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# RPM Changes Are on the Table; Hospital Settles CMP Case Over RPM Amid Greater Scrutiny

By Nina Youngstrom

Sometimes patients who are signed up for remote patient monitoring (RPM) don't put on a blood pressure cuff or test their blood glucose 16 days a month or comply with other Medicare requirements for billing RPM, throwing providers a billing curveball. Patient noncompliance is one factor that may open providers up to claim denials, investigations and self-disclosures, which seem to be on the rise, as Medicare watchdogs question the medical necessity of RPM and technical compliance, an attorney said.

"The first thing RPM companies and providers realize can kick them in the teeth is how hard it can be to get patients to do 16 days of readings," said attorney Thomas Ferrante, with Foley & Lardner LLP. "This is one of the biggest friction points in the RPM world in terms of billing." Sometimes providers have 14 days of data "and nothing to show for it" in terms of reimbursement, he said.

Changes may be coming that could reduce the considerable risk around RPM. The proposed 2026 Medicare Physician Fee Schedule (MPFS) rule—which is due in a week or so—may adopt new CPT codes for RPM. The American Medical Association's CPT Editorial Panel ended the requirement for 16 days of data, created alternate codes for 10 to 19 minutes a month of managing RPM data (instead of 20), and added and revised other remote physiologic monitoring and remote therapeutic monitoring codes. The CPT changes take effect Jan. 1, 2026, although it's TBD whether CMS pays for them.

Valerie Rock, a principal at PYA, said CMS probably will recognize and value the new RPM codes in the MPFS rule but may not cover them because new dollars spent on RPM would have to be offset in the fee schedule. But at least the codes pave the way for coverage by private payers. Rock noted the new codes are more specific for respiratory, musculoskeletal and cognitive behavioral therapy remote patient monitoring.

CMS also already has experience with providers billing RPM fewer than 16 days under COVID-19 waivers during the public health emergency, said Richelle Marting, an attorney and certified coder in Olathe, Kansas. But the same hesitation about a potentially budget-busting permanent telehealth expansion may keep CMS from opening the door to more RPM billing, Marting said. "Hopefully, the administration would recognize the intent of RPM/RTM for shorter periods is designed to achieve overall cost savings by avoiding readmissions, infections, and other complications."

## More Criminal Investigations, Another CMP

Meanwhile, the internal and external scrutiny continues. The "catalyst" seems to be a September 2024 HHS Office of Inspector General (OIG) report recommending more oversight of RPM, Ferrante said.[1]

"We have seen inquiries and investigations" from the U.S. Department of Justice (DOJ) criminal division, OIG and CMS "for technical payment issues," Ferrante said. And some organizations started to take a closer look at their arrangements. "That's what I've seen in the past 10 months," he noted.

Already there have been two civil money penalty settlements in less than a year for alleged RPM noncompliance, both stemming from self-disclosures. In May, Capital Health System Inc. in Trenton, New Jersey, agreed to pay $528,937 in a settlement with OIG for allegedly violating the Civil Monetary Penalties Law.[2] The hospital allegedly billed federal health care programs "for remote physiologic monitoring that did not meet the requirements for coverage and payment," according to OIG's website. Capital Health System declined to comment through its attorney. Last summer, Florence Wellness PLLC and Florence Inc. in Arizona agreed to pay $194,754 for allegedly submitting claims to Medicare for RPM without getting at least 16 days of biometric readings in a 30-day period.[3]

RPM involves the use of a device to collect and transmit patients' data (e.g., respiratory flow rate, blood pressure) remotely to their provider, who reviews the data and makes treatment decisions about the patient, such as adjusting their medication. The data must be collected for 16 days in a 30-day period.

The use of RPM has skyrocketed in traditional Medicare and Medicare Advantage (MA). OIG said 570,000 Medicare enrollees received RPM in 2022, up from 55,000 in 2019. Payments were 20 times higher in 2022 than 2019—$300 million versus $15 million. Most patients (94%) were on RPM for chronic conditions—more than half for hypertension.

There are three components of RPM:

- Enrollee education and device setup. They're billed with CPT code 99453 (initial set-up and patient education on use of equipment).
- Device supply (e.g., connected blood pressure cuffs, weight scales and pulse oximeters). This is billed with 99454 (30-day device supply with transmission of daily recordings or programmed alerts).
- Treatment management. That's CPT 99457 (RPM treatment management, at least 20 minutes of interactive communication with the patient or caregiver) and 99458 (each additional 20 minutes).

About 43% of people who received RPM didn't get all three services. "Although CMS does not require that providers bill for all three components, the high percentage of enrollees who did not receive all components raises questions about whether these services are being used as intended." OIG recommended more oversight of RPM and greater transparency and CMS agreed.

## Medical Necessity Animates Oversight

Investigations and audits run the gamut. For example, "You can have bad actors billing for deceased patients," Ferrante said. Treatment management requires live, interactive communication so it shouldn't take long to realize patients aren't participating either because they're noncompliant or dead. "If monitoring data isn't coming over and there's no interactive communication, you shouldn't be billing those claims," he noted. Some people interpret the CPT codes to mean an alert on the patient's device counts as communication whether or not the patient responds, but "that's an aggressive interpretation."

The main concern of Medicare, MA plans and Medicaid managed care organizations is whether RPM is medically necessary, Ferrante and Rock said.

"The biggest compliance issue we see is a lack of understanding of what medical necessity means," Rock noted. Medicare only covers RPM for patients who have acute or chronic conditions. "If they had an acute condition before but it has resolved, and there's still monitoring going on, then you should be billing the patient and not the payer," she said.

Auditors will look at whether hospitals or physicians are putting patients on a subscription model—signing them

up for RPM and continuing month after month—to generate more revenue. “It’s supposed to be individually tailored and rooted in the medical necessity for the specific patient,” Ferrante explained. Although some patients (e.g., with diabetes) may legitimately be on RPM forever, “other conditions may not go on in perpetuity,” he said. If they’re rubber stamped without documentation supporting the need for that specific patient to be on RPM with an individualized care plan, the claims will be rejected.

Another vulnerability may come from providers’ relationships with vendors they use for RPM. “Providers may do the billing but outsource the majority of the RPM service line to the vendor,” Ferrante said. Some providers may rely too much on vendors, using whatever information vendors give them to submit claims, but that’s asking for trouble. “At the end of the day, the responsibility falls on the billing provider. They will be on the hook for billing improprieties.”

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1 Christi A. Grimm, *Additional Oversight of Remote Patient Monitoring in Medicare Is Needed* , OEI-02-23-00260, Office of Inspector General, U.S. Department of Health and Human Services, OEI-02-23-00260, September 2024, https://bit.ly/3MZ2vR6.
2 U.S. Department of Health and Human Services, Office of Inspector General, “Capital Health System Agreed to Pay $528,000 for Allegedly Violating the Civil Monetary Penalties Law by Submitting Claims for Remote Physiologic Monitoring that Did Not Meet Coverage and Payment Requirements,” May 9, 2025, https://bit.ly/43RoGlB.
3 U.S. Department of Health and Human Services, Office of Inspector General, “Florence Wellness Agreed to Pay $194,000 for Allegedly Violating the Civil Monetary Penalties Law by Submitting Improper Claims for Remote Patient Monitoring,” August 27, 2024, https://bit.ly/3XJ3ud0.