What You Need to Know About Remote Patient Monitoring (RPM)

These devices have the potential to change healthcare.

BY PAUL KESSELMAN, DPM

Because CMS has not published final comments regarding Remote Patient Monitoring (RPM), some confusion remains about their potential applications. What should be clear is that RPM is not the same as Telehealth as these two separate programs are both very different, each with their own requirements.

Unlike Telehealth, RPM does not require sophisticated interactive video conferencing from a specially designated site; RPM is not subject to population density issues; RPM does not eliminate the use of RPM reimbursement if the patient was recently/or will soon be seen in the provider's office; RPM is not subject to state scope of practice limitations (as RPM is considered performed in the state you practice in); RPM is not subject to any other of the more stringent requirements of Telehealth.

Prior to getting into the details of the CPT used for RPM, first it's important to understand podiatric applications of RPM and how they may impact the practice of podiatry. RPM has its potential application with many devices that podiatrists commonly prescribe or dispense. This would include specialty socks for diabetic patients, foot orthotics, therapeutic shoes and inserts, surgical dressings, CAM boots, custom and pre-fabricated AFOs, prosthetics, and other DME. All of these devices can be implanted with microprocessor technologies, with the capacity to send signals to the provider (or some monitoring service) regarding the patient's compliance and many other indicators.

Some of the potential variables to be monitored include, but are not limited to pressure (peak plantar pressure), temperature (hot and cold spots), other physical forces such as shear, and other acute gait pattern changes. For wounds, characteristics such as moisture content, fluid and exudative changes, and infection indicators (to monitor bacterial presence and penetration in a wound) will have applications. Other applications such as limb circumference to monitor edema, and color changes to monitor erythema are but a few of the variables which micro-processing units may be used to monitor.

Miniaturized sensors which can be sent home on our patients' limbs to collect gait analysis data and be used to influence our prescription for foot orthotics are yet another possibility.

A "smart orthotic" device will have a built-in microprocessor which can differentiate the patient's activities and the potential to change the orthotic properties based on the patient's demands. Such a "smart" orthotic will have a shell which is no longer a static piece of matter, but one which can change its physical durometer (hardness) based on the data it receives from built-in microprocessors.

Imagine the impact monitoring the effects of foot orthotics on gait changes over billions of patients' use hours. The data pools generated will be enormous and be able to provide the evidence based medicine which insurance carriers now demand to influence and change carrier policy.

Imagine the ability for a microprocessor in a smart therapeutic insert which can alert your office (and/or the

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patient) should the patient's peak plantar pressure and/or temperature suddenly elevate. This scenario may result in the patient's phone app sending an alert to call your office and/or a central

nection from the "smart" device to a phone app, which then uses the patient's WiFi, or a bluetooth connection from the device to a wireless device placed in the patient's home which has its own Internet connection (the latter similar to a cardiac loop recorder).

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monitoring system, generating a phone call to your office. In these scenarios, the patient would be prompted to see the physician. This earlier intervention, prior to the onset of complications, is at the heart of the RPM policy.

It remains to be seen how the RPM smart technology would actually transmit data from the patient. Two possibilities include a bluetooth con-

Requirement of a Monitoring Service

However the connection is made, in order to report RPM, a monitoring service would be required to provide a calendar month of data, and you or your "clinical" staff would also need to spend a minimum of 20 minutes both reviewing the data and discussing this with the patient.

Discussions with the patient could be by any means of mutually acceptable communication, such as snail mail, by phone, or in person.

CPT Code 99453 is for remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment. 99453 has its potential use when dispensing a "smart" device". As with all DME, it would be expected that the patient would be provided written instructions on utilizing the device and how to transmit the information back to the provider.

CPT Code 99454 is for remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. CPT 99454 has the potential for reimbursement for actually providing the device and mon-

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itoring the device. This is a separate CPT code from the HCPCS code for the actual device itself and separate from providing the patient with the education needed to implement the use of the device. This code may be thought of as for the ongoing monitoring service itself, every thirty days.

CPT Code 99457 is for remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month. 99457 is for payment by the healthcare clinical staff (DMEPOS supplier, physician, etc.) for educating the patient on the use of the device. For this latter code to be used, the physician (or clinical staff) would need to be interactive with the patient. The inclusion of "clinical staff" is a huge differentiator between the predecessor CPT code 99091, in that it allows the reimbursement when clinical staff actually perform the patient education based on the RPM report.

Envisioning how this would work with the smart devices previously mentioned, on the day of dispensing, your office would bill CPT codes 99453 for the initial set-up and educating the patient on the use of the device; 99454 for monitoring the patient's initial thirty days and then again each subsequent 30 days. Each subsequent calendar month, your office could bill CPT 99457 for management services, that is for actually spending twenty minutes reviewing the RPM report and communicating your findings with the patient.

There are several questions which remain unanswered at this time:

1) CMS has not provided final comment on what variables are required to be monitored;

2) The DME LCD stipulates that the dispensing of a device is included in the global price of the device. This is in conflict with the new RPM codes. How this will be resolved is uncertain;

3) CMS has not stated whether RPM will be covered only for Medicare covered services or for HCPCS codes which are statutorily non-covered (e.g., foot orthotics, socks, etc.);

4) There remains some confusion about CMS comments regarding the requirement for "clinical staff" with respect to the provision of CPT 99457. Does the person providing the patient education require state licensure (RN, LPN, PA, DPM, MD, DO) or certification (e.g., certified podiatric or medical assistant), or can someone you trained and designated to provide education be used?;

5) The specifics of what documentation should be included by the mon-

itoring service and in your report remain unclear;

6) The costs of the monitoring services: Is it a one-time charge to set up the app on the patient's phone or home portal connected to their WiFi or separate connection? Who will the monitoring service bill… you or the patient? If you

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are billing CPT 99457 and the monitoring service is billing you, will this still be a profitable service to report? Most industry experts say yes. Is the cost of the monitoring service "invisible" and simply rolled into the cost of the product? For some products the answer is yes, for some no.

The Future

Those industry experts observing CMS speculate that CMS is steadfast on seeing RPM move forward and expand. Several other publications expect RPM services to

be expanded by those medical specialties already utilizing them, including but not limited to internal medicine and its sub-specialties such as cardiology and pulmonology. Smart glucose and A1C monitoring systems are already on the market making endocrinology another specialty widely expected to soon adopt this technology into daily practice.

Other specialties widely expected to adopt RPM include orthopedics (for the same reasons this makes sense for podiatry), dermatology (use for sensing skin cancer cells), etc. The innocent prescription bottle of the past may also soon be equipped with smart technology, having the capability of tracking your patient's compliance (how many doses has the patient skipped?) with medications and notifying you if the patient is non-compliant, and when the prescription should be refilled. A smart chip on the medication bottle may actually have the ability to send a message to the pharmacy that the patient's prescription needs immediate renewal (this is in addition to the phone messages your patients are already receiving), or to send a message to the doctor that it is time to write a new prescription and/or the need for the patient to be contacted regarding an appointment.

Summary and Conclusions

Carematix, a leader in remote patient monitoring programs, states that RPM technology can reduce ER visits by 60 percent, re-admissions by 30 percent, and increase pharmacy refills by 41 percent. It is expected that the huge potential increase in revenue for RPM across all specialties will be more than offset by a larger decline in unnecessary ER visits, and reduced hospital admissions and re-admissions. These are three of the largest expenditures in the CMS budget. It is also expected that RPM will reduce the incidence and cost(s) of treating complications caught earlier on when costs are lower and increase patients' compliance with prescriptive medications and orthotics and prosthetics (the latter with large estimates of low compliance and higher complications due to compliance failure). More than one expert also expects RPM to also be added to home healthcare as well.

This may all sound somewhat Orwellian and just another area where third-party payers may come knocking at your door to audit your practice. However, patient compliance will improve due to closer patient monitoring. Whether you have a general podiatry, sports medicine, surgical, or wound care practice, RPM and the use of smart technology have the potential to positively benefit your patients' health and your practice's revenue. **PM**

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