HEALTHCARE REGULATORY ROUND-UP #88

Providing and Billing Medicare for Care Management and Remote Patient Monitoring Services

February 12, 2025

Introductions

Lori Foley
Principal
lfoley@pyapc.com

Martie Ross
Principal
mross@pyapc.com

PYA

pyapc.com
800.270.9629

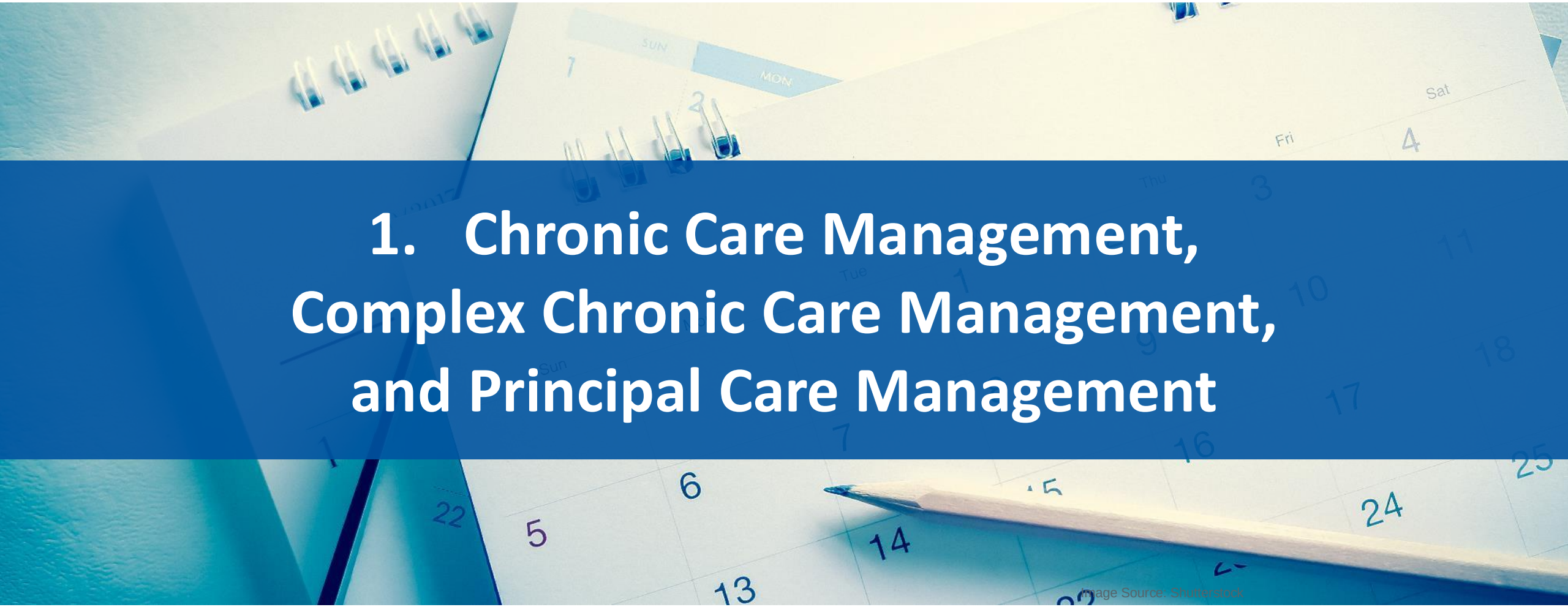
ATLANTA | CHARLOTTE | KANSAS CITY | KNOXVILLE | NASHVILLE | TAMPA

A Decade In the Making

	2015	2017	2018	2019	2020	2022	2023	2025
CCM	Chronic Care Management (CCM)	Complex CCM		CCM Personally Performed by Practitioner	Principal Care Management			
RPM			Interpretation and Analysis of Data (CPT 99091)	Remote Physiologic Monitoring	Remote Physiologic Monitoring Add-On Code	Remote Therapeutic Monitoring (RTM)	RTM Device Code for Cognitive Behavioral Monitoring	
APCM								Advanced Primary Care Management

Today's Agenda

1. Chronic Care Management, Complex Chronic Care Management, and Principal Care Management
2. Advanced Primary Care Management
3. Remote Patient Monitoring (Physiologic and Therapeutic)
4. RHC and FQHC Billing for Care Management
5. Other Payers



1. Chronic Care Management, Complex Chronic Care Management, and Principal Care Management

Image Source: Shutterstock

Chronic Care Management (CCM) – Clinical Staff

- **CPT 99490** – CCM services, at least **20 minutes** of clinical staff time directed by a physician or NPP, per calendar month, with the following required elements
  - Two or more chronic conditions expected to last at least 12 months, or until patient's death;
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline;
  - Comprehensive care plan established, implemented, revised, or monitored
- **CPT 99439** – Each additional **20 minutes** (up to 2 units)

CCM – Physician/NPP

- **CPT 99491** – CCM services, provided personally by a physician or other qualified healthcare professional, at least **30 minutes** of physician or other qualified healthcare professional time, per calendar month, with the following required elements
  - Two or more chronic conditions expected to last at least 12 months, or until patient's death;
  - Chronic conditions place the patient at significant risk of death, acute exacerbation /decompensation, or functional decline;
  - Comprehensive care plan established, implemented, revised, or monitored
- **CPT 99437** – Each additional **30 minutes** (up to 2 units)

Complex CCM

- **CPT 99487** - Complex CCM services performed by clinical staff under general supervision of physician or NPP, first **60 minutes** per calendar month,
  - Same requirements as CCM + patient's condition must require moderate or high complexity medical decision making
- **CPT 99489** – Each additional **30 minutes** (up to 3 units)
- No CPT code (and no separate Medicare reimbursement) for complex CCM performed by physician/NPP
- Reimbursement for CPT 99490 + 2 units of CPT 99439 (60 minutes total) is greater than reimbursement for CPT 99487
  - Complex CCM if at least 90 minutes of service

Principal Care Management – Clinical Staff

- **CPT 99426** -Care management services performed by clinical staff under general supervision of physician or NPP, first **30 minute**s per calendar month, for one complex chronic condition that -
  - Is expected to last at least 3 months that places patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death
  - Requires development, monitoring, or revision of disease-specific care plan; frequent adjustments in the medication regimen; and/or management that is unusually complex due to comorbidities
  - Requires ongoing communication and care coordination between relevant practitioners furnishing care
- **CPT 99427** – Each additional **30 minutes** (up to 3 units)

Principal Care Management – Physician/NPP

- **CPT 99424** –Care management services personally provided by physician or NPP, first **30 minutes** per calendar month, for one complex chronic condition that -
  - Is expected to last at least 3 months that places patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death
  - Requires development, monitoring, or revision of disease-specific care plan; frequent adjustments in the medication regimen; and/or management that is unusually complex due to comorbidities
  - Requires ongoing communication and care coordination between relevant practitioners furnishing care
- **CPT 99425** – Each additional **30 minutes** (up to 3 units)

2022 Traditional Medicare Utilization

Service	# of Practitioners	# of Beneficiaries	# of Services
CPT 99490 (CCM – clinical staff)	28,158	972,970	4,736,341
CPT 99491 (CCM – physician/NPP)	3,080	72,439	186,336
CPT 99487 (Complex CCM)	8,937	124,894	330,714
CPT 99426 (PCM – clinical staff)	1,518	22,148	70,623
CPT 99424 (PCM – physician/NPP)	495	19,689	75,335

- 29.7 million traditional Medicare beneficiaries in 2021; two-thirds have two or more chronic conditions
  - Only 5% of potentially eligible beneficiaries receiving CCM services
- Approximately 1 million physicians enrolled in Medicare, of which 360,000 are internal medicine/family practice
  - Approximately 10% of primary care physicians furnishing CCM services

https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-other-practitioners/medicare-physician-other-practitioners-by-geography-and-service

CCM, Complex CCM, and PCM Billing Rules

1. Consent
2. Established patient
3. Practice capabilities
4. General supervision of clinical staff
5. Care plan
6. Qualifying care management services
7. Double dipping
8. Claim submission

1. Consent

- Must explain following to patient and secure consent
  - Nature of CCM services and how accessed
  - Only one provider can furnish CCM at a time
  - Beneficiary may stop CCM services at any time by revoking consent, effective at end of then-current calendar month
  - Beneficiary responsible for copayment/deductible
- Written/verbal consent documented in patient's medical record
- If beneficiary revokes consent (including signing up with new provider), cannot bill for CCM after then-current calendar month

2. Established Patient

- Initiating visit required if new patient or patient not seen within last year
  - Comprehensive E/M visit (Levels 2-5), transitional care management, annual wellness visit, or initial preventive physical exam
    - Must include discussion of CCM
    - Separately reimbursable
      - HCPCS G0506 – add-on code for assessment/care planning
    - May be performed via telehealth only if reimbursable service
- Billing practitioner vs. referring practitioner
  - CCM billed under NPI of practitioner providing general supervision of clinical staff
  - Use of case management companies (general supervision arrangements)
  - Shared/centralized care management services – degree of clinical integration

3. Practice Capabilities

- Use of certified EHR for specified purposes
  - Structured recording of patient demographic information, problem list, medications/medication allergies
  - Creation of structured summary care record
- Beneficiary access to care
  - Means for patient to access provider on 24/7 basis to address acute/urgent needs
  - Patient's ability to get successive routine appointments with member of care team
- Transitions of care
  - Follow-up after ER visit, provide transitional care management (not necessarily billable service)
  - Coordinate referrals and share information electronically with other clinicians
- Coordination of care
  - Coordinate with home and community-based clinical service providers to meet patient's psychosocial needs and functional deficits
  - Document such communications in patient's medical record

4. General Supervision of Clinical Staff

- CPT definition
  - “person who works under the supervision of a physician or [NPP] and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.”
- Billing practitioner responsibilities
  - Provide oversight and direction for care management program
  - Ensure staff has experience and expertise to perform specified care management activities (delegation of authority)
  - Available to address staff questions and concerns
  - Not required to be physically/virtually present when staff providing services or to review/sign-off on staff documentation

5. Care Plan

- Develop and regularly update electronic care plan
  - Based on physical, mental, cognitive, psychosocial, functional, and environmental assessment of beneficiary's needs
  - Inventory of resources and supports
  - Addresses all health issues (not just chronic conditions)
    - Except PCM care plan focuses on specific condition
  - Congruent with beneficiary's choices and values
  - Can be developed by clinical staff, reviewed by billing practitioner
- Access to care plan
  - Make paper or electronic copy available to patient
  - Share electronically with other providers involved in patient's care

6. Care Management Services

- Types of services (non-exclusive)
  - Performing medication reconciliation, oversight of beneficiary self-management of medications
  - Ensuring receipt of all recommended preventive services
  - Monitoring beneficiary's condition (physical, mental, social)
  - Addressing social determinants of health (SDOH)
- Documentation
  - Date and time (start/stop?)
  - Person furnishing services (with credentials)
  - Brief description of services

Counting Minutes

- May include face-to-face services (exception, not the rule)
- Not required to directly interaction with patient (performing services on patient's behalf)
- May include billing practitioner time if not part of separately reimbursable service (but not vice-versa for practitioner-furnished CCM/PCM)
- May count time for services furnished on same day as E/M visit, provided time and effort not counted twice
- Minutes can be aggregated across multiple days, but total minutes cannot be rounded up (e.g., CPT 99490 not billed if only 19 minutes)
- Cannot carry 'unused' time over to following month
- May be provided by different individuals, but cannot count time for two staff members providing services at the same time
- If provide services for 2 patients at same time, allocate time between patients

7. Double Dipping

- Only one practitioner can bill for CCM for same patient during same month
  - One practitioner cannot bill CCM and PCM for same patient during same month
  - One practitioner can bill for CCM and another can bill for PCM for same patient during same month (even if both practitioners are part of same group practice)
- Cannot bill CCM/PCM and any of the following during same 30-day period
  - Home health care supervision (G0181)
  - Hospice care supervision (G0182)
  - ESRD services (90951-90970)
- Cannot count time furnishing services if patient is -
  - Hospital inpatient
  - SNF Part A stay
  - Receiving transitional care management services

7. Claim Submission

- Bill under NPI of practitioner providing general supervision of clinical staff
- Place of service = where face-to-face visit normally would occur
    - Although ‘incident to’ billing not applicable in hospital outpatient department, practitioner reimbursed for supervision of hospital staff furnishing care management services
- Date of service = any date within calendar month after minimum time threshold is satisfied
    - Codes for additional units of time billed on same data as initial unit of time (e.g., if 60 minutes of CCM in calendar month, bill CPT 99490 and two units of CPT 99439 with same DOS)
- CMS maintains it does not have authority to waive copayment for care management services

CCM Enforcement

- **Cardiac Monitoring Companies to Pay More than $44.8 Million to Resolve False Claims Act Liability Relating to Services Performed by Offshore Technicians *(December 20, 2022, U.S. ex rel. Doe v. BioTelemetry, Inc., et al., No. No. 2:18-cv-01688-PD (E.D. Pa.)***
  - Resolves allegations that monitoring occurred, in part, outside US and by technicians who were not qualified to perform such tests.
  - https://www.justice.gov/opa/pr/cardiac-monitoring-companies-pay-more-448-million-resolve-false-claims-act-liability-relating

Common CCM Billing Compliance Issues

- **Patient Initiation** – If billing practitioner has not seen beneficiary in last 12 months (or if beneficiary is new patient), practitioner must discuss CCM with the beneficiary as part of regular office visit, annual wellness visit, or initial preventive physical exam prior to billing for CCM. Such visit may be billed separately.
- **Lack of Patient Consent** – Providers must obtain patient consent prior to providing (and billing for) CCM services. Providers should maintain documentation of patients' consent to CCM services on hand, and this documentation should make clear that the patient received an explanation of the services and understands their potential financial responsibility.
- **Inadequate Documentation** – Providers must maintain comprehensive documentation to substantiate their CCM billings, including ocumentation of patient eligibility, patient consent, and services rendered and billed on monthly basis.

Common CCM Billing Compliance Issues

- **Insufficient Care Plan** – CCM requires comprehensive care plan that addresses all of patient's needs, not just chronic conditions. Care plans must be patient-centered based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment of patient's needs, and must be regularly updated (at least annually). Copy must be made available to patient/patient's designee in form specified by patient (electronic or paper).
- **Billing for Ineligible Practitioners or Staff** – Providers must ensure that they only bill for CCM provided by eligible practitioners and staff. Requirements vary depending on CPT code used.
- **Inflating Time Spent Providing CCM Services** – All care management codes require providers to spend minimum amount of time each month providing services to eligible patient
- **Improper Supervision** – CCM must be billed under NPI of provider supervising care team; this may be different provider from who ordered the service or who has primary relationship with patient.

2. Advanced Primary Care Management

Image Source: Shutterstock

Overview

- New reimbursement for employing advanced primary care delivery model
  - “We anticipate that a practitioner using the advanced primary care model will bill for APCM services for all or nearly all the patients for whom they intend to assume responsibility for primary care.”
- 3 new codes based on patient complexity (vs. level of service provided)
  - G0556 – beneficiaries with one or no chronic conditions
  - G0557 – beneficiaries with multiple chronic conditions
  - G0558 –beneficiaries with multiple chronic conditions who are Qualified Medicare Beneficiaries
- No monthly minimum time requirements
- Services “provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services”

Service Elements and Practice-Level Capabilities

- Prerequisites to billing services for individual beneficiary
  - Consent (prior CCM consent sufficient?)
  - Initiating visit for patients not seen within last 3 years (separately paid)
  - Electronic patient-centered comprehensive care plan
- Practice capabilities (services provided to individual beneficiary as appropriate)
  - 24/7 access to care to address urgent needs
  - Continuity of care (ability to schedule successive routine appointments)
  - Alternatives to traditional office visit to meet patient's needs
  - Comprehensive care management services
  - Coordination of care transitions
  - Enhanced communication opportunities (e.g., secure messaging, patient portal, virtual services) *
  - Communication and coordination with community-based organizations
- Ongoing practice activities
  - Analysis of patient population data to identify gaps in care and needed services*
  - Assessment through performance measures (primary care quality, total cost of care, meaningful use)*

**APCM elements beyond CCM/ PCM requirements*

TABLE 25: APCM Service Elements* and Practice-Level Capabilities

Consent
- Inform the patient of the availability of APCM services; that only one practitioner can furnish and be paid for these services during a calendar month; of the right to stop services at any time (effective at the end of the calendar month); and that cost sharing may apply* (may be covered by supplemental health coverage)
- Document in patient's medical record that consent was obtained

Initiating Visit for New Patients (separately paid)
- Initiation during a qualifying visit for new patients
- An initiating visit is not needed: (1) if the beneficiary is not a new patient (has been seen by the practitioner or another practitioner in the same practice within the past three years) or (2) if the beneficiary received another care management service (APCM, CCM, or PCM) within the previous year with the practitioner or another practitioner in the same practice.

24/7 Access to Care and Care Continuity
- Provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week. In the event of afterhours communication with a beneficiary, whoever is responsive to the patient's concerns must document and communicate their interaction with the beneficiary to the primary care team/practitioner.
- Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
- Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours, as appropriate

Comprehensive Care Management
- Overall comprehensive care management may include, as applicable
  - Systematic needs assessment (medical and psychosocial)
  - System-based approaches to ensure receipt of preventive services
  - Medication reconciliation, management and oversight of self-management

Patient-Centered Comprehensive Care Plan
- Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan which is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver

Management of Care Transitions (for example, discharges, ED visit follow-up, referrals, as applicable)
- Coordination of care transitions between and among health care providers and settings, including transitions involving referrals to other clinicians, follow-up after an emergency department visit, or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities, as applicable
- Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care.
- Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after ED visits and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated

Practitioner, Home-, and Community-Based Care Coordination
- Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), as applicable, and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors in the patient's medical record

Enhanced Communication Opportunities
- Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication technology-based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate
- Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits)

Patient Population-Level Management
- Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate
- Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients
- A practitioners who is participating in a Shared Savings Program ACO, REACH ACO, Making Care Primary, or Primary Care First satisfies this requirement

Performance Measurement
Be assessed on primary care quality, total cost of care, and meaningful use of CEHRT, which can be met in several ways:
- For practitioners who are MIPS eligible clinicians, by registering for and reporting the Value in Primary Care MVP**
- A practitioner who is part of a TIN participating in a Shared Savings Program ACO satisfies this requirement through the ACO's reporting of the APM Performance Pathway***
- A practitioner who is participating in a REACH ACO, a Making Care Primary, or a Primary Care First practice satisfies this requirement by virtual of meeting requirements under the CMS Innovation Center ACO REACH, Making Primary Care Primary, or Primary Care First models.

Performance Measurement – Four Options

- If part of TIN that participates in Medicare Shared Savings Program
  - Also satisfy patient population-level management requirement
- If participate in ACO REACH, Making Care Primary, or Primary Care First
  - "[Practitioners participating [in these models] would satisfy the … patient population-level management … and practice-level capabilities by virtue of meeting requirements of their model participation"
- If achieve status as Qualifying APM Participant under Quality Payment Program
- If MIPS eligible clinician who registers and reports Value in Primary Care MVP
  - If do not qualify as MIPS eligible clinician (newly enrolled, low volume), requirement is waived

Medical Record Documentation

- Electronic patient-centered comprehensive care plan
- “[W]e will expect that any actions or communications that fall within the APMC elements of service will be described in the medical record and, as appropriate, their relationship to the clinical problem(s) they are intended to resolve and the treatment plan, just as all clinical care is documented in the medical record.”
- Bill APCM for month during which no specific action take and no direct communication with or on behalf of beneficiary?
  - “We also reiterate our assumption that beneficiaries receiving APCM services may not required any services on month and may have increased utilization the next month.”
  - CMS acknowledges resources required to maintain practice capabilities and continuous readiness and monitoring activities
  - Primary care models with population-based payments have not required monthly activities on per-beneficiary basis

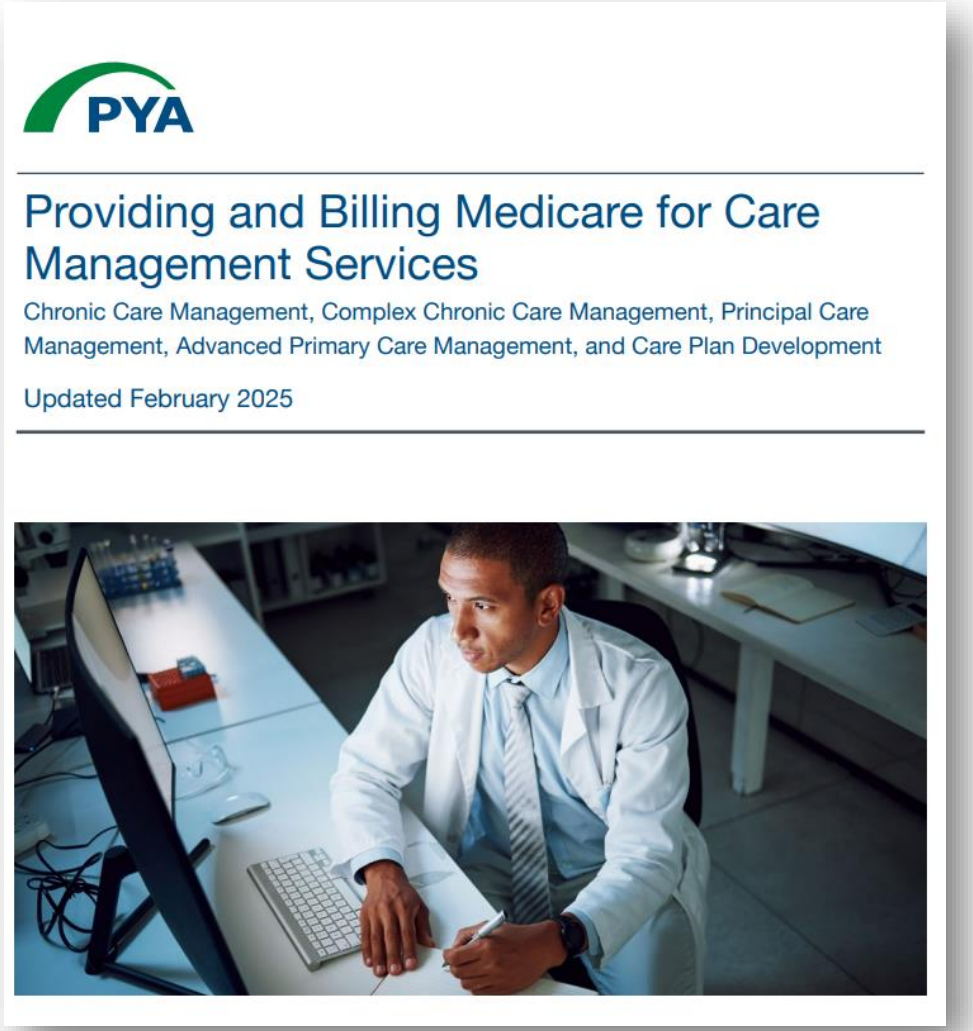
Billing for APCM

- Submission of claim = attesting to compliance with required practice capabilities
- Billed once per calendar month (no add-on code) by practitioner who has assumed responsibility for beneficiary's primary care
- Billing practitioner/another practitioner in same practice and same specialty cannot bill following services in same month as APCM: CCM, PCM, TCM, interprofessional consultation, remote evaluation of patient video/images, virtual check-in, e-visit
  - Can bill separately for remote patient monitoring (RPM, RTM), behavioral health integration (CPT 99492-94, 99484, G0323), interprofessional consultation (CPT 99446-49 and 99451)
- Medicare cost-sharing applies

Care Management Reimbursement

Code	Descriptor	2025 MPFS Payment (Non-Facility)	2025 MPFS Payment (Facility)	2025 OPPS Payment
99490	CCM, clinical staff, initial 20 min	$60.49	$47.87	APC 5822 = $92.50
99439	CCM, clinical staff, +20 min	$45.93	$32.99	N/A
99491	CCM, physician/NPP, 30 min	$82.16	$72.46	N/A
99437	CCM, physician/NPP, +30 min	$57.58	$47.87	N/A
99487	Complex CCM, clinical staff, 60 min	$131.65	$87.01	APC 5823 = $160.67
99489	Complex CCM, clinical staff, +30 min	$70.52	$47.23	N/A
99424	PCM, physician/NPP, 30 min	$80.87	$72.13	N/A
99425	PCM, physician/NPP, +30 min	$58.87	$49.17	N/A
99426	PCM, clinical staff, 30 min	$61.78	$47.55	APC 5822 = $92.50
99427	PCM, clinical staff, +30 min	$50.46	$34.29	N/A
G0556	APCM	$15.20	$11.97	APC 5821 = $29.72
G0557	APCM	$48.84	$36.23	APC 5821 = $29.72
G0558	APCM	$107.07	$79.90	APC 5822 = $92.50

For More Information



https://www.pyapc.com/wp-content/uploads/2025/02/Providing-and-Billing-Medicare-for-CCM-PYA-020325.pdf

3. Remote Patient Monitoring

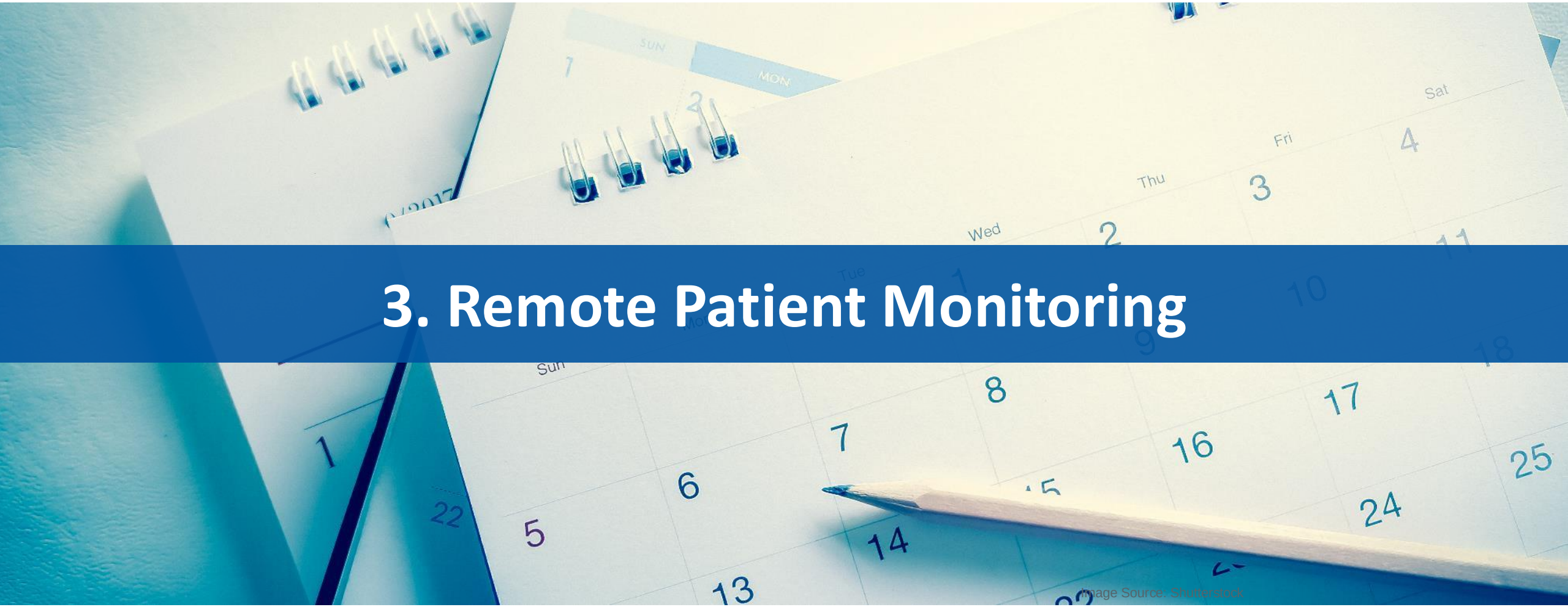


Image Source: Shutterstock

Remote Physiologic Monitoring

- Collect and analyze physiologic data relating to patient's chronic and/or acute illness or condition to be used in developing and managing treatment plan relating to such illness or condition
- Device requirements
  - Meet definition of "medical device" under the Federal Food, Drug and Cosmetic Act
  - Automatically upload patient physiologic data (i.e., data not self-recorded and/or self-reported by patient)
  - Be capable of generating and transmitting either (a) daily recordings of the beneficiary's physiologic data, or (b) an alert if the beneficiary's values fall outside pre-determined parameters

Ordering and Consent

- Must be ordered and billed by **eligible practitioner**
  - Physicians and NPPs eligible to bill for E/M services
  - RHCs and FQHCs (more later)
- Must have **established patient** relationship
  - Distinct from CCM's initiating visit requirement
  - Definition used to determine whether to bill new patient E/M codes (i.e., received professional services from practitioner or another practitioner in same group/same specialty within prior 3 years)?
  - Referring practitioner vs. billing practitioner
- Must obtain **consent** prior to or at initiation of service
  - Acknowledgment of responsibility for co-payment or deductible
  - May be verbal - but must be documented in medical record

CPT 99453 – Service Initiation

- Report for device set-up and patient education
  - Practice expense only; no assigned work RVUs
- Report only once for each episode of care even if multiple devices are provided to beneficiary
  - Per CPT Guidelines, episode of care "begin[s] when the remote monitoring physiologic service is initiated, and ends with attainment of targeted treatment goals"
  - Only one provider can be reimbursed for CPT 99453 for same patient during same time period
- Collection/transmission of 16 days of data in 30-day period is pre-condition for billing CPT 99453
  - Count 30-day period from date on which data is first collected

CPT 99454 - Data Transmission

- Report for provision and programming of device for daily recording or programmed alert transmissions over 30-day period
  - Data must be transmitted automatically (not patient reported)
  - Practice expense only; no assigned work RVUs
- Can only be billed once per 30-day period even if multiple devices utilized
  - Only one provider will be reimbursed for CPT 99454 for same patient during same time period
- Collection/transmission of 16 days of data in 30-day period is pre-condition for billing CPT 99454

CPT 99091 - Data Analysis and Interpretation

- "[A]fter the data collection period for CPT 99453 and 99454, the physiologic data that are collected and transmitted may be analyzed and interpreted as described in CPT 99091…."
  - Minimum of 30 minutes of time in 30-day period; no add-on code for additional time
- Performed by physician/NPP or by clinical staff if "incident to" requirements are met
  - Requires direct (not general) supervision by billing practitioner
    - Direct supervision is permitted via interactive audio/visual real-time communications technology through 12/31/23 (CMS proposes to extend to 12/31/24)
- *Appears* collection/transmission of 16 days of data in 30-day period is pre-condition for billing CPT 99091

RPM Treatment Management Services

- **CPT 99457** - At least **20 minutes** per calendar month of clinical staff time under general supervision of physician or NPP
  - No corresponding code for services directly performed by physician/NPP
  - Must involve “live interactive communication” with patient
    - “real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission”
    - Not required for full 20 minutes
  - Collection/transmission of 16 days of data in 30-day period is NOT pre-condition for billing CPT 99457
  - Only one provider will be reimbursed for CPT 99457 for same patient during same time period
  - May bill CPT 99457 and care management code(s) for same patient for same time period, provided documentation supports distinct service
- **CPT 99458** – Each additional **20 minutes** (up to 3 units)

CPT 99457 and 99091: Separate…but Together?

- According to CPT Codebook, CPT 99091 and 99457 cannot both be billed for same time period for same beneficiary
- However, CMS has determined that "in some instances when complex data are collected, more time devoted exclusively to data analysis and interpretation by a [practitioner] may be necessary such that the criteria could be met to bill for both CPT codes 99091 and 99457 within a 30-day period."
  - CMS cautions that one cannot use same time to meet criteria for both CPT 99091 and 99457

RPM Reimbursement

CPT Code	Service Description	2025 MPFS Payment (Non-Facility)	2025 MPFS Payment (Facility)	2025 OPPS Payment
99453	Service Initiation	$19.73	$19.73	APC 5012 = $128.87
99454	Data Transmission	$43.02	$43.02	APC 5741 = $37.29
99457	Treatment Mgmt (20 min)	$47.87	$28.79	N/A
99458	Treatment Mgmt (+20 min)	$38.49	$28.79	N/A

Remote Therapeutic Monitoring vs. RPM

- Both require FDA medical device; both appear to require 16 days of data
- RTM permits patient-reported data (vs. automatic transmission for RPM)
- RTM limited to 3 conditions: respiratory, musculoskeletal, and cognitive behavioral therapy
- Established patient requirement does not apply to RTM
- Because RTM codes are not E/M codes -
  - May be billed by any professional who can bill under MPFS
  - No 'incident to' billing – must be personally performed by billing professional
    - PTs/OTs to bill for RTM services furnished by PTAs/OTAs under general supervision
- Provider cannot bill RPM and RTM codes for same patient during same time period

RTM Reimbursement

CPT Code	Service Description	2025 MPFS Payment (Non-Facility)	2025 MPFS Payment (Facility)	2025 OPPS Payment
98975	Service Initiation	$19.73	$19.73	APC 5012 = $128.82
98976	Data Transmission Respiratory System	$43.02	$43.02	APC 5741 = $37.29
98977	Data Transmission Musculoskeletal System	$43.02	$43.02	APC 5741 = $37.29
989X6	Data Transmission Cognitive Behavioral Therapy	Contractor Priced	Contractor Priced	N/A
98980	Treatment Mgmt (20 min)	$50.14	$29.44	N/A
98981	Treatment Mgmt (+20 min)	$39.14	$28.79	N/A

RTM/RPM Billing Compliance Issues

- **Insufficient Care Plan** – For RPM/RTM treatment management services, care plans must be patient-centered, focused on condition/disease being monitored, and must be regularly updated (at least annually)
- **Improper Supervision** – Services must be billed under the provider who is supervising the care team; may be different than provider who ordered service or who has primary relationship with patient
- **"Auto-Pilot"/Roster Billing** – Services must be medically necessary and clinically appropriate for each individual patient billed; risk of roster billing (same service patient to patient) or being billed on "auto pilot"
- **HIPAA Privacy and FDA** – Potential issues regarding FDA regulations and HIPAA privacy concerns associated with device

For More Information

https://www.pyapc.com/wp-content/uploads/2025/02/Providing-and-Billing-Medicare-for-RPM-PYA-020325.pdf

4. RHC/FQHC Billing for Care Management Services

Image Source: Shutterstock

Rural Health Clinics and Federally Qualified Health Centers

- Previously billed for care management and remote monitoring under HCPCS G0511
  - Reimbursed at ~$80 (not AIR or PPS)
- Effective January 1, 2025, now bill under appropriate CPT code
  - Reimbursed under non-facility national payment rate (not AIR or PPS)
  - May bill HCPCS G0511 through June 30, 2025, but reimbursement reduced

5. Other Payers

Image Source: Shutterstock

Other Payers

- Medicare Advantage plans
  - Coverage vs. reimbursement
- State Medicaid programs
- Commercial payers

Our Upcoming Healthcare Regulatory Round-Up Webinars

- **February 26, 11 am – 12 pm ET**
  Proposed Changes to the HIPAA Security Rule: Speak Now or Forever Hold Your Peace
- **March 5, 11 am – 12 pm ET**
  Tightening Your Belt: Prepare for Site-Neutral Payment Reforms

Thank you for attending!

PYA's subject matter experts discuss the latest industry developments in our popular Healthcare Regulatory Roundup webinar series twice each month.

For on-demand recordings of this and all previous HCRR webinars, and information on upcoming topics and dates, please follow the link below.

https://www.pyapc.com/healthcare-regulatory-roundup-webinars/

pyapc.com | 800.270.9629

ATLANTA | CHARLOTTE | KANSAS CITY | KNOXVILLE | NASHVILLE | TAMPA

A national healthcare advisory services firm providing consulting, audit, and tax services