



May 03, 2021

Secretary Xavier Becerra  
U.S. Department of Health and Human Services  
200 Independence Avenue S.W.  
Washington, D.C., 20201

Acting Administrator Liz Richter  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Secretary Becerra and Acting Administrator Richter,

Telehealth and remote physiologic (or patient) monitoring (RPM) are at the forefront of the new standard of care that must be available to all Americans, especially Medicare beneficiaries. We applaud the important steps taken to date to expand access to RPM services as part of America's COVID-19 response while setting a precedent for greater access after the conclusion of the pandemic. RPM enables beneficiaries to remain safely in their home where they can be properly supported to manage their conditions while also reducing the strain on the healthcare system. We ask the agency to consider our recommendations for improving access to remote patient monitoring services as you prepare the fiscal year 2022 Medicare Physician Fee Schedule (PFS).

Aligning Policy Timelines

First, we urge the Centers for Medicare and Medicaid Service (CMS) to align the timelines associated with policies for telehealth and RPM in the FY22 Physician Fee Schedule. The policies that have been amended for the purposes of responding to the public health emergency (PHE) for RPM should extend beyond the expiration of the PHE and align to match the same time frames as telehealth policies, either December 31, 2021, or the end of the calendar year in which the COVID-19 PHE ends.



## Enabling Clinical Appropriateness to Guide RPM Policy

### *Minimum Monitoring Requirements*

CMS has consistently stated that the codes initiating RPM (99453 and 99454) and the order for RPM should include monitoring for at least 16 days in a 30-day period. During the COVID-19 PHE, CMS has decreased that requirement to 2 days for COVID-19 positive or suspect patients to increase access to services. In the FY21 PFS, CMS stated that post-PHE, the requirement will revert to 16 days of data collection over a 30-day period. We urge you to reconsider this policy for all acute and chronic conditions.

There is a diverse range of clinical scenarios for which 16 days of monitoring data is not necessary. Rather than keep an arbitrary day requirement for billing RPM services or have multiple codes with multiple different day requirements, we recommend that the requirement be consistent with clinical protocols as directed by the physician or clinical staff. This ensures that the frequency of data collection over a 30-day period is clinically appropriate.

Patient-entered data, such as Likert Pain Scale, is critical for effective remote care management, and there is currently no provision for the acquisition and utilization of such manually entered data. We recommend that patients may also manually enter data into a qualifying “device” for the appropriate number of days for their specific condition.

### *Clinical Necessity of Multiple RPM Devices*

CMS stated in the FY21 PFS that codes 99453 and 99454 are not to be billed more than once per patient during a 30-day period even when multiple devices are supplied to a patient. As we seek to empower individuals to effectively manage their conditions at home, we need to ensure they have all of the devices necessary to generate the data their care team needs to track their conditions.

The current interpretation of these codes could be severely limiting for patients with chronic conditions or acute conditions that may require different devices for monitoring different physiological functions. Given the high prevalence of comorbidities among the 147 million Americans living with chronic conditions, individuals may have multiple devices to manage multiple conditions remotely. We urge CMS to clarify in the FY22



PFS that the codes can only be billed once per device and that additional codes can be billed for monitoring of additional physiological conditions, as clinically appropriate by a single clinician or across an individual's care team managing multiple conditions.

Finally, we would also highlight the current copay structure as an impediment to beneficiary adoption and continued use of remote patient monitoring and other innovative digital health tools. A recurring monthly copay for beneficiaries living with high-cost chronic conditions can serve as a deterrent to using remote patient monitoring technologies which are proven to improve health outcomes. We applaud the policy of the Office of the Inspector General (OIG) to not enforce cost-sharing requirements for digital health during the pandemic, and we encourage CMS to work with OIG on a reexamination of cost-sharing requirements for remote patient monitoring technologies moving forward.

Thank you for your continued dedication to ensuring Medicare beneficiaries have access to quality health care regardless of where they live. The ability to leverage technology and digital health solutions, including remote monitoring and telehealth, will both continue to be valuable in the nation's ongoing response to the pandemic and as we establish a new standard of care for all Americans in the future. We look forward to your response and urge you to continue working with Congress to expand access to these important technologies beyond the pandemic. If you have any questions or would like to further discuss the telehealth industry's perspective, please contact the ATA's Public Policy Director Kyle Zebley, [kzebley@americantelemed.org](mailto:kzebley@americantelemed.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Ann Mond Johnson", with a horizontal line extending to the right.

Ann Mond Johnson  
CEO  
American Telemedicine Association