



PAYMENT

Reimbursement Tips:

Community Health Center Requirements for Remote Physiologic Monitoring (RPM) & Self-Measured Blood Pressure (SMBP)

Remote Physiologic Monitoring (RPM), including self-measured blood pressure (SMBP), involves a patient's use of devices to assess and record physiologic data outside of the clinical setting, usually in the home. RPM may require additional treatment management services which may be furnished by a qualified provider. CMS currently does not reimburse RPM services separately from the FQHC PPS payment.

During the Public Health Emergency (PHE):

CPT code 99473 "self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration" is included on the CMS list of temporary telehealth services that may be provided during the PHE. In order to be reimbursed for this service, FQHCs would bill for it using the telehealth G2025 code and receive \$99.45. There is no reimbursement separate from the PPS payment if CPT 99473 services are provided in a face-to-face visit during the PHE.



Program Requirements

Remote Physiologic Monitoring (RPM) refers to the use of device(s) for remote monitoring of physiologic parameters (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate). The medical devices used must be defined by the FDA, and the service must be ordered by a physician or qualified health professional (QHP).

Self-measured blood pressure (SMBP) refers to blood pressure measurement that takes place outside the clinical setting, often at home. SMBP can assist with both diagnosis and management of hypertension and increases patient participation in their own care. Devices used for SMBP must be validated for clinical accuracy. Two new codes for SMBP were added effective January 1, 2020. **With respect to coding, SMBP is a type of RPM.**

Remote Physiologic Monitoring Treatment Management Services (RPM TMS) are provided when clinical staff/physician/other qualified health care professional use the result of RPM to manage a patient under a specified treatment plan. RPM TMS involves interactive communication which includes real-time synchronous, two-way audio interaction that is capable of being enhanced with video of other kinds of data transmission.



Patient Eligibility & Consent

A FQHC practitioner (e.g., MD, DO, NP, PA) determines if patients meet the criteria for RPM and if they are likely to benefit from these services. RPM may be used for patients with acute conditions as well as patients with chronic conditions. The inclusion of acute conditions was confirmed by CMS effective January 1, 2021 as written in section 84543 of the CMS [2021 PFS Final Rule](#).

Patient consent for RPM is required and must be documented. If blood pressure or other measurement devices are offered by health centers, consent can be included as part of the agreement to provide the device.



Timeframe & Services

Remote Physiologic Monitoring (RPM)

Can be used with patients to:

- Develop and manage a treatment plan for acute or chronic illnesses.
- Monitor physiologic parameters (e.g., pulse oximetry, blood pressure, weight).
- Collect and interpret physiologic data (e.g., blood pressure, blood glucose, heart rate, EEG).
- Provide RPM TMS to manage patients involved in existing treatment plans.

CPT CODE	Services	Billable Outside of PPS
CPT 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 and is billable once in each 30-day billing period.	No
CPT 99453	Initial set-up and patient education on use of device(s) for remote monitoring of physiologic parameters (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate). May not be reported for more than one episode of care which is defined as beginning with initiation of RPM and ending when targeted treatment goals are achieved. Think of this as the code to use one time to report patient education on the device.	No
CPT 99454	Supply of the device used for daily recording or programmed alert transmissions of physiologic parameters, each 30 days. In short: Data transmission; providing the device to and programming it for the patient.	No

Providers can perform 99453 and 99454 services, if medically necessary, without being required to perform 99091 or 99457 services. FQHCs are encouraged to collect and report any RPM services they provide, even when not reimbursed for them. Reporting the applicable service codes helps support the case that FQHCs furnishing RPM services should be reimbursed outside of the Medicare PPS payment.

Community Health Center Requirements for RPM & SMBP

The CPT® Manual also notes for code 99453 and 99454:

- Monitoring of at least 16 days per 30-day period is required;
- May only be reported once per practitioner, per patient, in a 30-day period;
- If multiple medical devices are being used, data needs to have been collected on at least one device before services can be billed;
- Do not report 99454 more than once per patient in a 30-day period when multiple devices are in use; and
- Do not report in conjunction with code for more specific parameters (e.g., 93296).

Self-Measured Blood Pressure (SMBP)

Can be used with patients to:

- Confirm or rule out a HTN diagnosis when in-office blood pressure is elevated.
- Manage treatment for patients already diagnosed with HTN.
- Assess masked HTN (patients with normal blood pressure readings in the health center but who experience increases in blood pressure at other times of the day or in different settings).
- Monitor changes resulting from medication.

SMBP services include educating and training patients in use of SMBP and device calibration and could vary in the amount of clinical staff time provided, the level of involvement of the billing provider, and the treatment plan.

WHAT PROVIDER CODES	Services	Billable Outside of PPS
CPT 99473	Staff time for self-measured blood pressure using a device validated for clinical accuracy; patient education/ training and device calibration. This code may only be submitted once per device.	Yes: Telehealth during PHE; billed as G2025 No: Face-to-face
CPT 99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient.+	No

*During the PHE, calibration has been waived as a requirement for this code although it requires use of a validated device.

+Clinical guidelines for SMBP, as opposed to coding requirements, are for 2 measurements, 1 minute apart, in the morning and evening for a 7-day period. At least 3 days (12 measurements) are the minimum needed for SMBP. Average all SMBP measurements from the 7-day period into one systolic BP average and one diastolic BP average.

CPT codes 99473 and 99474 may not be used in the same calendar month as codes for RPM (99453-8, 99091), CCM (99487, 99489-99491), or ambulatory blood pressure monitoring (99473, 93786, 93788, 93790).

If other E/M services are provided the same day as 99091 or 99474, they should be considered part of the E/M service and not reported separately.

Coding for SMBP During the PHE

WHAT PROVIDER CODES	Services	What FQHC bills to CMS	CMS/Medicare 2021 Fees
Any CMS permitted telehealth code	Any CMS Telehealth covered services	G2025* *On and after Jul 1 2020 till the end of COVID PHE	\$99.45

RPM Treatment Management Services (RPM TMS)

RPM TMS services codes are submitted when clinical staff/physician/QHP use the data gathered through RPM to manage a patient under a specific treatment plan. The devices must qualify as a FDA medical device. These RPM TMS services may be reported in the same service period as CCM, TCM, and BHI. The CCM, TCM, BHI time and treatment plan would be separately documented and care managed according to the requirements of those care models.

RPM TMS time cannot be counted on the same day as the physician or QHP reports other services. CPT 99457 cannot be reported with CPT 99091. As the list of exceptions is extensive, please refer to the CPT Manual for the full list of these services.

RPM TMS CPT Codes

CPT CODE	Services	Billable Outside of PPS
CPT 99457	Clinical staff/physician/QHP treatment management services time to manage a patient under a specific treatment plan using the results of RPM; first 20 minutes. Requires that at least 20-minutes of services must be provided to bill for RPM TMS services and can include time for furnishing care management services as well as for required interactive communication. May be reported only one time in a calendar month regardless of RPM modalities performed.	No
CPT 99458	Add-on to 99457 for each additional 20 minutes of remote monitoring treatment management services provided.	No

Community Health Center Requirements for RPM & SMBP

The initial commentary in the 2021 PFS Final Rule caused debate regarding the requirement for 20 minutes of “interactive communication.” After the Final Rule was published, CMS issued a correction that this 20 minutes of time includes both “interactive communication” as well as non-face-to-face care management during the 30 days of service period.

Devices

RPM services must involve a medical device as defined by [Section 201\(h\) of the Federal Food, Drug, and Cosmetic Act](#). The device must be reliable and valid and the data must be electronically (i.e., digitally and automatically) collected and transmitted rather than self-reported. Interactive communication is required, although an interactive video connection is not needed. Medical necessity requirements for the use of RPM must be met.

SMBP requires use of a device validated for clinical accuracy if submitting a SMBP CPT code (e.g., 99473). Choosing a device on the [US Blood Pressure Validated Device Listing \(VDL™\)](#) is the easiest way to ensure clinical accuracy. However, some devices may not be listed on the VDL until they are independently reviewed to be validated for clinical accuracy. Whenever possible, all devices used for SMBP (regardless of whether SMBP CPT codes are used) should also be calibrated (checked for accuracy) by the care delivery organization against an office-based machine. All devices sold in the U.S. are cleared by the FDA, which is different from having been tested using an accepted clinical validation protocol (validated for clinical accuracy).



Authorized Provider/Staff

CMS clarified in the 2021 PFS Final Rule that RPM falls under the E/M services category. Therefore, RPM can be ordered and billed only by physicians or non-physician practitioners who are Medicare eligible and can bill for E/M services.

Furnishing of RPM services varies based upon the service. For example, CPT 99091 can be furnished only by a physician or other QHP while CPT codes 99457 and 99458 can also be provided by clinical staff under the general supervision (not direct) of the physician or QHP. The CPT code descriptions should be thoroughly reviewed and understood before FQHCs develop staffing models to support RPM services.

Another significant clarification provided by CMS in the 2021 PFS Final Rule is that because of the lack of definition in the CPT code descriptions, they are taking the position that auxiliary personnel, in addition to clinical staff, may furnish CPT 99453 and 99454 code services. Auxiliary personnel operating under general supervision of the physician or QHP may include employees, contractors, or leased employees.

99453, 99454, 99473, 99474

Ordering and Billing Provider					Other care staff who can perform
Physicians (MD or DO)	Non-Physician Practitioners				Clinical Staff or Auxiliary Personnel
	NP	PA	CNM	CNS	
X	X	X	X	X	X

Medical Doctor (MD) and Doctor of Osteopathy (DO)

Non-Physician Practitioners include: Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Clinical Nurse Specialists (CNS).

Other care staff performs services under general supervision of physician or QHP.

All supervision requirements (regardless of CMS/ Medicare policy) are subject to applicable State law, licensure, and scope of practice definitions.



Documentation

To be eligible for reimbursement for RPM, including SMBP services under CPT code 99473 billed as G205 if delivered via telehealth during the PHE, a provider or QHP must include specific documentation demonstrating:

- The medical necessity of the device and the condition for which the patient is being monitored.
- An order for the device, which validated device was chosen, when it was provided to the patient, and the date device training was provided.
- Patient consent.
- The date the device begins to record data and the last day the device records data and transmits to the provider.
- **Time spent assessing, reviewing, and/or interpreting the data and by whom.**
- **Time spent communicating with the patient** (and family caregiver, if applicable), along with the details of the communication.
- How the data is used to manage a patient under a specific treatment plan.
- Use of digital tools “in such a way that allows them to **provide ongoing guidance and assessments for patients outside of the in-office visit,**” including “the collection and use of” patient-generated health data.
- Use of platforms and devices that work as part of an “**active feedback loop,**” providing data in real time (or near-real time) to the care team as well as offering patients automatic and ongoing one-way guidance.

Coding & Billing

Medicare currently does not reimburse FQHCs separately for RPM, although some state Medicaid programs and private payers do. Medicare's position is that RPM is a component of care management under the PPS qualifying visit and is therefore covered through the associated PPS payment rate. State Medicaid and private payer coverage for RPM varies, requiring FQHCs to check with each prior to offering or billing for RPM services. While FQHCs have been receiving grants to support the growth of digital capabilities (e.g., RPM devices, digital storage) associated with telemonitoring care models, reimbursement is needed to sustain them. It is important for FQHCs to collect and report the RPM services they do provide, even when not reimbursed for them. Reporting the services helps support the case to reimburse FQHCs separately for these services from Medicare PPS payment.

According to the [Center for Connected Health Policy](#), only 27 states offer reimbursement for RPM as part of their Medicaid program. Further, many have limitations on how RPM may be used. This research, recently conducted in February 2021, shows that half the country still offers no Medicaid reimbursement for RPM.

Exceptions During the Public Health Emergency

RPM and SMBP can be furnished to both new and established patients. FQHC practitioners may render services without first conducting a new E/M service. If a new E/M visit (i.e., 99202-99205) is needed, Medicare is allowing the use of real-time interactive audio-video technology to satisfy the E/M face-to-face visit elements. Following the public health emergency (PHE), there must be an established patient-provider relationship for RPM services to be furnished. Specifically, outside the PHE, a new patient visit is required in order for the practitioner to gather, through a history and physical exam, the necessary information to analyze the patient's physiologic data and develop a treatment plan prior to ordering RPM.

Patient consent is required for RPM services, but can be obtained at the same time services are provided, whether at the same time services are provided, whether in-person or via telehealth. If via telehealth, consent can be obtained through any qualified health professional working within their scope.

Additionally, CMS allows beneficiary consent to be obtained by auxiliary staff working under the general supervision of the billing practitioner. Cost sharing may be reduced or waived by a physician or QHP.

For the purposes of treating suspected or confirmed COVID-19, monitoring for fewer than the required 16 days within a 30-day period is waived so long as the monitoring is not less than 2 days and meets all other billing code requirements.

The portion of the Annual Wellness Visit requirement for vital signs may be satisfied if the visit, when conducted via telehealth, meets all other billing code requirements. This means that the patient has access to the necessary equipment confirmed to self-report vital signs.

Any direct supervision requirements associated with "incident to" services may be met through virtual audio/video real-time communications technology.

References

- American Medical Association, CPT® 2021 Professional Edition
- CMS 2021 PFS Final Rule ([CMS-1734-F](#))
- [CMS COVID-19 FAQs on Medicare Fee-for-Service Billing](#)
- SMBP Coding <https://www.ama-assn.org/system/files/2020-06/smbp-cpt-coding.pdf>
- [CCHP RPM Medical Reimbursement](#)
- [CMS COVID-19 PHE Telehealth Service List](#)

In Medicare, a new patient is one that has not been seen within the past three years by a FQHC provider covered by Medicare (dentists would not count as they are non-covered). This definition differs from the traditional CPT definition of a new patient. FQHCs may choose to use a single definition.