Telehealth is the perfect partner for remote patient monitoring. Remote patient monitoring detects worsening clinical status early when an intervention could prevent an ER visit or a hospital stay. Telehealth is how you rapidly deliver the needed interventions.

Remote Patient Monitoring is how you measure how well chronic illness is controlled. Telehealth is how you improve the control of chronic illness and prevent future complications. By adding Telehealth and Remote Patient Monitoring dramatically increases CPT revenue to the provider.

There are two approaches to Remote Patient Monitoring (RPM). These two strategies are broadly described as Fee for Service (FFS) or Value.

The **FFS** model generates income from billing Medicare. This approach is most profitable when you minimize device expense by deploying one low-cost device such as a blood pressure cuff. While this strategy maximizes profit from RPM services it misses other opportunities to increase revenue and reduce total medical costs.

The **Value-Based** approach makes money by improving quality, reducing costs, earning quality bonuses, documenting illness burden, and sharing in the medical cost savings. The earnings opportunity is much greater with the Value-Based approach.

There are four ways the Vitals360® helps reduce medical costs and drive value-based revenue.

- Vitals360® supports better care of chronic illness while helping physicians earn quality bonuses. As an example, high blood pressure is seldom a reason for a potentially preventable ER visit or hospitalization. However, uncontrolled blood pressure over a long period of time increases costs by being a factor in the development of strokes, heart attacks, peripheral vascular disease, and kidney failure. Controlling blood pressure should be a goal for all patients. Doing so will have long-term benefits but it will not reduce medical costs in the short term. Achieving blood pressure control requires regular follow-up that can be delivered via in-person or telehealth visits. Telehealth is more convenient for many patients resulting in better compliance and is part of the VoCare Vitals360® solution.
- Vitals360® enables early detection of worsening of chronic illness and provides telehealth to help avoid ER visits and hospital stays. Essentially the trade-off is a $90 telehealth visit versus a $14,000 hospital stay. Congestive heart failure (CHF) is a chronic illness that is responsible for potentially avoidable hospitalizations. RPM for CHF should include daily measures of pulse, weight, oxygen, EKG, and

respiratory rate. Any of these measures could identify CHF that is worsening and might lead to hospitalization. Telehealth then allows you to intervene and make adjustments thus avoiding an ER visit or hospital stay.

- Vitals360® allows physicians to safely care for acute conditions at home by using remote monitoring and telehealth. Many patients are hospitalized due to the anxiety physicians feel about caring for them at home. A patient with community-acquired pneumonia may be safely cared for at home by monitoring their oxygen level, pulse, respiratory rate, and temperature. Knowing these are heading in the right direction is reassuring to physicians and makes them more comfortable sending these patients home. For every patient you care for at home the savings will typically be $10,000 or more.
- Vitals360® supports documentation of illness burden which leads to higher monthly payments from Medicare in the Medicare Advantage program. The way this works is you start with the location and demographic factors which you add to the illness factors and then multiply that times the base rate. So say a patient who has no documented chronic illnesses has a demographic adjustment of 1.0 and the insurance company monthly payment from Medicare is $1,000. The physician does a telehealth visit and notes that the patient has stable angina (RAF 0.14), an amputated toe (RAF 0.55), and a gangrenous ulcer (RAF 1.4). The total RAF is 2.09. The monthly payment is a base rate of $1,000 times the demographic adjustment + the RAF or 3.09 times $1,000 or $3,090. The annual increase in revenue from Medicare for this one patient is $25,080. Illness burden documentation is the single largest contributor to being successful in Medicare risk and it can occur via telehealth with two-way video.

As recently as three years ago, CMS limited Medicare reimbursement for telehealth to live, real-time, synchronous voice and video contact. CMS's reimbursement rules were very restrictive. They required that the patient present in a health professional shortage area and limited where telehealth could occur and the type of services a clinician could provide.

While CMS reimbursed for remote patient monitoring services, reimbursement was limited. Recent changes have greatly expanded reimbursement for telehealth *and* remote patient monitoring.

Providers may now receive Medicare payment for a broad range of telehealth services. These include:

- Telehealth visits (A visit with a provider that uses telecommunication systems between a provider and a patient.)
- Virtual check-ins with established patients (brief check-ins with patients via telephone or another telecommunications device to decide whether an office visit or other service is needed)
- e-visits (communication between a patient and their provider through an online portal)

Medicare has also created reimbursement codes that are specific to certain health conditions. These include:

- Telehealth visits with patients having two or more chronic conditions
- Telehealth visits with patients having one chronic or high-risk condition
- Interactive communication with patients experiencing a transition in care settings
- Behavioral health services

- Clinical assessment of dialysis patients
- Treatment of substance use disorders, including opioids

Recent Medicare reimbursement changes have also expanded reimbursement for remote patient monitoring. Providers may now receive Medicare payment for providing the following remote patient monitoring services:

- The supply and provisioning of devices used for remote patient monitoring programs
- The set-up and patient education on remote patient monitoring equipment
- The remote monitoring of physiological data as part of the patient's treatment management services
- Interactive time spent between a caregiver and a patient (up to three separate sessions lasting a minimum of 20 minutes)

Payment for these services will enable Medicare beneficiaries to stay in close contact with their caregivers, reduce avoidable health care expenses and experience a level of convenience that was not previously possible.

The following table describes many of the most common telehealth and remote patient monitoring services reimbursable by Medicare. For a complete listing of reimbursable services, visit: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
Telehealth Visits				
99202-99205	Telehealth-enabled office or other visits for **new patients**	Medicare Part B Providers or Qualified Health Professionals	Once	$73.97 - $224.36
99211-99215	Telehealth-enabled office or other visits for **established patients**	Medicare Part B Providers or Qualified Health Professionals	No limitation	$23.03 - $183.19
G0425-27	Telehealth consultations	Medicare Part B Providers or Qualified Health Professionals	No limitation	$101.19 - $200.29
G0406-08	Follow-up inpatient telehealth consultations furnished to beneficiaries in a hospital or SNF	Medicare Part B Providers or Qualified Health Professionals	No limitation	$38.38 - $103.28
Virtual Check-ins				

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
G2010 G2012	A brief (5-10 minutes) check via telephone or other telecommunications device to decide whether an office visit or other service is needed. It may also include a remote evaluation of recorded video and/or images submitted by an established patient.	Medicare Part B Providers or Qualified Health Professionals	No limitation	$12.21 $14.66
e-visits				
99421-423	Patient-initiated communications between an established patient and their provider through a HIPAA-compliant secure platform.	Medicare Part B Providers or Qualified Health Professionals that can bill for E/M services.	Once during a 7-day period	$15.00 - $47.46
Remote Patient Monitoring				
99091	The 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 health care professional. In this instance, a QHP is qualified by education, training, licensure/regulation (when applicable). The code requires a minimum of 30 minutes of interpretation and review.	To bill for CPT Code 99091, the initial provider service must occur in the physician's office or other applicable sites. Additionally, only a physician or QHP may perform these services, distinguishing it significantly from 99457, in which a clinical staff member can provide services "incident to."	Once in a 30-day billing period.	$56.88
99453	The initial set-up of devices, training, and education on the use of monitoring equipment and any services needed to enroll the patient on-site.	Not specified; not required to be clinical staff (Practice Expense Only Code)	Once per patient, only first month of reading for 99454	$19.19

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
99454	The supply and provisioning of devices used for RPM programs.	Not specified; not required to be clinical staff (Practice Expense Only Code)	Once in a 30-day billing period; required 16 days of readings	$63.16
99457	The remote monitoring of physiologic data as part of the patient's treatment management services. To receive reimbursement, the physician, QHP, or other clinical staff must provide RPM treatment management services for at least 20 minutes per month.	Those in indirect general supervision of clinical staff	Once per month	$50.94
99458	Each additional 20 minutes of remote monitoring and treatment management services provided.	Those in indirect general supervision of clinical staff	Once per month	$41.17

Chronic Care Management				
99490	The first full 20 minutes of **non-complex** Chronic Care Management of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements: • Multiple (2 or more) chronic conditions expected to last at least 12 months or until the death of the patient; • Chronic conditions place the patient at significant risk of death, acute exacerbation, decompensation, or functional decline; • Comprehensive care plan established, implemented, revised, or monitored.	Medicare Part B Providers or Qualified Health Professionals	Once per month	$41.17

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
99487	The first 60 minutes of clinical staff or QHP or provider time for moderately or **highly complex** CCM.	Medicare Part B Providers or Qualified Health Professionals	Once per month	$91.77
99489	An additional 30 minutes of time spent in the same billing cycle as 99487 with high or moderate complexity patients who require more time.	Medicare Part B Providers or Qualified Health Professionals	Once per month	$43.97
Principal Care Management				
G2064	An interaction between a **physician or non-physician practitioner** with a patient with one chronic disease or high-risk condition lasting at least 30 minutes per calendar month.	Medicare Part B Providers or Qualified Health Professionals	Once per month	$90.37
G2065	An interaction between **clinical staff** with a patient with one chronic disease or high-risk condition lasting at least 30 minutes per calendar month.	Medicare Part B Providers or Qualified Health Professionals	Once per month	$38.73
Transition Care Management				
99495	Transitional Care Management services, including interactive contact with the moderately complex patient within two days of discharge, with a face-to-face visit within 14 days of discharge.	Medicare Part B Providers or Qualified Health Professionals	Once per discharge	$207.96
99496	Extra care incentives for highly complex patients with interactive contact within two days of discharge for TCM services, with a face-to-face visit within seven (7) days of discharge.	Medicare Part B Providers or Qualified Health Professionals	Once per discharge	$281.59

VoCare does not represent that this list of billing codes constitutes all of the opportunities available to providers to bill for telehealth and remote patient monitoring services. This information is subject to change by CMS. Consult your medical billing partner of Medicare Administrative Contractor for more detail about these and other telehealth and remote patient monitoring billing codes.

Sources:

https://capturebilling.com/telemedicine-billing-tips/