



February 6, 2026

T. March Bell
Inspector General
Office of Inspector General
Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

RE: Call to Action on High-Quality Remote Physiologic Monitoring

Inspector General Bell,

Thank you for your leadership in reducing fraud, waste, and abuse in the Medicare program. We write today to request a meeting during which the leaders of the Remote Monitoring Leadership Council will discuss recommendations for additional guardrails/guidance on the use of remote physiologic monitoring (RPM) services in Medicare. These concrete recommendations would build on the HHS OIG's reports ([OEI-02-23-00260](#) and [OEI-02-23-00261](#)).

We believe that high-quality, technology-enabled disease management through RPM is transforming how care is delivered to seniors. This care is delivering real result for the Medicare program – RPM is improving health outcomes while reducing costly hospitalizations, saving money for federal taxpayers. We write today to offer our collective expertise in striking the appropriate balance between expanding access to care and ensuring the Medicare program does not pay for services which will not yield these impressive clinical results.

The Remote Monitoring Leadership Council

The [Remote Monitoring Leadership Council](#) brings together eight companies operating across all 50 states and collectively offering a large percentage of all remote monitoring and care management services being delivered to Americans. In addition to advancing patient access to these important tools, we have agreed to promote [best practices and standards](#) for the delivery of RPM services. In this context our work is aligned – we both want to elevate and strengthen RPM services. Our goal is to ensure patients only receive high-quality RPM that will lead to cost-savings for tax payers.

Please consider meeting with us directly to discuss the following recommendations in greater detail.

Raising the Bar for RPM and Eliminate Fraud, Waste, and Abuse

As leaders in remote monitoring, we are working to elevate our industry. The Council supports high-quality RPM services and welcomes safeguards that do not create new barriers to legitimate patient care. The members of the Council have committed to a [shared set of principles](#) to ensure the delivery of high-quality, patient-centered care. The principles include concepts such as the need for documentation from an ordering provider and that the health data collected through RPM must be used to inform the patient's care plan. We do not believe that RPM is being used appropriately if the captured data is not directly relevant to managing a patient's condition and showing impact for both

the patient and the broader health system. It should deliver tangible patient improvements, effectively drive cost avoidance for the health system, and reduce administrative burden.

Data captured by RPM should create opportunities for both care teams and patients to monitor vitals and use this information to support the care plan. Patients often report increased self-efficacy as they gain metacognitive feedback from seeing their data trends over time and understanding how medication adherence and lifestyle choices impact their health. To this end, all RPM should include appropriate use of clinical staff to support continuity of care and ensure ongoing patient engagement. These clinicians serve as healthcare liaisons to build patient knowledge and self-management capability, which has been consistently shown to improve clinical outcomes.

The Council is invested in analyzing and publishing our work, both in terms of clinical outcomes and effects on cost of care for the chronic or acute conditions we manage. Research using longitudinal, consistent monitoring of patient data may also foster the identification of novel risk factors – such as daily blood pressure variability, medication interactions, and other emerging patterns – that can help predict health problems before they arise.

Recommendations for Best Practices

Given our collective experience, below, we recommend a set of [best practices](#) that we encourage HHS to promote to ensure high-quality delivery. We request the opportunity to work with you to further develop best practices that encourage high quality RPM services.

- RPM programs should strengthen continuity of care through a capability for timely and proactive outreach to the patient in response to reported biometrics and, as appropriate, alerts to the qualified health care practitioner.
- RPM programs should ensure all data is available to the clinical care team by sending it to the EHR of the qualified health care provider in a timely manner.
- RPM programs should create opportunities for patient empowerment and greater patient ownership of the care plan through knowledge of their vitals data.
- RPM services should only be provided with purposeful patient inclusion and exclusion criteria to ensure the program is appropriate for that patient's condition(s).
- RPM programs should take appropriate steps to protect patient data, without creating barriers to patient access.
- In addition to device setup, RPM programs should provide ongoing technical support for patients to ensure devices continue to be used appropriately.

Recommendations for Additional Guidance

In addition to the best practices above, we believe specific guidance clarifying the permissibility of certain actions that do not align with high-quality RPM services. HHS should:

- Clarify that only a transmission of physiologic data captured by an FDA-cleared or approved medical device meets requirements for billing 99454.

- Clarify that providers must use auditable, accurate electronic time tracking methodologies and should bill based on actual time spent delivering services.
- Clarify that providers must separate and distinguish time to prevent double counting of time spent performing RPM versus other care management services such as chronic care management.
- Reinforce existing guidance on the use of appropriate clinical staff for RPM.
- Reaffirm that 99457 and 99458 require “interactive communication”, which CMS has [defined as](#) “a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission.”

Additional Input for OIG

Broadly, consultation with industry expertise is needed prior to the implementation of previous OIG recommendations on RPM to ensure that real-world experience is incorporated into policy development. We believe our best practices and guidance recommendations address realities of patient care and would further mature the RPM industry.

While we support strong oversight of RPM services, we do believe it is important to consider context for the emergence of RPM. We believe some challenges with RPM have been the result of the emergence of RPM during the COVID-19 public health emergency (PHE). While in its nascent stage, there were several waivers implemented. Some of the “misuse” may be a result of confusion of before, during, and after PHE waivers. Clear guidance can stamp out these practices.

Some examples OIG highlighted included instances of DME companies or pharmacies signing patients up for RPM without an ordering provider with a clinical relationship or a medical condition appropriate for treatment through RPM. These situations do not reflect our understanding of appropriate use of RPM. We urge OIG to differentiate these examples from appropriate use of RPM.

As a guardrail to ensure RPM is used only when clinically indicated, the Council has urged CMS to direct the ordering provider to document the condition(s) being monitored with appropriate ICD-10 codes and the device that is relevant and appropriate for monitoring the condition(s) as part of the demonstration of medical necessity.

One area where additional discussion is warranted is the OIG-raised concern about whether RPM services are being used properly based on the observation that some RPM enrollees did not receive certain component services, such as education and setup on the device and treatment management. There are specific scenarios where it is entirely appropriate and consistent with CMS guidance to bill one component service without the others. For example, there may be a situation where a patient is utilizing RPM but is also participating in another care management program where a different code is billed for the care provided to avoid double billing, consistent with CMS requirements. Scenarios like these must be considered as part of any oversight effort.

RPM as an extension of a clinical relationship

The OIG also recommended that all remote patient monitoring services be ordered by a qualified health care professional and that information about the ordering provider be included on claims and

encounter data for remote patient monitoring. We support requirements that RPM services be ordered by a qualified health care professional and would support documentation if it strengthened CMS's ability to detect and prevent fraudulent billing.

Duration for which RPM is offered

We believe it is reasonable to require that patients and their clinicians set goals as part of a care plan and reevaluate those goals based on progress in the course of the service. We understand that some have suggested a blanket duration limit on RPM. Unfortunately, this takes away the choice of the provider to continue a care plan that may be showing results. A mandatory limit is also insufficiently nuanced to capture variation in patient progress, outcomes, and conditions. There are many variables that contribute to patient health, including comorbid chronic conditions that exist alongside the primary condition for which RPM is ordered. The nature of patient care is different for these varied conditions, and results in different timelines for progress and outcomes. Data show that high-quality RPM programs demonstrate positive clinical outcomes and cost savings over 12 months, at a minimum.¹

Given the risk that a duration limit undermine high-quality, legitimate care, we encourage HHS to engage in a robust stakeholder process to discuss appropriate steps to ensure RPM services do not continue when they are no longer directly improving patient health. For example, the Council has recommended that CMS require providers not enrolled in risk-based models to re-evaluate medical necessity for patients' continued use of remote monitoring on an annual basis.

Our priority in this conversation is the need to preserve the clinical judgment of the ordering provider, who will have oversight of many variables related to patient care. This may include the existence of comorbidities, the patient experience, or general thoughts on concerns related to the patients overall health and need for monitoring and clinical support.

Conclusion

We respectfully request a meeting with OIG to discuss top opportunities to limit the inappropriate billing for RPM in Medicare. The Council is committed to high-quality, patient-centered RPM care, and believes our collective expertise would be extremely useful in ensuring appropriate utilization of these services.

Please contact Chris Adamec (cadamec@rpmleadershipcouncil.org) with any questions about this letter and to schedule a meeting with the members of the Remote Monitoring Leadership Council.

Respectfully,

Remote Monitoring Leadership Council

¹ A [study \(slide 15\)](#), shows over \$1,300 in total savings to Medicare at 12 months following enrollment in an RPM program for congestive heart failure, hypertension, or type 2 diabetes. A peer-reviewed [study](#) in the American Journal of Managed Care found similar results with a 75 percent reduction in stage 2 hypertension over 12 months. A [study](#) found strong evidence that RPM delivered cumulative health gains over time, indicating greater value when treated as a sustained, longitudinal component of chronic care management.

Attachment 1

Remote Physiologic Monitoring (RPM)

Opportunities to reduce inappropriate billing in Medicare and ensure high-quality care delivery

As national leaders in remote patient monitoring (RPM), we have committed to a [shared set of principles](#) to ensure the delivery of high-quality, patient-centered care and to shape the future of our industry. Recognizing the critical role RPM plays in the future of health care, we endorsed these shared principles to define and uphold standards of excellence.

Building upon our efforts to uphold standards of excellence in RPM, we have collected a list of specific practices that we do not believe reflect the spirit or intent of the RPM CPT codes, or appropriate patient care.

99454 Data- Within billing for CPT 99454, we are aware of organizations that have misinterpreted what constitutes a data transmission by counting:

- a device status indication as a data reading.
- a ping to a cell tower.
- SMS interactions with a patient as a reading under 99454, even if no patient data is transmitted.
- a “null data point” as a reading (e.g., counting the absence of data as a data point - even if the patient did not transmit anything).

Recommendation: CMS should clarify that only a transmission of physiologic data captured by an FDA-cleared or approved medical device meets requirements for billing 99454.

99454 Relevance– Within billing for CPT 99454, we are aware of situations in which the monitoring is not clinically indicated or sufficiently directed by the provider. Such situations include:

- organizations tracking physiologic data unrelated to or not clinically indicated for the patient’s diagnosed medical condition. (e.g., a device does not support requirements for condition and there is no clear clinical indication for RPM).

Recommendation: CMS should direct the ordering provider to document the condition(s) being monitored with appropriate ICD-10 codes and the device that is relevant and appropriate for monitoring the condition(s) as part of the demonstration of medical necessity.

CPT 99457/8- Within billing for CPT 99457/8, we are aware of organizations that have adopted an inadequately rigorous tracking of time spent on care, such as:

- intentionally rounding the time (e.g., a provider meets 18 minutes for CPT 99457, but rounds up to 20 minutes).

- operationalizing potentially inflated assumptions for how long a service/condition may take to perform/treat and billing that time rather than documenting actual time spent (e.g., assuming review of vitals readings for a heart failure patient takes 3 minutes and billing as such rather tracking and billing actual time spent).
- double counting time spent providing RPM services alongside time spent providing chronic care management services.
- exploiting unclear definitions/understanding of roles that constitute clinical staff. This includes the inappropriate use of staff outside of the United States.
- tracking time that does not result in the occurrence of any clinically meaningful activity (e.g., staff counts time during which they were not documenting the patient visit, or counts time attempting to contact a patient they never spoke with).

Recommendations:

- *CMS should clarify that providers must use auditable, accurate electronic time tracking methodologies and should bill based on actual time spent delivering services.*
- *CMS should clarify that providers must separate and distinguish time to prevent double counting of time spent performing RPM versus other care management services such as chronic care management.*
- *CMS should reinforce existing guidance on the use of appropriate clinical staff for RPM.*
- *CMS should reaffirm that 99457 and 99458 require “interactive communication”, which CMS has [defined as](#) “a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission.”*

RPM plan of care – As the RMLC has previously communicated to CMS, we are aware of concerns around the appropriate clinical duration for RPM services, including situations such as:

- organizations in which a vendor organization drives patient selection without appropriate provider direction and oversight.
- the delivery of RPM outside of a care plan that is regularly re-evaluated by the supervising clinician and patient based on progress. We believe RPM should exist as part of a plan of care with goals or benchmarks for the conditions upon which medical necessity should be re-evaluated.

Recommendation: *CMS should require providers not enrolled in risk-based models to re-evaluate medical necessity for patients’ continued use of remote monitoring on an annual basis.*