CLIENT ALERTS & INSIGHTS

CMS Finalizes New RPM and RTM Guardrails: Direct-Employment Requirement Delayed to 2029, While Patient-Relationship and Reimbursement Changes Begin in 2027

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Featured Practices: Healthcare, Medicare & Medicaid Reimbursement

Key Takeaways

- **CMS finalized new Medicare requirements for RPM and RTM beginning January 1, 2027**. The requirements include an initiating visit for new remote-monitoring patients and an established-patient requirement for RTM. At the same time, CMS delayed the more significant direct-employment requirement for clinical staff until January 1, 2029.

- **The Final Rule provides organizations more flexibility than CMS initially proposed.** Contracted clinical staffing is allowed through 2028, preserving practice-expense inputs for treatment-management services and retaining the existing RPM and RTM code structure. However, revised valuations for several setup and device-supply codes could create reimbursement pressure beginning in 2027.
- **Providers and remote-monitoring companies should begin preparing now.** It's a good time to update intake and documentation processes, review vendor and clinical-staffing arrangements and model the impact of the new reimbursement rates. The two-year employment transition provides additional time to restructure, but existing Medicare oversight and billing requirements continue to apply.

On November 4, 2026, the Centers for Medicare & Medicaid Services ("CMS") released the Calendar Year ("CY") 2027 Medicare Physician Fee Schedule ("PFS") Final Rule (the "Final Rule"). The Final Rule:

- Delays the clinical-staff direct-employment requirement until January 1, 2029;
- Requires a face-to-face initiating visit for new remote physiologic monitoring ("RPM") and remote therapeutic monitoring ("RTM") patients beginning January 1, 2027;

- Limits RTM to established patients beginning January 1, 2027;
- Provides transition relief for patients already receiving remote monitoring before January 1, 2027;
- Revalues several RPM and RTM setup and device-supply codes, subject in certain cases to the statutory phase-in for significant relative value unit ("RVU") reductions;
- Retains direct practice-expense inputs for treatment-management codes; and
- Does not adopt the four HCPCS G-codes on which CMS had solicited comment.

General effective date: January 1, 2027

Direct-employment requirement: January 1, 2029

The Final Rule substantially adopts the RPM and RTM guardrails CMS proposed in July 2026 (the "Proposed Rule"), but it softens their immediate operational impact in several important respects. Most notably, CMS delayed the controversial direct-employment requirement by two years, preserved practice-expense inputs for treatment-management services and declined to collapse the existing RPM and RTM code families into four bundled G-codes.[1]

The Final Rule follows the proposals discussed in our July 2026 alert.[2]

I. Background: CMS Converts Program-Integrity Concerns into Conditions of Payment

The Final Rule responds to program-integrity concerns raised by the Office of Inspector General ("OIG") of the U.S. Department of Health and Human Services, including incomplete services, limited practitioner involvement and enrollment of patients without a meaningful prior treatment relationship.[3] CMS relied on those concerns in the Proposed Rule.[4]

II. Direct-Employment Requirement Finalized-but Delayed Until 2029

The Final Rule's most consequential change is CMS's decision to require that clinical staff whose services support RPM or RTM billing be direct employees of the billing practitioner or the practitioner's practice. CMS did not abandon that policy, but it delayed implementation from January 1, 2027, until January 1, 2029.

Through December 31, 2028, practices may continue using contracted clinical staff, provided the arrangement satisfies Medicare's existing "incident to," supervision and documentation requirements.[5]

CMS emphasized, however, that the transition period is not a safe harbor. Vendor models with limited practitioner oversight or weak clinical integration may fail existing billing criteria even before 2029.

What "direct employee" means remains unresolved

CMS did not define "direct employee" or reconcile the new requirement with 42 C.F.R. § 410.26's express recognition of leased employees and independent contractors. CMS instead indicated that additional subregulatory guidance may be needed to identify other permissible clinical-staff arrangements before the 2029 effective date. Whether leased-employee, co-employment or independent-contractor models will qualify in 2029 remains an open question that will turn on the specifics of each arrangement.

The requirement targets clinical labor, not technology

Practices may continue to source devices, software platforms, connectivity and technical support from vendors. The critical question is whether the vendor also supplies the clinical staff time used to support billing.

III. RTM Established-Patient Requirement Begins January 1, 2027

Beginning January 1, 2027, RTM may be furnished only to an established patient, bringing RTM into alignment with the established-patient policy that already applies to RPM.

For physicians and other qualified healthcare professionals, CMS uses the familiar PFS concept of an established patient: a patient who has received professional services from the practitioner-or from another practitioner of the same specialty in the same group practice-within the preceding three years.

The initiating visit discussed in Section IV can itself establish the patient relationship.

IV. New Initiating-Visit Requirement for RPM and RTM

Also beginning January 1, 2027, the billing practitioner must furnish a separately reportable initiating visit before RPM or RTM billing begins for a new remote-monitoring patient.

The initiating visit must:

- Be furnished by the billing practitioner;
- Be face-to-face, either in person or through qualifying Medicare telehealth;
- Be separately payable under Medicare; and
- Include an actual discussion of RPM or RTM with the patient.

A routine office or telehealth visit may qualify if remote monitoring is actually discussed and found clinically appropriate.

CMS did not adopt a separate documentation standard, but the record should support that the billing practitioner discussed and initiated the service.

A new initiating visit is not required merely because the device changes, the patient's condition changes or responsibility shifts to another practitioner in the same practice.

The visit may be furnished via telehealth if it satisfies Section 1834(m) of the Social Security Act.[6] Because current telehealth flexibilities run through December 31, 2027,[7] some patients may require an in-person initiating visit beginning in 2028 unless Congress acts again.

V. Transition Relief for Existing Patients

CMS adopted an important transition rule: beneficiaries already receiving RPM or RTM before January 1, 2027, do not need a new initiating visit merely to continue their existing monitoring services, provided all other Medicare requirements remain satisfied.

The relief is narrow: it excuses only the new initiating visit, and CMS specifically cautioned against accelerated enrollment before the effective date.

VI. CMS Finalizes Setup and Device-Supply Revaluation

CMS finalized revised work and direct practice-expense ("PE") inputs for CPT codes 99445, 99453, 99454, 98975, 98976, 98977, 98984 and 98985. These changes generally crosswalk RPM and RTM setup and device-supply resources to the PE inputs of other established services.

CMS also moved CPT codes 98978 and 98986 from contractor pricing to national pricing.

For existing codes facing total RVU reductions of 20% or more, the statutory phase-in limits the first-year reduction to 19%.[8]

Affected codes may face material payment pressure in 2027 and beyond, and program economics should be modeled against final values rather than proposed-rule estimates.

VII. Treatment-Management PE Inputs Preserved

CMS did not finalize its proposal to eliminate direct PE inputs for treatment-management CPT codes 99470, 99457, 99458, 98979, 98980 or 98981.

CMS agreed with commenters that clinical staff perform portions of this work. That is a meaningful improvement for practices that otherwise would have absorbed in-house staffing costs while losing the associated PE valuation.

VIII. CMS Does Not Adopt the Four G-Codes

CMS declined to adopt the four bundled HCPCS G-codes (GRPM1, GRPM2, GRTM1 and GRTM2) on which it had sought comment. The existing CPT structure remains in place for 2027, although CMS may revisit consolidation in future rulemaking.

IX. Practical Implications and Recommended Actions

Providers, physician groups, therapy practices and remote-monitoring companies should consider the following actions:

- **Update intake workflows before January 1, 2027.** Enrollment processes should account for the initiating-visit and RTM established-patient requirements.
- **Identify transition patients.** Practices should be prepared to demonstrate which beneficiaries were receiving monitoring before the effective date.
- **Review vendor arrangements now.** Agreements that bundle technology with clinical staffing, or that extend beyond December 31, 2028, warrant review well before the 2029 deadline.
- **Do not treat the delay as relaxed enforcement.** Contracted models must still demonstrate meaningful practitioner oversight.
- **Model reimbursement using final values.** Projections should reflect the finalized valuation changes and the potential cost of a future staffing transition.
- **Monitor CMS guidance.** The meaning of "direct employee" remains a material open question.

X. Conclusion

The Final Rule is less disruptive than CMS's July proposal, but it still marks a significant regulatory reset for Medicare remote monitoring. The immediate changes-an initiating visit for new RPM and RTM patients, an established-patient requirement for RTM, and revised setup and device-supply valuations-take effect January 1, 2027. The most consequential structural change, the direct-employment requirement, follows on January 1, 2029.

The two-year delay provides time to restructure, but it is not a reason to wait. Organizations should begin evaluating their staffing models, vendor relationships and enrollment workflows now.

The Benesch Healthcare team regularly advises providers, physician groups, therapy practices and digital-health companies on Medicare remote-monitoring compliance, vendor arrangements and operational restructuring, and will continue to monitor CMS guidance on permissible clinical-staff arrangements.

For further information, please contact the authors of this article or any member of the Benesch Healthcare team.

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[1] *See* Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 91 Fed. Reg. 70,992,

71,268-90 (Nov. 9, 2026) (to be codified at 42 C.F.R. pts. 400, 405, 406, 407, 410, 414, 415, 417, 422, 423, 424, 425, 427, 428 & 512).

[2] *See* Nesko Radovic et al., *CMS Proposes Sweeping Restrictions on Remote Patient Monitoring: The Outsourcing Ban, Reimbursement Revaluation, and Potential Code Consolidation in the CY 2027 Physician Fee Schedule Proposed Rule*, Benesch Healthcare (July 2026).

[3] *See* U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., *Additional Oversight of Remote Patient Monitoring in Medicare Is Needed*, OEI-02-23-00260 (Sept. 2024), https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., *Billing for Remote Patient Monitoring in Medicare*, OEI-02-23-00261 (Aug. 2025), https://oig.hhs.gov/documents/evaluation/10901/OEI-02-23-00261.pdf.

[4] See Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 91 Fed. Reg. 43,842, 43,892-95 (proposed July 16, 2026).

[5] *See* 42 C.F.R. § 410.26(a)(1), (b)(5) (2026).

[6] *See* Social Security Act § 1834(m), 42 U.S.C. § 1395m(m).

[7] *See* Consolidated Appropriations Act, 2026, Pub. L. No. 119-75, § 6209 (2026).

[8] *See* Social Security Act § 1848(c)(7), 42 U.S.C. § 1395w-4(c)(7).