CLIENT ALERTS & INSIGHTS

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

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Featured Practices: Healthcare, Dialysis, Nephrology & Vascular Access

Key Takeaways

- CMS’s CY 2027 Proposed Rule would significantly restrict Medicare reimbursement for Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM), including banning outsourced clinical staffing, adding new patient-relationship and initiating-visit requirements, reducing certain reimbursement rates, and exploring consolidation of existing billing codes.
- CMS is turning years of OIG scrutiny and enforcement activity into formal payment policy. If finalized, the proposal could disrupt many existing RPM and RTM business models while increasing compliance and False Claims Act risk for providers and vendors.
- Organizations should begin evaluating staffing arrangements, financial exposure, onboarding and consent workflows, and overall compliance readiness now. Stakeholders have a limited window to submit comments before the September 14, 2026 deadline and help shape the final rule.

Effective date if finalized: January 1, 2027 Comment deadline: September 14, 2026

The CY 2027 Proposed Rule marks a sharp reversal. Only a year earlier, the CY 2026 PFS rule expanded RPM and RTM-lowering the 16-day data-transmission threshold, adding shorter-duration treatment management codes and creating new billing pathways to broaden access. As we discussed in our prior alerts, that expansion coincided with an intensifying enforcement arc-OIG’s November 2023 Consumer Alert, its September 2024 oversight report and August 2025 Data Snapshot, and DOJ’s first False Claims Act settlement for RPM billing misconduct. CMS now proposes to restrict the very services it recently expanded, translating those enforcement findings into binding payment conditions. What was an enforcement risk is now poised to become a coverage prohibition.

This alert reviews the Proposed Rule's remote monitoring provisions and outlines practical implications for providers, physician groups and remote monitoring technology partners.

I. Background: OIG Findings That Drove the Proposed Rule

Two OIG reports serve as the regulatory foundation for the Proposed Rule. The first, "Additional Oversight of Remote Patient Monitoring in Medicare Is Needed" (OEI-02-23-00260, September 2024), documented RPM's tenfold growth-from roughly 55,000 enrollees in 2019 to 570,000 in 2022-and payment growth from $15 million to over $300 million. Critically, about 43% of enrollees who received RPM did not receive all three required components (education/setup, device supply and treatment management). OIG made five recommendations and CMS concurred with or agreed to consider all five.

The second report, "Billing for Remote Patient Monitoring in Medicare" (OEI-02-23-00261, August 2025), escalated the concern: RPM payments exceeded $500 million in 2024, and OIG flagged troubling patterns-enrollment spikes of 150%+ month-over-month (one practice billed ~3,400 new patients in a single month), 34 practices with overlapping claims for the same beneficiary, and billing for patients with no prior relationship. Both reports singled out outsourcing arrangements in which contracted staff had "little to no established relationship with the beneficiary or care team." CMS cites these findings as the primary justification for the direct-employment requirement.

II. Proposed Elimination of Third-Party Outsourcing

The most consequential proposal would prohibit Medicare payment for RPM and RTM services performed by clinical staff who are not direct employees of the billing practitioner or practice. Under current policy, the "incident to" framework at 42 C.F.R. § 410.26 has permitted practices to contract with third-party remote monitoring companies whose dedicated staff perform the monitoring, data analysis, triage and patient communication functions-often from centralized call centers with no physical or clinical connection to the billing practice. The Proposed Rule would close this pathway entirely.

Under the proposal, all clinical staff furnishing RPM or RTM must be direct employees of the billing practitioner or practice. Staff need not be physically co-located, but they must work under general supervision and satisfy all other incident-to requirements. Services performed by contracted third-party staff-regardless of quality-cannot be counted toward Medicare billing. The proposal would not bar practices from purchasing software, connected devices or data platforms from third-party vendors; it targets clinical staffing specifically. As a practical matter, though, many vendors sell bundled technology-plus-staffing packages, making the distinction less clean than it appears.

CMS stated that outsourcing "can fragment care, lead to insufficient involvement and oversight of the billing practitioner, or result in services that do not actually represent or facilitate all required aspects of RPM or RTM services." CMS is requesting comments on how often such arrangements occur, how the proposal could affect beneficiary access (particularly in rural and underserved areas), and whether alternative safeguards, such as enhanced supervision or mandatory disclosure of subcontracted staff, could address the concerns short of a complete prohibition.

III. New Established-Patient Requirement for RTM

RPM services have long been required to be furnished only to established patients-a requirement CMS reinstated after the expiration of COVID-19 Public Health Emergency flexibilities. The Proposed Rule would now extend this same requirement to RTM services, reasoning that a practitioner with an existing clinical relationship will have already gathered the relevant history, performed appropriate examination, and developed the clinical context necessary to appropriately order and interpret remotely collected therapeutic data. This is a direct response to OIG's finding that some practices billed for remote monitoring services for patients with whom they had no prior treatment relationship whatsoever-a pattern consistent with the "cold calling" enrollment schemes OIG identified in its November 2023 Consumer Alert.

IV. New Initiating Visit Requirement

CMS proposes requiring a separately reportable face-to-face initiating visit before RPM or RTM services may begin for a given patient. The visit may be conducted in person or via Medicare-covered telehealth, but it must include an actual discussion of the monitoring plan with the patient, a clinical determination that RPM or RTM is appropriate for the patient's condition, and documented patient consent for the monitoring services. The visit must be separately billable under Medicare, meaning that CPT codes which do not involve a face-to-face encounter with the billing practitioner, or which are not otherwise separately payable, cannot serve as the initiating visit. Similarly, a visit at which RPM or RTM is not actually discussed with the patient does not qualify, even if it is otherwise billable. This approach mirrors CMS's treatment of chronic care management ("CCM"), where an initiating visit is required before billing may commence.

V. Revaluation of Practice Expense Inputs

CMS proposes to revalue the practice expense (PE) components of several RPM and RTM codes downward, citing a lack of reliable invoice and pricing data for remote monitoring devices and concern that current valuations overstate actual costs.

These changes track the direct employment proposal: if the practice employs the monitoring staff, those personnel costs sit in the practice's overhead. CMS is seeking comments on actual device costs, invoicing practices and clinical workflows to inform final valuations.

VI. Potential Consolidation into Four New G-Codes

Although CMS is not formally proposing code consolidation at this time, it is soliciting comments on a more fundamental restructuring that could follow in a subsequent rulemaking: replacing all 17 existing RPM and RTM billing codes with just four bundled HCPCS G-codes. The proposed structure is summarized below:

Proposed G-Code	Scope	Monthly Requirements to Bill
GRPM1	RPM-initial setup and patient education	One-time setup and education for the monitoring device

GRPM2	RPM-monthly device supply and treatment management	At least two days of data transmission *and* at least 20 minutes of treatment management, including at least one real-time interactive communication with the patient
GRTM1	RTM-initial setup and patient education	One-time setup and education for the monitoring device
GRTM2	RTM-monthly device supply and treatment management	At least two days of data transmission *and* at least 20 minutes of treatment management, including at least one real-time interactive communication with the patient

CMS has not proposed valuations and is seeking comments first.

VII. Practical Implications and Recommended Actions

With OIG's audit metrics now embedded in contractor algorithms, DOJ pursuing FCA liability for RPM billing failures, and CMS proposing coverage restrictions, remote monitoring faces tightening on payment, enforcement, and program-integrity fronts simultaneously. Programs built around the recent CY 2026 expansions could become non-billable within months. Stakeholders should consider the following actions:

- **Assess staffing models immediately.** Organizations relying on outsourced clinical staff for RPM or RTM should evaluate whether they can realistically transition to a direct-employment model by January 1, 2027. This assessment must address not only the employment relationship itself but also compliance with general supervision requirements, incident-to documentation standards and the operational capacity to perform monitoring functions previously handled by specialized vendors.
- **Model the financial impact of PE revaluations.** Practices should model revenue at proposed reimbursement levels against current program costs-including the added expense of directly employing monitoring staff-to determine whether RPM/RTM programs remain financially viable.
- **Submit comments by September 14, 2026.** CMS has specifically requested data on outsourcing prevalence, beneficiary access impacts, actual device costs, and views on G-code consolidation. Organizations with operational data, device invoices, or evidence regarding patient outcomes under outsourced versus in-house models may find their comments particularly relevant. Industry coalitions and trade associations should coordinate submissions to maximize impact.
- **Review intake and consent workflows.** Practices should assess whether existing onboarding processes include a separately billable face-to-face visit with the billing practitioner at which RPM/RTM is actually discussed and patient consent is documented.
- **Prepare for multidimensional regulatory exposure.** OIG's audit metrics are already informing contractor review algorithms, and DOJ has demonstrated that RPM billing misconduct carries False Claims Act liability. Organizations should not wait for the final rule to begin compliance

assessments, particularly where current arrangements involve the outsourced staffing model CMS has now expressly identified as incompatible with Medicare billing requirements.

- **Consider congressional and industry engagement.** Given the breadth of these proposals and their potential to reduce beneficiary access, particularly in rural and underserved communities lacking infrastructure to build in-house monitoring capacity, stakeholders may consider strategic outreach to congressional offices and industry organizations to propose alternative approaches (such as enhanced supervision requirements or mandatory staff disclosure) that address CMS's concerns without a categorical outsourcing prohibition.

VII. Conclusion

Just one year after expanding RPM and RTM, CMS is proposing to restrict the very services it broadened; driven by OIG findings that the outsourced delivery model produced fragmented care, insufficient oversight and billing for services not fully rendered. The direct-employment requirement alone could disrupt hundreds of third-party monitoring companies and force practices to choose between building in-house capacity or discontinuing their programs. Combined with downward PE revaluations and potential code consolidation, the Proposed Rule signals a fundamental regulatory reset.

Organizations have roughly two months to comment and five months to restructure before the proposed January 1, 2027 effective date. Given the scope and pace of these changes, **submitting comments before the September 14, 2026 deadline is essential**-CMS has expressly invited stakeholder input on nearly every major provision, and the comment record will directly shape the final rule. Proactive engagement, in both the comment process and internal compliance planning, is critical.

The Benesch Healthcare Practice Group will continue to monitor CMS, OIG and DOJ developments in RPM and RTM. Our team is prepared to assist stakeholders with formulating and submitting comments to CMS, engaging in advocacy efforts and evaluating and restructuring current workflows to ensure compliance in preparation for the final rule. For further information or to discuss how these proposed changes may affect your organization, please contact the authors of this article or any member of the Benesch Healthcare team.