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Medical assistants' role in remote physiologic monitoring services

In past issues of *CMA Today*[1,2], I have argued that appropriately educated and credentialed medical assistants such as CMAs (AAMA)® meet the criteria for *clinical staff* for several well-known and new programs:

- Medicare Chronic Care Management (CCM) and Transitional Care Management (TCM) programs
- Medicare appropriate use criteria program for advanced diagnostic imaging services

But what about other services, like remote physiologic monitoring (RPM) services?

In September 2018, the CPT Editorial Panel revised the Current Procedural Terminology (CPT) code structure and descriptor for CPT code 99457, which became effective January 1, 2020, as follows:

> Chronic care remote physiologic monitoring (RPM) services involve the collection, analysis, and interpretation of digitally collected physiologic data, followed by the development of a treatment plan, and the managing of a patient under the treatment plan. The current CPT code 99457 is a treatment management code, billable after 20 minutes or more of clinical staff/physician/other qualified professional time with a patient in a calendar month. …
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> [A new code descriptor that will be effective in 2020 is for] CPT code 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)*.[3]

In 2019, the Centers for Medicare & Medicaid Services (CMS) proposed that RPM services reported with CPT code 99457 may be furnished under general supervision—rather than direct supervision—and included as designated care management services.[3]

With these changes in mind, health care providers and other professionals may have questions, like the following sent to me via email (November 2019), about how to bill for RPM services:

> After reading your article [on the role of medical assistants in CCM and TCM programs,[1] I see that] there is congruence between the way CMS has allowed medical assistants to administer the CCM services and the way RPM is presented to be administered and billed.
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> … Is the patient's physician (who is also generally supervising the [medical assistants] who are working off-site and in our offices [and] utilizing our software and communication channels to administer the service) permitted to bill "incident to" for the RPM CPT code 99457?

To address this question, first note the following from CMS on designated care management services:

> Designated care management services can be furnished under general supervision. Section 410.26(b)(5) of our regulations states that designated care management services can be furnished under the general supervision of the "physician or other qualified health care professional (who is qualified by education, training, licensure/regulation and facility privileging)" … when these services or supplies are provided incident to the services of a physician or other qualified healthcare professional. The physician or other qualified healthcare professional supervising the auxiliary personnel need not be the same individual treating the patient more broadly. However, only the supervising physician or other qualified healthcare professional may bill Medicare for [incident-to] services.[3]

So, what would be the medical assistants' role within RPM services? The question submitter provided the following background

on RPM services and an additional query about medical assistants' scope of practice:

> There are two roles that manage patients in RPM [programs]:
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> The **care provider** ([e.g.,] the patient's physician) sets the treatment plan for the patient, including the goals (e.g., reduce body weight by 5% over the next three months or maintain blood glucose levels between 110 and 115 over the next six months), and provides general supervision when the patients require it. The care provider may receive escalated issues, such as high-risk alerts, from the second role.
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> [The] **care coordinator** … is the first clinician to monitor and oversee the patient's progress and needs in the RPM program. They will send information relevant to the patient's conditions, questions, and the data received from the patient. Data received is in the form of (1) physiological health data (e.g., [blood pressure], blood glucose readings, heart rate, weight), (2) answers to questions (e.g., How are you feeling? Do you feel dizzy? What makes you feel dizzy?), and (3) direct communications sent to the clinician team by the patient through the RPM software.
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> [The care coordinator] is the role we're seeking to fill [with] a medical assistant.
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> The care coordinator would *not* diagnose or clinically assess the patient outside of providing general coaching and guidance to the patient in order to help them receive education, tips, and better disease management information. The software systems are designed and developed by designated physicians to send alerts back to the care coordinator. The alerts are preprogrammed and not determined to be above or below normal levels. The care coordinator intervenes to help the patient. Examples of interventions include:
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> - Calling the patient's provider
> - Sending the patient a relevant video, such as on managing diabetes
> - Providing emotional support
> - Discussing the patient's need to limit sugar
> - Calling the patient's registered nurse to discuss biometrics that were out of range

Several of my general legal principles may be used to serve as guidance when determining the legal scope of practice for medical assistants; I have emphasized a key point:

- It is not permissible for medical assistants to be delegated and to perform any tasks that constitute the practice of medicine or require the knowledge and skill of a physician or another provider.
- It is not permissible for medical assistants to perform tasks that are restricted in state law to other health professionals—often licensed health professionals (e.g., acupuncturist, physical therapist).
- It is not permissible for medical assistants to perform tasks that *require the exercise of independent clinical judgment and/or the making of clinical assessments, evaluations, or interpretations.*

It is my legal opinion that, if medical assistants functioning as care coordinators "would *not* diagnose or clinically assess the patient outside of providing general coaching and guidance to the patient in order to help them receive education, tips, and better disease management information," it is legally permissible for knowledgeable and competent medical assistants to function in this role. *(I discuss how medical assistants are ideal candidates for patient care coordinators in my Public Affairs article of the May/June 2016* CMA Today[4]*.)*

Moreover, there is a distinction to be made between *triage* and *non-triage communication* that illuminates what can be permissible to assign to medical assistants.

I define *triage* as a communication process with a patient (or patient representative) during which a health care professional is required to exercise independent clinical judgment and/or to make clinical assessments or evaluations. It is my legal opinion that *it is not permissible* for medical assistants to be delegated triage (as I define the term).

I define *non-triage communication* as a process during which a non-provider health care professional follows provider-approved protocols or decision trees in verbatim-receiving and verbatim-conveying of information. In non-triage communication, the health professional does *not* exercise independent clinical judgment. It is my legal opinion that *it is permissible* for knowledgeable and competent unlicensed professionals such as medical assistants to be delegated non-triage communication.

My legal opinion is that it is permissible for providers to delegate the presenting of patient education to knowledgeable and competent unlicensed professionals such as medical assistants working under their authority and direction in outpatient settings as long as (a) the content of such education has been approved by the delegating provider and (b) the medical assistant is not permitted to exercise independent clinical judgment or to make clinical assessments or evaluations during the education process.

Finally, I recommend asking a malpractice insurance carrier for a written opinion about whether it would cover any negligence by a medical assistant in functioning in this role. ✦

Questions may be directed to CEO and Legal Counsel Donald A. Balasa, JD, MBA, at dbalasa@aama-ntl.org or 800/228-2262.

References

1. Balasa DA. Medicare CCM and TCM programs: defining medical assistants' roles and services. *CMA Today*. 2018;51(2). https://www.aama-ntl.org/cma-today/archives/article?id=4a58db4a-4840-6a90-a81c-ff00003b2c18#.WpbWt-jwaUk/. Accessed February 18, 2020.
2. Balasa DA. Appropriate use criteria program: CMAs (AAMA) meet *clinical staff* criteria under the CMS rule. *CMA Today*. 2019;52(5). https://www.aama-ntl.org/cma-today/archives/article?id=228fde4a-4840-6a90-a81c-ff00003b2c18. Accessed February 18, 2020.
3. Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; […]. *Fed Regist*. 2019;84(157):40555-40556. To be codified at 42 CFR §403, 410, 414, et al.
4. Balasa DA. One credential, many roles: why CMAs (AAMA) are uniquely qualified for advanced positions. *CMA Today.* 2016;49(3). https://www.aama-ntl.org/cma-today/archives/article?id=80acd74a-4840-6a90-a81c-ff00003b2c18. Accessed February 18, 2020.