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**Re: Follow-up to February 10, 2022 pre-filing submission and subsequent discussion regarding Remote Monitoring services in the CY23 Physician Fee Schedule**

Dear Administrator Brooks LaSure, Director Seshamani, Mr. Tee, and Ms. Grayson:

Thank you again for your willingness to engage with the American Telemedicine Association (ATA) and its members around telehealth policy in general and remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) in particular. By way of reminder, CMS team members from the Hospital and Ambulatory Policy Group (HAPG) met with leaders from the ATA's Special Interest Group for Remote Patient Monitoring on January 14, 2022 to discuss current and future policy around RPM and RTM. At the conclusion of that meeting, CMS requested that the ATA compile its recommendations for changes/additions to RPM and RPM policy in the CY23 Medicare Physician Fee Schedule (PFS). Accordingly, the ATA submitted a pre-filing with its recommendations by letter to these addressees dated February 10, 2022 (see attached). At ATA's request, CMS scheduled a meeting with the RPM Special Interest Group leadership to further discuss the pre-filing submission for March 22, 2022. While the CMS team in attendance at that meeting did not include participants from the January meeting, the CMS team members, led by Ms. Grayson, had the pre-filing submission previously submitted by ATA for reference.

The purpose of this letter is to clarify and reiterate our recommendations for policy changes relating to RPM and RTM in response to the request by CMS staff at the March meeting to articulate existing pain points in RPM/RTM policy. The most significant pain points stakeholders



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have identified, framed in the context of our recommendations to address those pain points, are set forth below.

### **Eliminate the 16 day requirement for Remote Physiologic Monitoring**

In its discussion of RPM in the CY21 PFS, CMS interpreted language included in the American Medical Association's CPT Manual indicating "do not report 99453 [or 99454] for monitoring of less than 16 days" (see CPT Professional Edition) to mean that "16 days of data each 30 days must be collected and transmitted to meet the requirements to bill CPT codes 99453 and 99454." (see CY21 PFS). This interpretation is not reflected in the code descriptors and is likely inconsistent with the original intent of the CPT Committee when formulating these codes. Further, the interpretation does not align with numerous clinically valid use cases for RPM where having a patient take 16 days of readings is actually contra-indicated by the standard of care for a particular condition.

First, the CPT Manual's guidance stating "do not report 99453 [or 99454] for monitoring of less than 16 days" does not necessarily translate into a requirement that 16 days of data must be collected and transmitted by a device in order to bill for these two codes. **Historical knowledge of CPT Committee deliberations suggests that the 16 day guidance was intended to prohibit reporting of 99453 (for initial setup and education) and 99454 (for supply of device) for use with *diagnostic monitoring*, as distinguished from *remote patient monitoring*.** Diagnostic monitoring (such as use of a Holter monitor for diagnosing cardiac conditions) is typically of shorter duration than remote patient monitoring, which is used as a longer-term component of care management services. The prefatory language to the code descriptors in the CPT Manual supports this interpretation. The sentence "Codes 99453, 99454 are not reported if monitoring is less than 16 days" is immediately followed by the sentence "Do not report 99453, 99454 when these services are included in other codes for the duration of time of the physiologic monitoring service," citing 95250 for continuous glucose monitoring of 72 hours – a diagnostic service -- as an example. The American Medical Association, which oversees the CPT Committee, has stated its support for modifying CMS's interpretation in the CY21 PFS to eliminate a requirement for 16 days of data transmission.

Additionally, requiring 16 days of data transmission in order to report 99453 and 99454 means that clinically proven RPM use cases are not billable because the standard of care dictates less than 16 days of monitoring. For example, when managing obesity through a monitored weight loss regimen, the standard of care would involve having the patient step on a scale to measure weight no more than once per week, and it would actually be detrimental to the patient to request additional measurements. For another example, sleep physicians currently monitor data from continuous positive airway pressure (CPAP) machines while patients sleep. That



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information paired with data from a device indicating how often the patient was awake versus asleep at night would be clinically useful. That data from a few nights' sleep (rather than 16) is clinically useful.

Finally, prohibiting reporting of 99453 and 99454 when less than 16 days of data are transmitted means that NO reimbursement for supply of device is received when the device is actually supplied and used by a patient as clinically indicated. **Eliminating the reimbursement opportunity for “device(s) supply” where a device has clearly been supplied and utilized dramatically impacts the viability of the RPM business model and will result in under-utilization of RPM programs as a whole** – despite the proven improvements to patient outcomes and reductions in overall cost of care.

For these reasons, and in response to CMS' request for comments in the CY21 PFS on the number of data transmissions appropriate for effective RPM, **we recommend that the 16 day requirement as interpreted in the CY21 PFS be revised in deference to the billing provider's medical decision-making on the frequency with which data should be collected and transmitted for RPM services.**

#### **Permanently eliminate the requirement of an established physician-patient relationship for RPM services**

During the COVID-19 public health emergency (PHE), CMS has allowed for RPM programs to be initiated by providers for both new and established patients. Continuing this policy after the PHE ends will remove unnecessary barriers for patients presenting with acute illnesses which may require short-term remote monitoring AND for patients who present with a previously unmanaged chronic condition or conditions.

#### **Allow non-physician billing practitioners to order and bill for RPM**

ATA urges CMS to implement complementary G-codes to allow for RPM treatment-assessment services, which would allow nonphysician providers to bill for RPM. These nonphysician practitioners (NPPs) would be allowed to bill these codes within their benefit categories and scopes of practice. Doing so would further the goal of aligning the RPM and RTM code sets.

#### **Recognize Remote Therapeutic Monitoring as a Designated Care Management Service by adopting and reimbursing RTM E/M codes**

Recognizing medicine codes as the sole vehicle for reimbursement of RTM services means that physicians and non-physician practitioners are unable to benefit from use of clinical staff under general supervision to assist with care coordination and management of these patients.



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Unlike with E/M codes, a direct consequence of general medicine codes is that the billing provider (even physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified midwives) may not employ the use of clinical staff or auxiliary personnel to assist in the performance of RTM services. In specialties such as pulmonology and respiratory care, much of the work performed with patients is accomplished by respiratory therapists (RTs). Under general medicine, the use of RTs is strictly under direct supervision, thereby limiting the use of RTs in the provision of RTM services.

The ATA recommends that CMS, in coordination with the American Medical Association's CPT Committee, create and implement complimentary parallel E/M codes for the existing general medicine RTM Treatment Management Service code family, thereby allowing physicians/QHP's to bill the E/M codes directly, allowing them the use of clinical staff time to be counted "incident to" the practitioner's services, and keeping the general medicine RTM codes to allow nonphysician providers the ability to report those codes.

**Implement Condition-agnostic Device Coverage for Supply of RTM Device(s)**

Currently, the codes providing reimbursement for supply of RTM devices are limited exclusively to devices addressing musculoskeletal and respiratory conditions. However, behavioral, mental health, vascular, endocrine, neurological, gastrointestinal/digestive, and other conditions also present applicable RTM uses. The ATA urges CMS to consider the broader needs for RTM services by creating a condition-agnostic CPT supply code for RTM, similar to the general RPM supply code 99454.

Thank you for your continued dedication to ensuring Medicare beneficiaries have access to quality health care regardless of where they live. 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 me at [kzebley@americantelemed.org](mailto:kzebley@americantelemed.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Kyle Zebley", is written over a light gray circular watermark.

Kyle Zebley  
Vice President, Public Policy  
American Telemedicine Association