

NC AHEC

**RECRUIT
TRAIN
RETAIN**

About NC AHEC

The North Carolina Area Health Education Centers Program was established in 1972 to recruit, train and retain the state's health workforce needs.

NC AHEC's Program Office, nine regional centers, and the Duke AHEC Program provide educational programs and services that bridge academic institutions and communities to improve the health of the people of North Carolina with a focus on underserved populations.

Health Careers & Workforce Diversity

Student & Preceptor Services

Graduate Medical Education Services

Continuing Professional Development

Practice Support

Library Services

AHEC Practice Support

- **The aim is to help practices thrive with value-based care across their entire patient panel including Medicaid, Medicare and all other payors.**
- **This service is offered at no cost via a team of 42 practice support coaches located at 9 regional AHEC centers across North Carolina.**
- **Our coaches work 1:1 with independent primary care practices and specialists, FQHCs, rural health centers, health departments with primary care services, behavioral health providers and some health system primary care/specialist practices.**

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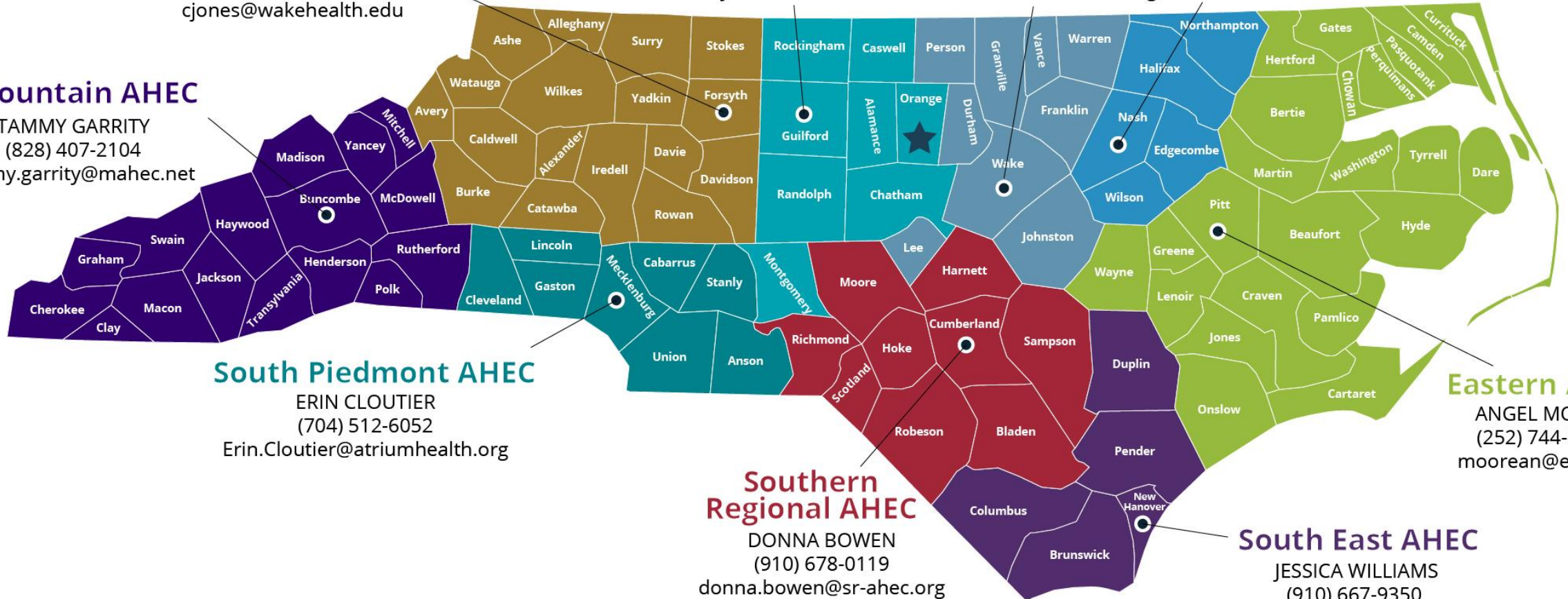
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Practice Support Services

Quality & Health Equity Improvement (Medicaid, Medicare QPP/MIPS, All Payors)

Medicaid managed care education & issue resolution

Clinical workflow redesign & process improvement

Behavioral health integration (including Collaborative Care Model)

COVID19 vaccine & clinical workflow assistance

Practice operational assessments

EHR optimization, telehealth integration

HIE training and optimization

Revenue cycle management & billing/coding guidance

MOC-IV Credit for Clinicians Involved in Quality Improvement

Advanced Medical Home (AMH) tier education and support

Tailored Care Management (AMH+/CMA) support

Community Health Worker integration and training

Social Drivers of Health Workflow, Healthy Opportunities & NCCARE 360 Optimization

Practice Manager Academy & Specialty Learning Collaboratives

Today's Agenda



- What is Remote Patient Monitoring?
- Why Remote Patient Monitoring?
- How
 - Best Practices
 - Devices
 - Billing and Coding
 - Case Example
 - Staff Roles
 - Workflows
- Challenges
- Resources
- *Note
 - We will specifically talk about Medicare/Medicaid implementation.
 - If you have commercial payor questions, please put into chat for follow up.
 - If you have specific optimization questions, please put into chat for follow up.

What is Remote Patient Monitoring (RPM)?



- Use of connected devices to collect and transmit health data from patients to providers.
- Monitors metrics like BP, glucose, weight, and oxygen levels.
- Enables proactive and personalized care.

Common Uses of RPM	RPM Technology Tools
High Blood Pressure	Weight Scales
Diabetes	Pulse Oximeters
Weight Loss or Gain	Blood Glucose Meters
Heart Conditions	Blood Pressure Monitors
Chronic Obstructive Pulmonary Disease	Heart Monitors
Sleep Apnea	Fetal Monitors
Asthma	Apnea Monitors
	Breathing Apparatuses

Why RPM Matters in FQHCs?

- Supports underserved patients between visits.
- Improves [chronic condition management](#) and [reduces ER visits](#).
- Aligns with UDS quality measures and care coordination.

UDS Measure	RPM Support	CMS ID & Measure Details	Example RPM Devices
Controlling High Blood Pressure	Enables regular BP monitoring and early intervention.	CMS165v11 Details	Bluetooth or cellular blood pressure cuffs (e.g., Omron, Withings)
Diabetes: Hemoglobin A1c Poor Control (>9%)	Facilitates real-time glucose monitoring and medication adjustment.	CMS122v11 Details	Connected glucometers (e.g., Dexcom G6, OneTouch Verio Flex)
Weight Assessment and Counseling (Children/Adolescents)	Tracks weight and physical activity, enabling personalized counseling.	CMS155v11 Details	Digital scales, wearable activity trackers (e.g., Fitbit, Garmin)
Tobacco Use Screening and Cessation	Delivers reminders and coaching for cessation plans.	CMS138v11 Details	Mobile apps or text-based platforms for smoking cessation tracking
Depression Screening and Follow-Up	Facilitates mood check-ins and ensures follow-up after screening.	CMS2v11 Details	Tablet-based or app-based mood tracking tools (e.g., PHQ-9 check-ins)
Colorectal Cancer Screening	Delivers reminders and education for at-home screening completion.	CMS130v11 Details	Patient portal or app delivering FIT/Cologuard reminders and education

Best Practices for RPM in FQHCs



- Start with high-need populations (e.g., diabetes, hypertension).
- Use cellular devices to bypass Wi-Fi needs.
- Integrate RPM into care management workflows.
- Assign dedicated RPM staff and document in EHR.
- FQHC Examples:
 - [Case Study How Federally-Qualified Health Center STRIDE Community Health Center Prepared for the Shift to Value-Based Care by Increasing Engagement & Improving Outcomes Among Medicaid Patients](#)
 - [Federally qualified health center patients' experiences with remote patient monitoring as part of telehealth services for self-measured blood pressure monitoring](#)

RPM Devices Used in FQHCs



- Wearables and connected data hubs.
- Bluetooth or cellular BP monitors and glucometers.

Device	Function	Examples
Continuous Glucose Monitors (CGM)	Tracks blood glucose levels continuously	Dexcom G6/G7, Abbott FreeStyle Libre
Ambulatory Blood Pressure Monitors	Measures blood pressure over 24+ hours	Omron Evolv, Withings BPM Connect
Pulse Oximeters (Wearable)	Monitors oxygen saturation and heart rate	Masimo MightySat, Wellue O2Ring
Wearable ECG Monitors	Detects arrhythmias, AFib, heart rate	Zio Patch (iRhythm), KardiaMobile, QardioCore
Smart Patches	Tracks vitals (temp, HR, respiration) via skin adhesion	BioIntelliSense BioSticker, VitalConnect VitalPatch
Smart Watches (clinical)	Health tracking with clinical dashboards	Withings ScanWatch, Fitbit Sense (FDA cleared ECG)

Medicare & NC Medicaid Coverage for RPM



- As of April 1, 2025, [CMS Guide](#) (pages 9-11)
 - Medicare and Medicaid: As of January 1, 2025, FQHCs DO NOT use G0511 (General Care Management) to bill RPM. Must bill with the individual codes.
 - *Note: G0511 can be used until [September 30, 2025](#) (Under Care Coordination Link) ALSO Under [Chapter 13 230](#)
- Bill standard RPM CPT codes (99453–99458) directly.
 - 99453- initial RPM counseling.
 - 99454- 20 minutes minute review of RMP data of at least 16 time in 30-day period.
 - 99457- patient counseling of RPM data (in-person OR telehealth with audio and video).
 - 99458(add on code)- minute 21 and above for RMP patient counseling of RPM data.

Medicare Coverage for RPM



- [MLN901705 - Telehealth & Remote Patient Monitoring](#) (Page 11)
- File with usual place of service code.
- Confirm current billing and cost policies per payer.

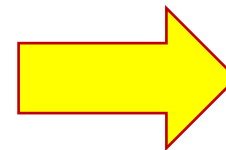
RPM CPT and HCPCS Codes

CPT/HCPCS Code	Description	Time	Audio-only coverage
99091	Monthly review of data	30 minutes	N/A
99453	Initial setup and monitoring	N/A	N/A
99454	Monthly review of RPM data	16 or more days over a 30-day period	N/A
99457	Patient-provider communication related to RPM data	20 minutes	Yes
99458	Patient-provider communication related to RPM data	Additional 20 minutes	Yes
98975	RTM device setup and patient education	N/A	N/A
98976	RTM monitoring, respiratory	16 or more days over a 30-day period	N/A
98977	RTM monitoring, musculoskeletal	16 or more days over a 30-day period	N/A
98980	Patient-provider communication related to therapeutic device	20 minutes	Yes
98981	Additional time required for 98975–98978 or 90980	Additional 20 minutes	Yes

NC Medicaid Coverage for RPM



- [NC Medicaid: 1H](#) (Page 18)
- File with usual place of service code.
- Confirm current billing and cost policies per payer.



C.3. Remote Patient Monitoring Services

Eligible Providers						
Eligible Services/ Codes	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwives	Code-Specific Guidance
Self-Measured Blood Pressure Monitoring Codes (see additional guidance below)						
99473+	X	X	X	X	X	Providers may bill once per beneficiary, per device. May be performed remotely. No more than one provider may bill for the same beneficiary.
99474+	X	X	X	X	X	Providers may bill once in a 30-day period if they complete a minimum of 12 readings. No more than one practice may bill for the same beneficiary in the same month.
Remote Physiologic Monitoring Codes (see additional guidance below)						
99453+	X	X	X	X	X	May be billed only once for each episode of care, which begins

						when the RPM is initiated and ends with attainment of targeted treatment goals.
99454+	X	X	X	X	X	May be billed once every 30 days continuously (not calendar month, by contrast with code 99457 below).
99457+	X	X	X	X	X	May be billed for the first twenty minutes of communication with the beneficiary or caregiver in the calendar month, and only once per calendar month per beneficiary.
99458+	X	X	X	X	X	May be billed for each additional twenty minutes of communication with the beneficiary or caregiver in the calendar month

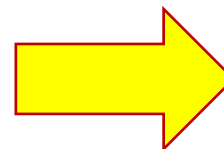
Services billable by FQHCs, FQHC Lookalikes and RHCs are identified with a plus sign (+).

Case Example

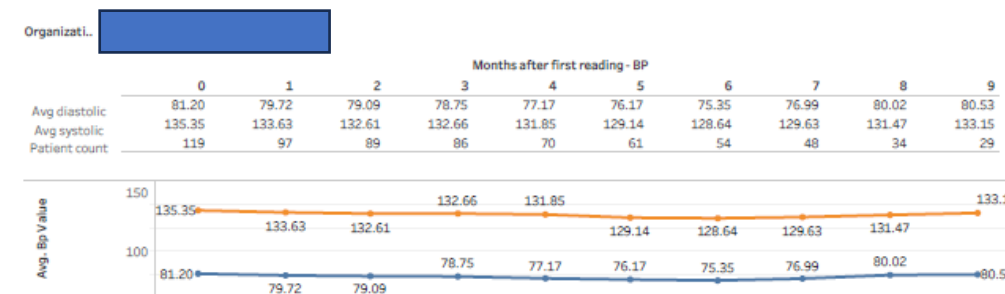


NC FQHC Testimonial

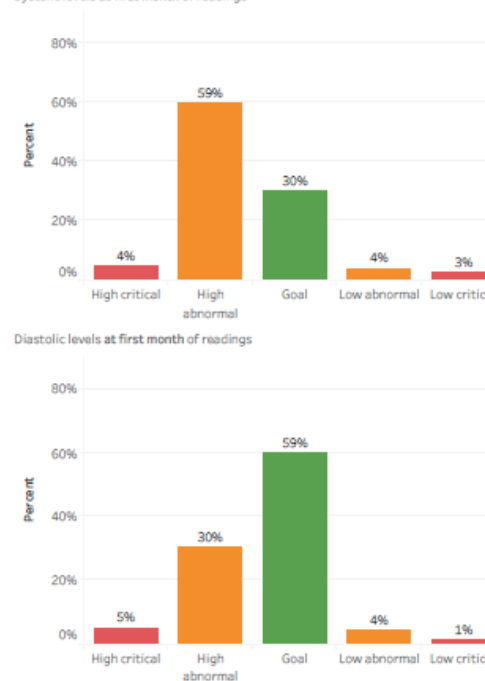
“We only offer BP RPM currently. We use our vendor (Optimize) for the monitoring as well and get critical notifications and daily summaries. We can bill 99453-99458. The company sends us a list of who is eligible for what at the end of the month. We do not charge our uninsured and we do not charge any co-pays or fees towards deductibles for our insured pts. We have about 30ish people in our program at a time. Some have been on it for years and some only stay on a few weeks, up to pt and provider.”



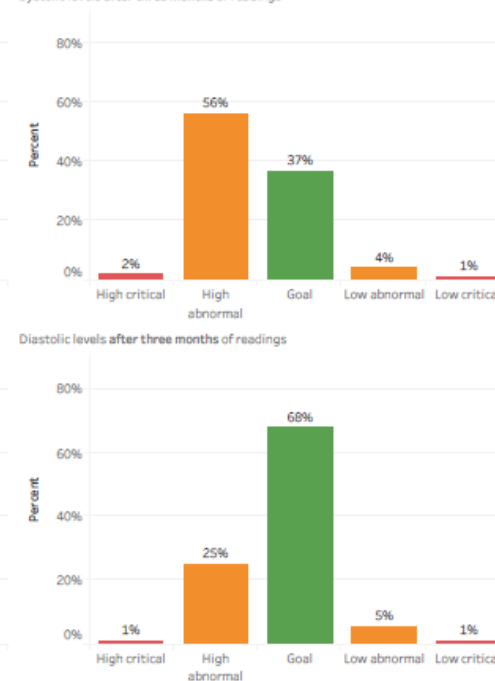
RPM Metrics - Reading Averages Blood pressure evolution



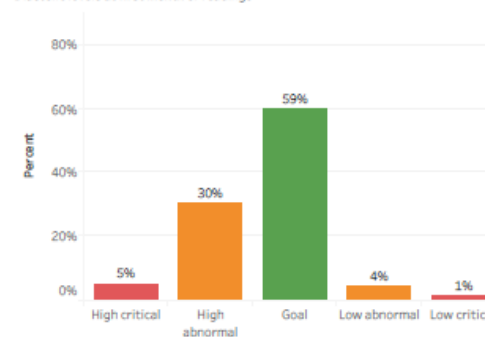
Systolic levels at first month of readings



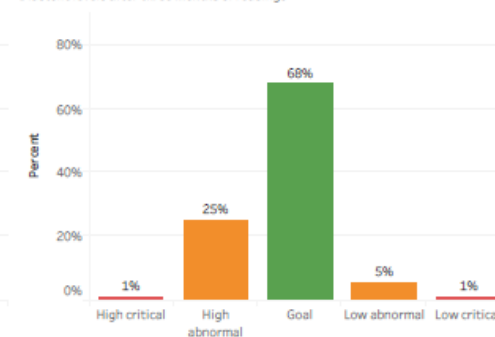
Systolic levels after three months of readings



Diastolic levels at first month of readings



Diastolic levels after three months of readings



Systolic levels at first month of readings

Systolic levels after three months of readings

Staff Roles for RPM in FQHCs



- MAs: Onboard and train patients.
- RNs: Review data and escalate care.
- Providers: Supervise and update care plans.
- CHWs: Promote engagement and education.
- Billing staff: Ensure compliant documentation and claims.

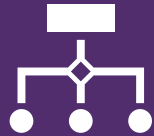
Sample RPM Workflow in FQHCs



- 1. Identify patient (e.g., high BP).
- 2. Enroll and provide device.
- 3. Collect data daily.
- 4. RN reviews and escalates if needed.
- 5. Provider updates treatment.
- 6. Log care for 99453, 99454, 99457, 99458 billing.

Example: [Rockingham Remote Patient Monitoring Guide Workflows](#)

Implementation Tips



- Pilot small groups before scaling.
- Use automated alerts and dashboards.
- Secure startup funding (e.g., HRSA, FCC).
- Train staff and support patients continuously.

Challenges & Mitigation



- Tech literacy: Use simple devices.
- Language: Provide multilingual materials.
 - Example: [English Patient Material](#)
 - Example: [Spanish Patient Material](#)
- Workflow: Integrate documentation into EHR.
- Reimbursement: Stay up to date with policies.

Resources



- Policies:
 - CMS
 - [CMS Telehealth & RPM Policies Overview](#)
 - [List of Medicare Telehealth Services](#)
 - [Telehealth & Remote Patient Monitoring Fact Sheet MLM 901705](#)
 - [Telehealth FAQ for Calendar Year 2025](#)
 - [230 Care coordination services](#)
 - NC DHHS
 - [NC Medicaid Telehealth, Virtual Communications and Remote Patient Monitoring](#)
 - [NC DHHS Remote Patient Monitoring Tip Sheet](#)
 - [NC Practice Support Services](#)
- Compliance:
 - Remote Patient Monitoring: Use & Bill Correctly
 - In a [report](#), the Office of the Inspector General recommended additional oversight of remote patient monitoring in Medicare. About 43% of enrollees who received remote patient monitoring didn't receive all 3 components, raising questions about whether it's being used as intended.
 - [Remote Patient Monitoring](#) webpage
- [CMS: Telehealth & Remote Patient Monitoring \(PDF\)](#) booklet
- Explore Funding: [HRSA grants](#)

Resources



- Example Vendors: [CareSignal](#), [Rimidi](#), [Validic](#), [CoachCare](#)

Feature	CareSignal	Rimidi	Validic	CoachCare
Approach & Delivery	Deviceless: SMS & IVR, no hardware required caresignal.health	Connects clinician clinical apps with consumer-grade devices	Data platform: integrates 570+ devices and wellness apps via API	Provides both software and device-driven RPM, with support services
Key Strengths	Highly accessible; published outcomes (↓ED visits, HbA1c)	Strong clinical decision support and EHR integration	Scalable data ingestion; AI-driven workflows reduce clinician burden	End-to-end setup including billing, reimbursement, clinical support
Device Requirement	None; relies on patient self-report via phone/text	Uses FDA-approved patient devices (e.g., BP monitors, glucometers)	Leverages patient-owned wearables, medical devices via integration	Includes connected devices supplied to patients
EHR / Workflow Integration	Integrates with Epic, Cerner, Meditech	SMART on FHIR, SSO, built into clinician workflow	Seamless EHR integration with Epic, Cerner, Oracle	Integrates with Athena, Epic, Cerner, others
Target Use Cases	Chronic disease (diabetes, COPD, HF), behavioral health	Chronic conditions (diabetes, HF, obesity, GI, COVID)	Large-scale clinical trials, wellness, chronic population management	Chronic conditions monitoring, weight management, hypertension
Patient Engagement	~75% engage >6 months; published behavior change metrics	Clinical alerts and prioritization tools enhance follow-up	Real-time alerts; AI-generated insights	Automated outreach, plus live coaching support
Billing & Reimbursement	Supports value-based care; ROI claims	Focus is clinical; billing not emphasized publicly	Platform-only—used by others for billing workflows	Full billing support, certified billing experts; claims success >95%
Notable Outcomes	59% ↓ HF ED visits, 2.03% HbA1c drop, \$200 PMPM savings	Improves guideline-based care via decision support	Enables large-scale, patient-generated data for research & monitoring	76% experienced BP reduction; ROI up to \$250K/year per practice

Key Takeaways



- RPM is feasible and impactful in FQHC settings.
- Start small, monitor outcomes, then scale.
- Align workflows with billing and staff capabilities.

