VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERIVCES (DMAS)
REMOTE PATIENT MONITORING (RPM)
DMAS SERVICE AUTHORIZATION CRITERIA (Form DMAS-P268)

The following criteria, in addition to patient/provider demographic data and any supporting documentation specified below, must be submitted to the DMAS service authorization contractor by direct data entry (DDE) via their provider portal. Submissions should be made at least 30 days prior to the scheduled date of authorization or reauthorization of services to avoid delays in care. See Appendix D of the *Physician/Practitioner* manual for details on the current service authorization contractor and accessing the provider portal. Final approval is contingent upon member and provider eligibility/enrollment edits. The Service Authorization (SRV AUTH) number will be made available to providers by the service authorization provider portal.

SECTION I: AUTHORIZATION CRITERIA

1. **Providers must select the RPM service CPT/HCPCS codes they propose to bill, and whose conditions they attest to satisfying if billed for. Please see the DMAS Physician/Practitioner Manual: *Supplement – Telehealth Services* for more detailed guidance around coverage and billing guidelines of RPM services.**

	CPT/HCPCS Code	Short Description	Notable Billing Criteria[a]
Device Setup/Education *(may not select more than 1 of the following)*			• Data must be monitored for a minimum of 16 days in a 30-day period • Devices must not have been supplied by patients, or previously supplied by Medicaid (i.e. as durable medical equipment) • Providers must only bill when there are not more specific codes available (including, but not limited to: 93296, 93264, 94760)
•	99453[1,4]	**Physiologic** monitoring device	
•	98975[1]	**Therapeutic** monitoring device	
Device Supply *(may not select more than 1 of the following; if also seeking authorization for 99453, may only select 99454; if also seeking authorization for 98975, may only select 98976 or 98977)*			
•	99454[2,4]	**Physiologic** monitoring device	
•	98976[2]	**Respiratory system** monitoring device	
•	98977[2]	**Musculoskeletal system** monitoring device	
Collection, Interpretation & Treatment Management Services *(may select more than one "Physiologic" or "Therapeutic" codes, but may not select a combination of "Physiologic" AND "Therapeutic" codes; may only select 99458 if also selecting 99457; may only select 98981 if also selecting 98980; it is not required to select "Device Setup/Education" or "Device Supply" codes in order to select and bill "Collection, Interpretation & Treatment Management Services codes")*			• Services counted toward time requirements for these codes must not be used to satisfy time or management requirements for any other billed service. Services performed on the day an E&M service is provided to the patient must not be used to satisfy RPM time or management requirements.
•	99457[2], 99458[3], 99091[2]	**Physiologic** monitoring services	
•	98980[2], 98981[3]	**Therapeutic** monitoring services	
Self-Measured Blood Pressure *(may not select any other if selecting a code(s) from this section; may select one of the following OR both)*			• Services counted toward time requirements for these codes must not be used to satisfy time or management requirements for any other billed service.
•	99473[1]	Education/training	
•	99474[2]	Review, interpretation, management	

a. Billing criteria include, but are not limited to, those criteria summarized in this table. See Supplement – Telehealth Services of the DMAS Physician/Practitioner Manual for details.

*1: May only be billed **once per set of authorized RPM services**; not eligible for coverage via reauthorization. Authorization date span of 3 months from the start of care date.*

*2: May only be billed **once per provider per month** for authorized RPM services, with the maximum number of authorizable uses equaling the number of months authorization is available (e.g., max of 6, pending the indication).*

*3: Add-on codes (i.e. 99458, 98981) will be authorized for up to **2 units per provider per month**, and shall only be billed when add-on code time requirements are met. The maximum number of authorizable uses equals the number of months authorization is available for multiplied by 2 (e.g., max of 12, pending the indication).*

4: Devices must automatically digitally collect (i.e., not self-recorded or reported by patients), upload and transmit either daily recordings of the beneficiary's physiologic data OR an alert if the beneficiary's values fall outside predetermined parameters

2. **Providers must identify the population (i.e. A-E), with its assigned authorization duration, the member satisfies all of the associated criteria for (select one):**
   - **A. Medically complex patient under 21 years of age | 6 month authorization**
     - Member less than 21 years of age at the time services are applied for AND has at least one of the following conditions:
       - Congenital disease; OR
       - Chronic lung disease with oxygen dependence; OR
       - Invasive or non-invasive ventilation for 16+ hours per day; OR
       - Premature birth AND under 1 year of age; OR
       - Diagnosis requiring NICU admission in the last 1 month; OR
       - Cystic fibrosis with at least one hospitalization in the prior 12 months; OR
       - Enrolled in hospice care
   - **B. Transplant patient | 6 month authorization**
     - Member actively listed for organ transplant for at least one of the following; OR
       - Kidney
       - Liver
       - Heart
       - Lung
       - Bone marrow
       - Small bowel
       - Stem cell
       - Pancreas transplantation
       - CAR-T cell therapy
     - Member is status-post transplantation of one of the conditions listed above in the last 6 months.
   - **C. Post-surgical patient | up to 3 month authorization**
     - Member has completed one of the following procedures in the last month:
       - Lower extremity total joint replacement
       - Cardiac surgery
       - Major vascular surgery
   - **D. Patient with a chronic health condition AND who has had 2+ hospitalizations, OR ED visits, related to the chronic health condition in the previous 12 months | 6 month authorization**
     - Member's qualifying hospitalizations, or ED visits, are associated with at least one of the following:
       - COPD
       - Asthma
       - Heart failure
       - Diabetes
       - Chronic pain
       - Stroke or TIA
       - End-stage renal disease on dialysis (hemodialysis or peritoneal)
       - Hypertension
       - Depression
   - **E. High-risk pregnant patient | 6 month authorization**
     - Resides in a primary care or mental health health professional shortage area (HPSA) as identified by HRSA; OR
     - Has at least one of the following qualifying diagnosis; OR
       - Pregestational/gestational hypertension
       - Pregestational/gestational diabetes
       - Chronic kidney disease
       - Heart disease
       - Fetal IUGR
       - Fetal anomalies
       - Fetal anemia
       - Maternal lupus
       - Maternal substance abuse
       - In-vitro fertilization
       - Maternal sickle cell disease
       - Postpartum depression
       - Peripartum cardiomyopathy (PPCM)
       - Multiple pregnancy
     - Has a history of one of the following qualifying diagnoses:
       - Preeclampsia
       - Gestational hypertension
       - Gestational diabetes

- **F. ADDITIONAL SCENARIOS**: Remote patient monitoring (RPM) services can also be covered for patients who fall under one of the 5 clinical populations outlined above (A-E), but who do not meet the pre-specified criteria listed for that population above, when all of the following criteria are met:
    - Patient falls under one of the 5 clinical populations: "Please explain why the patient might be considered a [name of the clinical population from Question 2 the provider believes the patient is eligible for RPM under]." *(text box provided in provider portal)*
    - Patient is at high risk for adverse health outcomes or high-acuity healthcare utilization: "Please explain why the patient might be considered to be at high risk for adverse health outcomes or high-acuity healthcare utilization." *(text box provided in provider portal)*
    - Peer-reviewed literature suggests RPM is likely to improve health outcomes or cost-effectiveness of care for the patient: "Please: 1) explain what patient data you intend to monitor, 2) explain how it will change your management of the patient, and 3) provide a citation from the peer-reviewed literature supporting the anticipated efficacy of your strategy at improving health outcomes or cost-effectiveness of care for your patient." *(text box provided in provider portal)*

Additionally, providers must be able to attest to the following conditions to the best of the provider's knowledge:

3. **The patient is an established patient. (Y/N)**
4. **The patient, or caregiver, has the ability to utilize the monitoring equipment and has stated a willingness to do so at the requested frequency. (Y/N)**
5. **RPM is expected to directly inform the active management of your patient. (Y/N)**
6. **The patient is not residing in a hospital, nursing facility, or other medical or psychiatric institution. (Y/N)**
7. **The patient is not having the same, or equivalent, data remotely monitored by another provider. (Y/N)**

SECTION II: REAUTHORIZATION CRITERIA

In addition to completing and satisfying all criteria in SECTION I above, providers must address all of the following when they have delivered RPM service to the member at any point in time in the last 12 months:

8. **Which reauthorization-eligible indication does the patient currently meet (same as the indication selected in Question 2):**
    - Medically complex and under 21 years of age | **6 months**
    - Transplant patient (member actively listed for organ transplant or status-post transplant) | **6 months**
    - Patient with a chronic health condition who has had 2+ hospitalizations or ED visits related to such chronic health condition in the previous 12 months | **6 months**
    - High-risk pregnant patient | **6 months** (*only eligible for one reauthorization*)
9. **Has the patient been adherent to previously authorized RPM services, defined as appropriate data collection on at least 16 of 30 days? (Y/N)**
10. **Has the patient been adherent to the treatment plan informed by RPM services? (Y/N)**
11. **If NO to question 10 OR 11, why do you believe the patient will now be adherent to monitoring and treatment expectations?** *(text box provided in provider portal)*