Remote Therapeutic Monitoring

Origination: 11/20/24	**Revised:**	**Annual Review:**
Line of Business: Commercial Only ☐ QHP/Exchange Only ☐ Medicare Only ☐ Commercial & QHP/Exchange ☒ Commercial, QHP/Exchange, & Medicare ☐		

Purpose:

To provide guidelines for Remote Therapeutic Monitoring to Population Health and Provider Alliances associates for reference when making benefit determinations.

Background:

- RPM codes are considered Evaluation and Management (E/M) services. As such, CPT codes 99457 and 99458 can only be furnished by a physician or other qualified healthcare professional, or by clinical staff under the general supervision of the physician (eligible to bill Medicare for E/M services).
- Monitoring must occur over at least 16 days of a 30-day period in order for CPT codes 99453 and 99454 to be billed.
- Even when multiple medical devices are provided to a patient, the services associated with all the medical devices can be billed only once per patient per 30-day period and only when at least 16 days of data have been collected. CMS also noted that CPT 99453 can be billed only once per episode of care where an episode of care is defined as "beginning when the remote physiologic monitoring service is initiated and ends with attainment of targeted treatment goals."

Coverage Guidelines:

- Allowed for patients with both chronic and acute conditions.
- Must be for an established patient, one with whom the physician has had a prior new patient E/M service. This E/M service is allowed to be done via telehealth.
- Monitoring must be medically reasonable and necessary.
- Monitoring beyond one year is not considered to be medically necessary unless there is documentation of significant therapeutic changes in the member's medical regimen.

References:

1. CMS MLN901705 April 2024 Remote Therapeutic monitoring

Remote Therapeutic Monitoring

Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.