Billing

RPM, RTM dodge bullets in final, but third-party ban threatens

Two of the physician fee schedule final rule's three major reforms of remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) billing were finalized, but a crucial and controversial third reform, related to third-party vendors, was delayed two years.

Starting in 2027, RTM services will be payable only when provided to established patients, and practices must furnish a separately reportable, face-to-face initiating visit before rendering either RPM or RTM services.

The initiating visit requirement ensures that the provider "would possess information needed to understand the current medical status and needs of the patient" and that "the practitioner collects and analyzes the patient's data and uses the results of remote therapeutic monitoring to manage the patient under a specific treatment plan or therapy plan of care," according to the final rule.

But the most seismic reform, which led to significant pushback from the provider community, is delayed until 2029. That proposal would have prohibited providers, as of Jan. 1, 2027, from using third-party vendors to provide remote monitoring, for which practices now bill incident-to.

The delay is to "allow for practices to hire and train staff for 'in-house' workflows for remote monitoring services," CMS says. Meantime "all of the existing 'incident to' and other rules for billing remote monitoring services under the PFS must be met."

"This policy would not prohibit working with vendors who do not supply third-party staff time, but supply software, devices, technical support, etc.," CMS clarifies. "The intent of this policy was not to require billing practitioners to develop proprietary monitoring platforms or devices."

Will they or won't they?

In at least some cases the established patient and initiating visit requirements are not much of a hindrance, according to Craig Johansen, director of research and insights for Medbridge, a digital care solutions company in Bellevue, Wash.

"For rehab therapy, RTM codes are classified as sometimes therapy codes, and for that you have to have a therapy plan of care in place — so those [initiating visit] requirements are already in place," Johansen says. Also, while CMS did state that the initiating visit would need to be face to face, Johansen notes that in the rule they also indicate telehealth is acceptable ("must be initiated by the billing practitioner during a face-to-face [in-person or telehealth] visit)." Therefore, programs that are combining telehealth with RTM, for example, "would be compliant as long as they had completed a plan of care and evaluation via telehealth."

But providers and experts are understandably frustrated about the third-party prohibition, however delayed.

The American Telemedicine Association (ATA), in a press release after the final rule appeared, called it "a reprieve ... not a fix." Kyle Zebley, CEO of the ATA and executive director of its advocacy arm ATA Action, said that his organization "will use the next two rulemaking cycles to press CMS to adopt targeted program-integrity safeguards that address fraud and abuse without cutting off access to proven remote monitoring programs. If we do not get this right before 2029, patients will lose access to care that works."

While "the delay provides time for advocacy and alternative approaches," according to Timothy McGibbney, a senior attorney with the Clark Hill law firm in Houston, it also "creates uncertainty for practices and vendors considering investments in new monitoring programs," which could be costly and demoralizing.

Claire Ernst, director of government relations and public policy at Hooper, Lundy & Bookman P.C., sees some grounds for optimism. "When they proposed [the third-party vendor prohibition] I wasn't convinced they would finalize it," she says. "I thought they might just be trying to get a sense of how much pushback there would be. I'm not sure that they will finalize this in two [more] years, either."

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Ernst admits that the administration's strong focus on CMS fraud, waste and abuse might suggest a third-party limitation, particularly considering OIG's repeated investigations of remote services and reports of Medicare overpayment (*PBN 9/15/25*). But while CMS concurred with OIG's findings on waste in the programs, they only said they'd take their findings "into consideration" and didn't promise such a sweeping change, Ernst explains.

Also, Ernst points out, OIG opened an audit on remote monitoring services in 2024, and it remains open, so maybe what OIG observes in that audit will have an effect on its planned prohibition. "I think that they are essentially saying, we're taking this seriously, and we'll give you two years to take it seriously," Ernst says.

Should the change go through, "a sizeable industry within the practice of medicine would be extinguished and medical offices would be required to quickly retain the staff and equipment necessary to provide RPM/RTM services in-house," observes Henry Norwood, a health care attorney with the Kaufman Dolowich firm in San Francisco. "Most [providers] view RPM/RTM services as beneficial to promoting patient outcomes, so the two-year delay likely indicates CMS will either significantly modify the proposed changes or abandon them altogether."

Norwood suggests that CMS might find other ways to reduce waste — for example, by addressing "the issue of monitoring multiple patients simultaneously. RPM/RTM third-party vendors have been alleged to monitor multiple patients simultaneously to maximize profits, while providing lesser care. CMS' approach to this problem has been to deny payment for RPM/RTM claims submitted simultaneously. Despite these efforts, the problem is believed to persist, which is a drain on the Medicare system."

Grim valuation omens

CMS also decided against finalizing some proposed changes to crosswalks and practice expense (PE) inputs related to RPM and RTM codes that would tend to lower their valuation, e.g., the proposal to eliminate direct PE RVU inputs for CPT codes **99470**, **99457**, **99458**, **98979**, **98980** and **98981**. CMS also refrained from a proposed "bundling [of] the RPM and RTM CPT codes and creating four new HCPCS G-codes to describe remote monitoring services," saying they'd consider these changes in future rulemaking.

But they did finalize others changes to work and PE RVU inputs on some codes. McGibbney is glad for what CMS held back on, calling it a "fairly big win as it reduces compliance costs, thus increasing margins." But other pieces are less than agreeable. "Statutory phase-in protections generally limit reductions in total relative value units for affected existing codes to 19% in the first year, but the adopted valuations could, by my estimate, produce cumulative reductions approaching 70% or more for certain device codes in 2028 if unchanged," he says.

CMS also mentions in the rule that the AMA has informed them that "in response to our concerns over a lack of data to inform accurate valuation of these services, all 19 RPM and RTM codes will have their practice expense reviewed at the January 2027 RUC [resource use committee] meeting." But, McGibbney says, "there is no guarantee CMS will revise its position" based on that. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCE

- OIG, "Audit of Medicare Part B Remote Patient Monitoring Services," Dec. 16. 2024: *https://oig.hhs.gov/reports/work-plan/browse-work-plan-projects/audit-of-medicare-part-b-remote-patient-monitoring-services/*

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