Hospital RPM Programs

Selling RPM to hospitals is a complex proposition requiring time and effort on your part. Is it worth it? Consider this: The average mid-size hospital has 125 -350 primary care doctors credentialed to admit and see patients. As the common denominator, a hospital account opens a massive opportunity.

Why would hospitals be interested?

Most of the in-patient revenue received by hospitals comes from Medicare in the form of DRG (disease-related group) reimbursement. These cover the top 20 diagnoses requiring hospitalization. The DRG has two interesting factors: a fixed payment amount, and a guarantee. The first factor means Medicare determined what hospitalization should cost and the hospital agreed to a flat fee for everyone admitted with that specific diagnosis. There are no extra payments for 'surprises' or mistakes. The second factor means that for usually 30 days (but sometimes 60 or 90) the hospital cannot ask for another payment for treating the same problem. Bottom line: when a patient is discharged the hospital does not want them back within the guarantee period.

Hospitals can reduce readmissions, generate patient good-will and derive indirect revenue through captive practices who continue the RPM program.

And there is tremendous good-will generated among independent physicians when patients are referred back to them with RPM devices.

How RPM fits

Research has shown there are three factors that reduce re-hospitalization by up to 70%: see your PCP within 5 days; get your prescriptions filled; take your medicine faithfully. Providing a remote monitor connected to their PCP significantly improves compliance with all three. For hospital programs, MediPhasics health coaches reach out within 24 hours to encourage compliance. We provide the patient, and family caregivers, with time, advocacy and expertise.

Discharge planning that includes RPM and connection to primary care holds great promise for success in the reduction of re-hospitalizations and ER visits.

Hospital reimbursement

Reimbursement rules for hospitals are different than for providers. Hospitals can give the device to the patient at no charge without violating Stark rules.
The hospital can bill CPT 99453 (average $120) for patient education and instruction. If the first reading is done in the hospital CPT 99454 (average $37) may be billed once. Total: $157. While there is no code for device cost it is amply covered in the service codes.

Hospitals cannot bill CPT 99454 again for that patient, nor can they bill CPT 99457; but a PCP can bill both, monthly, for as long as the patient stays on the program.

Practices owned by the hospital can bill 99454 and 99457 monthly in like manner to other clinical services performed by that Practice. The revenue therefore accrues to the hospital indirectly.

Handing off device-equipped patients to independent practices builds both revenue for that practice and a great relationship with the hospital.

Many hospitals have a mix of captive vs independent practices. It takes coordination for the program to work at its best but in the end, the benefits to all are obvious and many.

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