extend the waivers and flexibilities for remote monitoring services furnished after the conclusion of the PHE on May 11, 2023. In response to questions from interested parties about billing scenarios and appropriate use of codes, CMS reiterated and clarified the following previously established policies related to remote monitoring services:

- RPM services may only be furnished to established patients. However, if patients received initial monitoring services during the PHE, they can be considered established patients for purposes of the patient requirements effective after the end of the PHE.
- Monthly remote monitoring services may be reported only once during a 30-day period.
- Only one practitioner may bill under RPM or RTM codes during a 30-day period when at least 16 days of data are collected on at least one medical device (as defined by the Federal Food, Drug, and Cosmetic Act).
- Practitioners can bill RPM or RTM codes concurrently with other care management services codes as long as time or effort is not counted twice. However, RPM and RTM codes may not be billed together, even if multiple devices are used.

CMS also responded to comments on proposed clarifications and

feedback related to RPM and RTM services, confirming the following:

- CMS has not specified in prior rulemaking whether RTM services require an established patient relationship (as required with RPM services) but states in this final rule that there does not need to be an established patient relationship for RTM services. However, CMS expects RTM services will be furnished to a patient after an initial interaction between the patient and the billing practitioner and that RTM services will be furnished consistent with a treatment plan established during that initial interaction The agency intends to clarify this point in future rulemaking.
- Billing practitioners who receive a global service payment for surgery are prohibited from billing for RPM or RTM services furnished during the global period. However, practitioners (such as physical and occupational therapists) are permitted to furnish RPM or RTM services during the global period if the provider did not furnish the global procedure and thus did not receive the global service payment.
- Addressing an erroneous statement published in the proposed rule, CMS clarified that the 16-day data collection requirement **does not apply** to Current Procedural Terminology (CPT®) codes for certain remote monitoring treatment management services, including 99457, 99458, 98980 and 98981, which account for time spent in a calendar month.

PUBLIC COMMENTS IN RESPONSE TO CMS' REQUEST FOR INFORMATION ON DIGITAL THERAPIES

In the MPFS proposed rule, CMS requested information on digital therapies, including digital cognitive behavioral therapy (CBT). As previously noted, although CMS has established Medicare payment

rates for remote monitoring services, CMS has not established reimbursement for other types of digital therapies. In recent years, the US Food and Drug Administration (FDA) has reviewed and cleared several mobile medical applications that are intended to address specific health conditions and generally require a prescription or referral from a clinician. CMS sought information from stakeholders to better understand how digital technology is used in clinical practice and how that affects coding and payment.

Commenters noted the existing CMS authority to pay for durable medical equipment (DME) and services that are furnished “incident to” healthcare professionals’ services. Stakeholders encouraged CMS to use authority under these benefit categories to establish payment for digital therapeutics cleared by the FDA with other prescription medical devices that fall under existing benefit categories. Commenters also encouraged CMS to establish a separate set of G-codes to account for scenarios when digital therapeutic devices are acquired by a Medicare-enrolled practitioner and furnished to a patient.

CMS noted that existing RTM codes include monitoring patient adherence and therapy response for use with CBT and, in 2022, established a contractor-priced CPT code for the supply of a device for CBT monitoring. CMS recognized the new coding proposals on the public agenda for the September 2023 CPT Editorial Panel to allow for reporting of digital CBT, remote therapeutic treatment and other digital therapies as incident to services. Moreover, CMS expressed continued interest in feedback related to this topic, including commentary about any potential codes for review through the existing American Medical Association processes and considerations for future rulemaking that would improve the accuracy of coding and payment under the MPFS. The response did not rule out consideration for G-codes as part of

proposals to improve the accuracy of payment. CMS also recognized that for a digital therapeutic item to be designated DME, it must meet the Medicare regulatory definition of DME, as articulated in 42 C.F.R § 414.202.

REIMBURSEMENT FOR REMOTE MONITORING SERVICES FURNISHED BY RHCS AND FQHCS

When RPM and RTM services are furnished incident to a visit at an RHC or FQHC, payment is included in the all-inclusive rate paid to the RHC for all medically necessary services furnished to a patient on the same day, while FQHCs are paid under a prospective system. RHCs and FQHCs requested a separate payment for RTM and RPM services, specifically to improve access to services in rural and underserved areas, to reimburse for setup and patient education, and to account for monthly data transmission. In an effort to improve payment for care management and coordination, CMS has updated its payment policies and is establishing separate payment for monthly care management and behavioral health integration services that are not accounted for in the existing payment methodologies for RHCs and FQHCs.

Specifically, the CPT codes for RPM and RTM services will now be eligible for reimbursement under an existing Healthcare Common Procedure Coding System (HCPCS) code, G0511, that corresponds to general care management services. Although all commenters were supportive of CMS's proposal to allow reimbursement for RPM and RTM services, some requested separate codes for RPM and RTM services that would be equivalent to the national average payment rate for these services under the MPFS.

The current reimbursement available under HCPCS code G0511 is

based on the MPFS national average non-facility payment rate for each of the services identified as billable general care management services. Each payment rate is added and divided by the total number of codes to reach the payment amount for G0511. However, with the increased volume of CPT codes for care management services that have been recognized for reimbursement under G0511, CMS acknowledged that the payment amount calculation may not reflect the full cost of non-face-to-face work involved in furnishing a broad array of care management services.

In the final rule, CMS established a revised payment methodology for G0511 that calculates the payment rate based on the actual utilization of services using a weighted average. Because RPM and RTM are not yet utilized under the general care management code, utilization data included in the new calculation methodology is sourced from the MPFS. The new calculation methodology increases the weighted average to $72.98, which CMS believes matches the value of RPM and RTM services.

On an annual basis, CMS plans to obtain actual utilization data regarding the services that comprise G0511 using available data for services paid under the MPFS and to calculate a weighted average by multiplying the non-facility payment rate times the non-facility utilization for each code, then dividing the total by the summed non-facility utilization for codes included in the average.

To bill for services under the general care management code, RPM and RTM services must be medically reasonable and necessary, meet all requirements, and not duplicate services paid to RHCs and FQHCs under the general care management code for an episode of care in a calendar month. CMS clarified that RHCs and FQHCs may bill the

general care management code multiple times in a calendar month, provided all requirements are met and resource costs are not duplicated.

SUPERVISION REQUIREMENTS FOR RTM SERVICES BILLED BY PHYSICAL AND OCCUPATIONAL THERAPISTS

Under existing regulations for services furnished by occupational therapists (OTs) and physical therapists (PTs) in private practice, all services furnished by occupational therapist assistants (OTAs) and physical therapist assistants (PTAs) must be performed under the direct supervision of the supervising OT or PT. These regulations make it difficult for PTs or OTs to bill for RTM services performed by OTAs and PTAs, even though private practice PTs and OTs are expected to be some of the primary utilizers of RTM services.

In an effort to increase access to RTM services furnished by PTAs and OTAs, CMS finalized a regulatory change to permit PTs and OTs in private practice to provide general supervision to PTAs and OTAs who furnish RTM services. Of note, this regulatory change does not extend to PTs and OTs who are not enrolled in Medicare. Accordingly, only an OT or PT who is enrolled in Medicare may provide general supervision to an OTA or PTA who is furnishing RTM services. Any services furnished by an OT or PT who is not enrolled in Medicare still require direct supervision by a Medicare-enrolled OT or PT.

KEY TAKEAWAYS

Over the past several years, CMS has established separate reimbursement for RPM and RTM services in an effort to expand access to virtual care services that have the potential to significantly

improve care management. This trend continues with the final rule, particularly with the establishment of reimbursement for RPM and RTM services furnished by RHCs and FQHCs. Similarly, the change in supervision requirements for RTM services furnished by OTs and PTs has the potential to further expand access to these services.

However, despite recognition of the value of RPM and RTM services, CMS has reiterated that the COVID-19 PHE flexibilities have not been extended. CMS remains interested in the use of remote monitoring for CBT, and stakeholders should continue to monitor for new developments and provide feedback.

Mary Ryan contributed to this article.

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National Law Review, Volumess XIII, Number 321

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