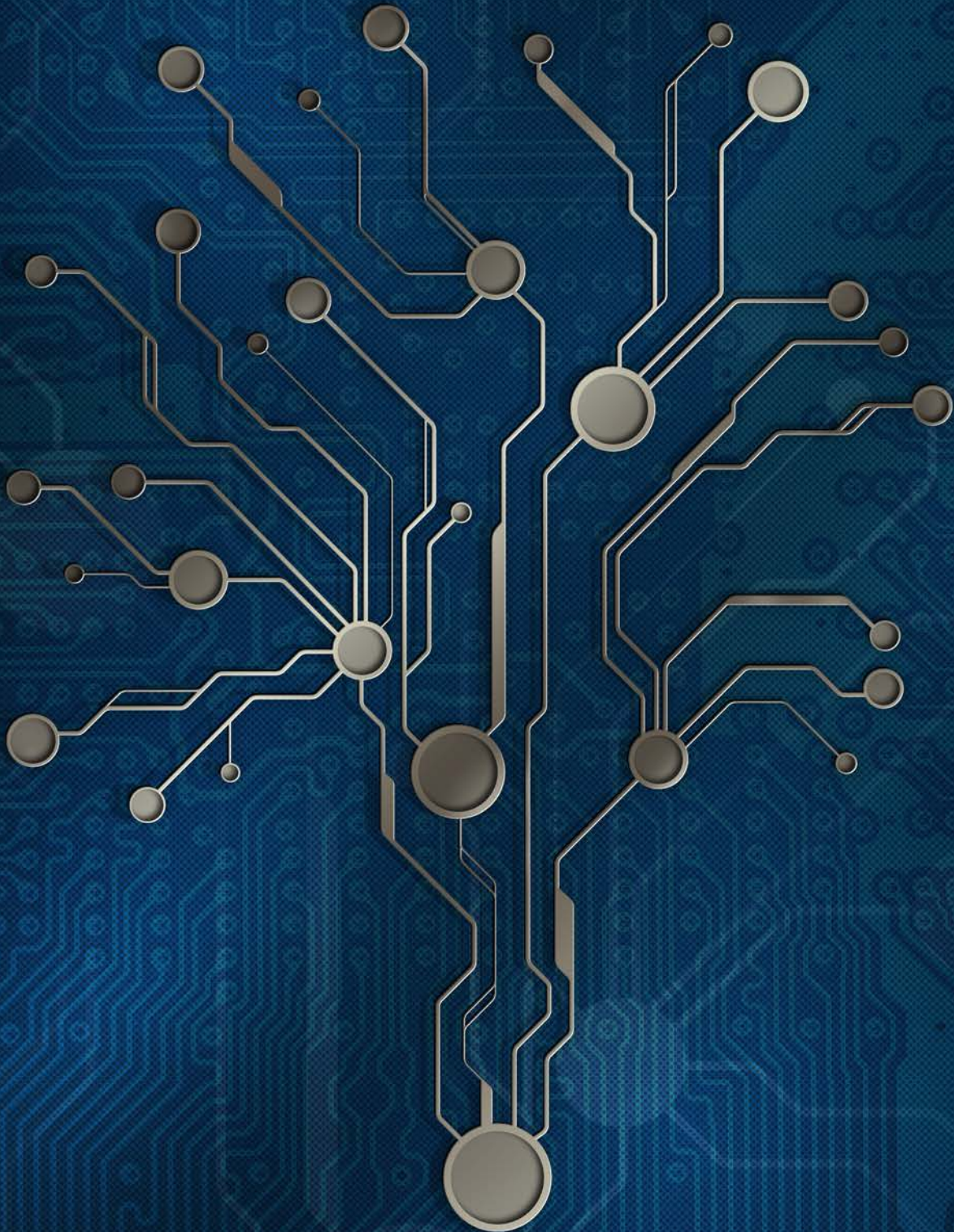


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Valuation of Remote Patient and Therapeutic Monitoring

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Overview

Remote patient (physiologic) monitoring (RPM) uses digital technology to capture and monitor certain patient physiologic data (e.g., heart rate, blood pressure, and blood sugar levels). This data is then “used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition.”¹ Medicare coverage for RPM in any form began in 2018 under a single Current Procedural Terminology (CPT) code. Since then, as discussed below, the number of RPM codes for which providers may be reimbursed has evolved and expanded.²

To fill in some of the “noteworthy gaps that exist in the current coverage and delivery of RPM” and “help patients experience more consistency and quality along the continuum of care, especially in the realm of chronic disease monitoring,”³ the Centers for Medicare & Medicaid Services (CMS) introduced remote therapeutic monitoring/treatment management (RTM).⁴ RTM “encompasses the collection and monitoring of therapy adherence and therapy response data along with treatment management services.”⁵ The concept was created in October 2020 by the CPT Editorial Panel.⁶

1 Nathaniel M. Lactman, Thomas B. Ferrante, and Rachel B. Goodman, “2021 Medicare Remote Patient Monitoring FAQs: CMS Issues Final Rule,” *Health Care Law Today* (blog), Foley & Lardner LLP, December 7, 2020, <https://www.foley.com/en/insights/publications/2020/12/2021-remote-patient-monitoring-cms-final-rule>.

2 Nathaniel M. Lactman, “Medicare Remote Patient Monitoring Reimbursement FAQs: Everything You Need to Know About Chronic Care Remote Physiologic Monitoring Codes,” *Health Care Law Today* (blog), Foley & Lardner LLP, November 2, 2018, <https://www.foley.com/en/insights/publications/2018/11/medicareremote-patient-monitoring-reimbursement-fa>.

3 Daniel Tashnek, JD, and Logan Lutton, “Remote Therapeutic Monitoring’s Debut: What You Should Know (for Now),” *Physicians Practice*, July 22, 2021, <https://www.physicianspractice.com/view/remote-therapeutic-monitoring-s-debut-what-you-should-know-for-now-?page=4>.

4 Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements, 86 Fed. Reg. 64996, 65114 (November 19, 2021), <https://www.federalregister.gov/documents/2021/11/19/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part>.

5 Carrie Nixon, “New Reimbursement for Remote Therapeutic Monitoring in the Final 2022 Medicare Physician Fee Schedule,” *Nixon Gwillt Law* (blog), November 3, 2021, <https://nixongwilltaw.com/nlg-blog/2021/11/3/new-reimbursement-for-remote-therapeutic-monitoring-in-the-final-2022-medicare-physician-fee-schedule> (internal quotations omitted).

6 “CPT® Editorial Summary of Panel Actions: October 2020,” American Medical Association, updated November 18, 2020, <https://www.ama-assn.org/system/files/2020-11/october-2020-summary-panel-actions.pdf>.

By promoting earlier identification and regular monitoring of health issues, reimbursing providers for RPM and RTM services is expected to improve patient outcomes and reduce overall health spending, especially for providers that participate in value-based reimbursement models. Additionally, RPM and RTM may improve data-driven clinical decision-making, allowing providers to construct personalized care plans to help achieve the best possible patient outcomes. Analyzing real-time data also allows providers to identify trends and adjust care plans proactively, which may result in shorter recovery times for patients and increased cost effectiveness. From the provider perspective, the use of RPM and RTM has been found to improve workflow efficiencies—e.g., by enhancing staff productivity and reducing administrative costs—which may lead to additional cost savings.

There are a number of similarities between RPM and RTM. For example, the two services are billed at the same general rates, as CMS has noted its intent to maintain payment parity between the two sets of codes.⁷ The CPT codes themselves generally mirror each other, but they differ in two notable ways: First, a greater number of provider types can order

and bill for RTM, including psychiatrists, physical therapists, occupational therapists, clinical psychologists, and dietitians.⁸ Second, RPM monitors physiologic data, such as heart rate, blood pressure, and blood sugar levels; RTM monitors non-physiologic health conditions, such as musculoskeletal system status, respiratory status, therapy/medication adherence, and therapy/medication response.⁹ RTM was created with the expectation that it would complement RPM.

Both RPM and RTM require the use of a device to collect and report nonphysiologic data. Those devices must be “medical devices” (rather than a general wellness device, such as an Apple Watch) as defined by the U.S. Food & Drug Administration (FDA).¹⁰ While RPM devices must automatically upload patient data,¹¹ RTM allows patients to self-report data, which may be gleaned from general wellness devices, provided the data is collected and submitted via software as a medical device (discussed further below), in addition to standalone peripheral devices.¹²

Table 1 provides examples of how RPM and RTM are used in practice.

Table 1: RPM and RTM Examples

| RPM Example | RTM Example |
|---|---|
| <p>“Ongoing measurement of blood sugar levels is advisable for people with diabetes (mainly those with type 1 diabetes) to detect noteworthy changes in blood sugar levels in near real-time and reveal sugar level highs and lows that fingerstick testing alone may not be able to identify. To perform ongoing measurement, patients are provided a continuous glucose monitoring system, often referred to as a CGM. To use a CGM, a small sensor is attached to the abdomen that includes a cannula which penetrates the skin and performs the ‘continuous measurement’ around the clock. ... The data captured is then sent to a device. If it’s a remote patient monitoring device, the equipment then transmits the information to the prescribing organization for review within the RPM system. ... [r]emote CGM provides endocrinologists with their patient’s blood sugar readings—and most importantly, any that raise red flags (i.e., glucose levels too high or low).”¹³</p> | <p>“An asthmatic patient is prescribed a rescue inhaler equipped with an FDA-approved medical device that monitors when the patient uses the inhaler, how many times during the day the patient uses the inhaler, how many puffs/doses the patient uses each time, and the pollen count and environmental factors that exist in the patient’s location at that time. This is non-physiologic data. The data is then used by the treating practitioner to assess the patient’s therapeutic response and adherence to the asthma treatment plan. This can enable the practitioner to better determine how well the patient is responding to the particular medication, what social or environmental factors affect the patient’s respiratory system status, and what changes could be made to improve the patient’s health.”¹⁴</p> |

7 Nixon, “New Reimbursement for Remote Therapeutic Monitoring.”
 8 Ibid.; Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements, 86 Fed. Reg. 64996, 65115 (November 19, 2021), <https://www.federalregister.gov/documents/2021/11/19/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part>.
 9 Ibid.
 10 Nixon, “New Reimbursement for Remote Therapeutic Monitoring.”
 11 Lacktman, Ferrante, and Goodman, “2021 Medicare Remote Patient Monitoring FAQs: CMS Issues Final Rule.”
 12 Nixon, “New Reimbursement for Remote Therapeutic Monitoring.”
 13 “A Comprehensive Guide to Remote Patient Monitoring,” Prevoounce, accessed September 20, 2022, <https://www.prevoounce.com/a-comprehensive-guide-to-remote-patient-monitoring>.
 14 Thomas B. Ferrante, Nathaniel M. Lacktman, and Rachel B. Goodman, “2022 Medicare Remote Therapeutic Monitoring FAQs: CMS Final Rule,” *Health Care Law Today* (blog), Foley & Lardner LLP, November 11, 2021, <https://www.foley.com/en/insights/publications/2021/11/2022-remote-therapeutic-monitoring-cms-final-rule>.

Reimbursement Environment

The U.S. government is the largest payer of medical costs, through Medicare and Medicaid, and has a strong influence on physician reimbursement. In 2020, Medicare and Medicaid accounted for an estimated \$829.5 billion and \$671.2 billion in healthcare spending, respectively.¹⁵ The prevalence of these public payers in the healthcare marketplace means they often act as price setters and are used as a benchmark for private reimbursement rates.¹⁶

Medicare pays for RPM and RTM through the Medicare Physician Fee Schedule (MPFS). MPFS payments are calculated according to Medicare's Resource Based Relative Value Scale (RBRVS) system, which is updated annually by CMS. The RBRVS system assigns relative value units (RVUs) to individual procedures based on the resources required to perform each procedure. Under this system, each procedure in the MPFS is assigned RVUs for three categories of resources:

1. The physician work (wRVU) component, which represents the physician's contribution of time and effort to the completion of a procedure. The higher the value of the code, the more skill, time, and work it takes to complete.
2. The practice expense (PE RVU) component, which is based on direct and indirect physician practice expenses involved in providing healthcare services. Direct expense categories include clinical labor, medical supplies, and medical equipment. Indirect expenses include administrative labor, office expenses, and all other expenses.
3. The malpractice expense (MP RVU) component, which corresponds to the relative malpractice practice expenses for medical procedures.¹⁷ These values typically are the smallest component of the RVU, and due to the variation in malpractice costs among states and specialties, must be weighted geographically and across specialties.¹⁸



Once a procedure's RVUs have been modified for geographic variance, they are summed, and the total is then multiplied by a conversion factor to obtain the dollar amount of governmental reimbursement for a given service.

RPM codes are classified as evaluation and management (E/M) services, which means that only physicians and nonphysician practitioners can bill for RPM. While RPM was initially introduced as a single CPT code (99091), there are currently five primary codes (see Table 2).¹⁹ Notably, two of these codes (99453 and 99454) are PE-only codes. Additionally, these two codes "can be billed by only one practitioner, only once per patient, per 30-day period, and only when at least 16 days of data have been collected."²⁰

Table 2 lists the primary RPM codes, but there are additional codes for more specific remote monitoring, such as continuous glucose monitoring (95250) and self-measured blood pressure monitoring (99473 and 99474).²¹

The 2022 MPFS introduced the five initial CPT codes for the reimbursement of RTM (see Table 3).²² Notably, three of these codes are PE-only codes, while two include professional work (wRVUs). Additionally, CPT codes 98975, 98976, and 98977 require the device to monitor at least 16 days' worth of data in each 30-day period.²³

15 "NHE Fact Sheet," Centers for Medicare & Medicaid Services, December 15, 2021, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>.

16 Anna Wilde Mathews and Tom McGinty, "Physician Panel Prescribes the Fees Paid by Medicare," *Wall Street Journal*, October 26, 2010, <https://www.wsj.com/articles/SB10001424052748704657304575540440173772102> (Accessed 8/16/22).

17 Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule, 75 Fed. Reg. 73169, 73208 (November 29, 2010), <https://www.federalregister.gov/documents/2010/11/29/2010-27969/medicare-program-payment-policies-under-the-physician-fee-schedule-and-other-revisions-to-part-b-for>.

18 Ibid.; "Introduction to Relative Value Units and How Medicare Reimbursement is Calculated," available at: https://labor.alaska.gov/wc/med-serv-comm/CMS_RVU_Calculations.pdf (Accessed 11/8/22).

19 "2022 Medicare Non-Facility Reimbursement for Care Management Services," Nixon Gwilt Law, accessed February 16, 2022, https://static1.squarespace.com/static/563c7acce4b028323896cb89/t/61efae41919a2427e0817691/1643097684198/Medicare+Non-Facility+Reimbursement+for++Mgmt+CPT+Codes+2022_NGL.pdf.

20 Nathaniel M. Lacktman, "CMS Revises 2021 Remote Patient Monitoring Rules, Issues Correction," *Health Care Law Today* (blog), Foley & Lardner LLP, January 25, 2021, <https://www.foley.com/en/insights/publications/2021/01/cms-revises-2021-remote-patient-monitoring-rules>.

21 Ibid.

22 "2022 Medicare Non-Facility Reimbursement for Care Management Services," Nixon Gwilt Law.

23 Ferrante, Lacktman, and Goodman, "2022 Medicare Remote Therapeutic Monitoring FAQs: CMS Final Rule."

Despite proposals to tweak the RTM codes in 2023 (in response to stakeholder comments and CMS concerns regarding who can perform certain codes), CMS ultimately decided not to make any changes, as it did not yet feel ready to do so. However, CMS’s commentary in the final rule indicates that substantive changes to RTM codes and requirements are imminent. The agency did clarify, though,

that any RTM service may be furnished under CMS’s general supervision requirements,²⁴ which will allow a greater number of nonphysician providers to help provide RTM, as requirements to directly supervise staff providing RTM care management services has overburdened billing clinicians.²⁵

Due to the relative newness of RPM and RTM, it is likely that CMS will continue to tweak the coverage of and payment for these services in the years to come.

Table 2: RPM Codes

| CPT Code | CPT Code Description | 2023 Non-Facility Reimbursement ²⁶ |
|----------|---|---|
| 99091 | Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient. | \$55.42 |
| 99453 | 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. | \$16.75 |
| 99454 | 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. | \$48.73 |
| 99457 | Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes. | \$30.46 |
| 99458 | Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes | \$30.46 |

Table 3: RTM Codes

| CPT Code | CPT Code Description | 2023 Non-Facility Reimbursement |
|----------|--|---------------------------------|
| 98975 | Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial setup and patient education on use of equipment. | \$17.20 |
| 98976 | Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days. | \$48.73 |
| 98977 | Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days. | \$48.73 |
| 98980 | Remote therapeutic monitoring treatment management services, physician/other qualified healthcare professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes—base code. | \$30.81 |
| 98981 | Remote therapeutic monitoring treatment management services, physician/other qualified healthcare professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional add-on code 20 minutes (list separately in addition to code for primary procedure). ²⁷ | \$30.92 |

24 In contrast to direct supervision, where the physician must be available to assist and direct during the procedure, general supervision only requires the physician to provide overall direction and control.

25 Kaitlyn O’Connor, Carrie Nixon, and Casey Papp, “Proposed Changes to Remote Therapeutic Monitoring Reimbursement in the Proposed 2023 Medicare Physician Fee Schedule,” *Nixon Gwilt Law* (blog), July 11, 2022, <https://nixongwiltlaw.com/hlg-blog/2022/7/11/proposed-changes-to-remote-therapeutic-monitoring-reimbursement-in-the-proposed-2023-medicare-physician-fee-schedule>.

26 Note that this reimbursement rate assumes the 4.48 percent cut to the Medicare Physician Fee Schedule goes into effect. At the time of publication, Congress was debating whether to intervene and provide additional funding to Medicare to reverse those payment cuts.

27 Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements, 86 Fed. Reg. 64996, 65114–65117 (November 19, 2021).

Regulatory Environment

Healthcare organizations face a range of federal and state legal and regulatory constraints, which affect their formation, operation, procedural coding and billing, and transactions. Fraud and abuse laws, specifically those related to the federal Anti-Kickback Statute (AKS) and the physician self-referral law (the “Stark Law”), may have the greatest impact on providers’ operations.

Enacted in 1972, the AKS makes it a felony for any person to “knowingly and willfully” solicit or receive, or to offer or pay, any “remuneration,” directly or indirectly, in exchange for the referral of a patient for a healthcare service paid for by a federal healthcare program. Violations of the AKS are punishable by up to five years in prison, criminal fines and civil monetary penalties, and/or potential exclusion from the Medicare and Medicaid programs.²⁸ Due to the broad nature of the AKS, legitimate business arrangements may appear to be prohibited. In response to these concerns, Congress created a number of statutory exceptions and delegated authority to the U.S. Department of Health & Human Services (HHS) to protect certain business arrangements by means of promulgating several safe harbors. These safe harbors set out regulatory criteria that, if met, shield an arrangement from regulatory liability and are meant to protect transactional arrangements unlikely to result in fraud or abuse. However, failure to meet all of the requirements of a safe harbor does not necessarily render an arrangement illegal.

The Stark Law prohibits physicians from referring Medicare patients to entities with which the physician or their family members have a financial relationship, for the provision of designated health services (DHS). DHS include, but are not limited to:

1. Certain therapy services, such as physical therapy
2. Radiology and certain other imaging services
3. Radiation therapy services and supplies
4. Durable medical equipment
5. Outpatient prescription drugs
6. Inpatient and outpatient hospital services²⁹

Under the Stark Law, financial relationships include:

- Ownership interests in an entity that provides DHS—through equity, debt, or other means—including interests in entities that have an ownership interest in an entity that provides DHS³⁰
- Compensation arrangements, which are defined as arrangements between physicians and entities involving any remuneration, directly or indirectly, in cash or in kind³¹

Notably, the Stark Law provides exceptions for a number of ownership interests, compensation arrangements, and forms of remuneration.³² Similar to the AKS safe harbors, without these exceptions, the Stark Law would prohibit legitimate business arrangements. However, unlike the AKS safe harbors, an arrangement must fall within one of the exceptions to be legally permissible under the Stark Law.³³

In December 2020, the HHS Office of Inspector General (OIG) and CMS released revised AKS and Stark Law regulations establishing new safe harbors/exceptions and revising existing safe harbors/exceptions.³⁴

Notably, violation of either the AKS or Stark Law is sufficient to state a claim under the False Claims Act, which prohibits individuals from knowingly submitting false claims to the government. The act allows private citizens to file “qui tam” suits on behalf of the federal government.

Technological Environment

The Food, Drug, and Cosmetics Act (FD&C Act) requires that a medical device be used in both RPM and RTM. The act defines “device” as:

An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is ... intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man.”³⁵

28 Criminal Penalties for Acts Involving Federal Health Care Programs, 42 U.S.C. § 1320a-7b(b)(1); Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, § 2, 101 Stat. 680, 680–681 (1987).

29 Limitation on Certain Physician Referrals, 42 U.S.C. § 1395nn(a)(1)(B); Definitions, 42 C.F.R. § 411.351 (2014). Note the distinction in 42 C.F.R. § 411.351 regarding what services are included as DHS: “Except as otherwise noted in this subpart, the term ‘designated health services’ or DHS means only DHS payable, in whole or in part, by Medicare. DHS do not include services that are reimbursed by Medicare as part of a composite rate (for example, SNF Part A payments or ASC services identified at § 416.164(a)), except to the extent that services listed in paragraphs (1)(i) through (1)(x) of this definition are themselves payable through a composite rate (for example, all services provided as home health services or inpatient and outpatient hospital services are DHS).”

30 Limitation on Certain Physician Referrals,” 42 U.S.C. §1395nn(a)(2).

31 *Ibid.*, §1395nn(h)(1).

32 *Ibid.*, §1395nn.

33 Linda A. Baumann, ed., *Health Care Fraud and Abuse: Practical Perspectives* (Washington, DC: BNA Books, 2002), 106.

34 Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements, 85 Fed. Reg. 77684, 77814–77815 (December 2, 2020), <https://www.federalregister.gov/documents/2020/12/02/2020-26072/medicare-and-state-health-care-programs-fraud-and-abuse-revisions-to-safe-harbors-under-the>.

35 Definitions; generally, 21 U.S.C. § 321(h).

Table 4 shows some examples of devices that may be used in RPM and RTM.

Table 4: Devices Used in RPM and RTM

| RPM Example | RTM Example |
|--|---|
| <ul style="list-style-type: none"> • A blood pressure monitor worn on a patient’s wrist that allows clinicians to virtually monitor and treat hypertension and high blood pressure. • A digital scale that can transfer information to the clinician every time the patient steps on it, allowing clinicians to track a patient’s weight, e.g., to monitor congestive heart failure. • A remote spirometer that allows clinicians to track a patient’s volume/flow of patient inhales/exhales, e.g., to monitor lung conditions such as COPD and asthma.³⁶ | <ul style="list-style-type: none"> • A sensor that attaches to an inhaler and sends information regarding where the inhaler is used (and links it to weather and air quality in the patient’s area) and how often it is used (i.e., medication adherence).³⁷ • A smart pill dispenser, which sends information regarding what drugs are dispensed and when (i.e., medication adherence). • A smart-sensor shoe insole that tracks the temperature, inflammation levels, and pressure being applied to a diabetic patient’s ulceration.³⁸ |

Software as a medical device (SaMD) is defined in the same way as a medical device, except that the software (rather than the physical hardware) is performing that function. Further, the software can be used without being part of a hardware medical device.³⁹ Some examples of this are “software that allows a smartphone to view images obtained from a magnetic resonance imaging (MRI) medical device for diagnostic purposes” and “Computer-Aided Detection (CAD) software that performs image post-processing to help detect breast cancer.”⁴⁰ In the RTM space, SaMD is likely the pathway through which patients will self-report data, such as pain levels and medication adherence.⁴¹

Valuation of RPM and RTM

Healthcare organizations and providers are increasingly seeking partnerships (often with healthcare tech companies that have developed an RPM/RTM medical device) to facilitate their provision of RPM and RTM services to eligible patients. Because only a licensed healthcare provider can bill for RPM and RTM services, these arrangements often involve the provider compensating the device manufacturer for the devices used to perform the RPM and RTM services. Such an arrangement can be beneficial to both the seller (device manufacturer) and the buyer (healthcare provider), as the seller would realize compensation from the provision of services and the buyer may experience increased patient volume, reduced

administrative/clinical burden (by not having to provide the services themselves), and reduced costs (by avoiding adverse effects from issues such as medication nonadherence).

While the objective and purpose of the subject engagement, the standard of value, and the availability and reliability of data must all be considered in the selection of applicable valuation approaches and methods, RPM/RTM-related compensation arrangements tend to lend themselves to the employment of the RBRVS method, which combines elements of the income and market approaches. The RBRVS method values services (both professional clinical and practice overhead) according to Medicare’s RBRVS (discussed above) that is used to calculate the amount Medicare pays for each practice procedure or service. The employed RBRVS method is derived from CMS’s reimbursement methodology that quantifies the amount intended to be paid, in part, for the RPM/RTM service(s) provided.

Because most other payers generally set their target reimbursement for each procedure as a percentage above, or below, that of Medicare, the RVU weights establish the relative proportion of the reimbursement for each practice service that is intended to pay for (1) the provider compensation and benefit costs to provide the service (i.e., wRVU), (2) the cost of its associated malpractice insurance (MP RVU), and (3) the practice expense, as well as other practice overhead

36 “A Comprehensive Guide to Remote Patient Monitoring,” Prevueance.
 37 Propeller, <https://propellerhealth.com/>.
 38 Orpyx SI Sensory Insoles, <https://www.orpyx.com/>.
 39 “Software as a Medical Device (SaMD),” U.S. Food & Drug Administration, December 4, 2018, <https://www.fda.gov/medical-devices/digital-health-center-excellence/software-medical-device-samd>.
 40 “What are Examples of Software as a Medical Device?,” U.S. Food & Drug Administration, December 6, 2017, <https://www.fda.gov/medical-devices/software-medical-device-samd/what-are-examples-software-medical-device>.
 41 Gerald Buggs, MSJ, “CMS Finalizes New Remote Therapeutic Monitoring Codes,” Health Recovery Solutions, accessed February 23, 2022, [https://www.healthrecoveryolutions.com/blog/cms-finalizes-new-remote-therapeutic-monitoring-codes#:~:text=Remote%20Therapeutic%20Monitoring%20\(RTM\)%20Codes&text=The%20submission%20of%20self%20reported,transmitted%20through%20existing%20hardware%20devices](https://www.healthrecoveryolutions.com/blog/cms-finalizes-new-remote-therapeutic-monitoring-codes#:~:text=Remote%20Therapeutic%20Monitoring%20(RTM)%20Codes&text=The%20submission%20of%20self%20reported,transmitted%20through%20existing%20hardware%20devices).



resources/costs, required to provide the service (PE RVU), including the medical device used to collect and report the nonphysiologic data for provider interpretation.

Under the RBRVS method, the various RPM/RTM services contributed by each party (provider, device manufacturer, etc.) may be determined, and the resulting economic benefit of those services may be allocated using the RVU weights of those services. As noted above, depending on the specific facts and circumstances surrounding the transaction, the reimbursement may need to be adjusted according to the patient-payer mix.

Conclusion

The market for RPM and RTM may experience growing demand in the coming years, due to an aging U.S. population and the growing prevalence of the chronic conditions RPM and RTM are designed to treat. These factors may increase

the number of individuals who are candidates for these services. In most industries, such demand may lead to rising prices. However, in the healthcare industry, the federal government has some power to set prices through Medicare and Medicaid. Because the CPT codes for RPM and RTM have only recently become effective, issues will likely arise in the near term that cause CMS to revise the payment amounts or billing requirements. In spite of (or perhaps because of) the nascency of RPM/RTM and the uncertainty surrounding how these services may be reimbursed in the future, as well as the regulatory scrutiny surrounding compensation arrangements between healthcare providers and third parties, RPM/RTM services present an opportunity for healthcare valuation professionals who can develop and prepare fair market value opinions related to these arrangements to satisfy federal and state healthcare laws. **VE**



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