REMOTE MONITORING LEADERSHIP COUNCIL

Proposed Program Integrity Restrictions on Remote Monitoring

In its CY2027 proposed rule, CMS communicates several concerns about payment for remote monitoring services. CMS cites Office of the Inspector General (OIG) reports on *Additional Oversight of Remote Patient Monitoring in Medicare Is Needed* [2] and *Billing for Remote Patient Monitoring in Medicare* [3] as the source of these concerns.

- CMS is concerned about remote monitoring arrangements in which vendors provide services with little interaction with the billing practitioner.
- CMS is concerned about the lack of transparency created by the billing of "incident to" services.
- CMS is concerned about accurate device costs, due to lack of information regarding the typical device used to perform these procedures.
- CMS is concerned about proliferation of the monitoring code family and instances in which all components were not documented in CMS records.

We share these concerns. The Remote Monitoring Leadership Council (RMLC) previously called on CMS to take action to strengthen program integrity oversight of Medicare remote monitoring, and the OIG for more robust auditing.

The CY2027 policy proposal does not successfully address the above concerns OR policy recommendations outlined by OIG. Below, we recommend actions CMS can take to address these concerns without jeopardizing patient access to care and providers ability to partner.

We urge CMS to adopt the following policies as logical outgrowths of the proposed CY2027 rule, and consider additional guardrails as outlined in further detail below.

1. Specify additional general supervision criteria that expand requirements to meet the "overall direction and control" necessary in the relationship between a remote monitoring provider and remote monitoring biller.

2. Adopt existing OIG recommendations (drafted in response to these exact concerns) that CMS can implement through existing oversight infrastructure, including an order/ordering-practitioner identification and incident-to modifier.

3. Adopt the proposed initiating-visit requirement, but grandfather current patients and allow exceptions for patients with a strong, longitudinal provider-patient relationship and certain post-acute situations.

4. Expand on the initiating visit requirement, by requiring documented recertification of medical necessity by the ordering provider if the patient's plan of care exceeds a year.

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RECOMMENDATIONS

PRIORITY OPTIONS FOR ADOPTION IN CY2027 FINAL RULE

Further Define General Supervision "Overall Direction And Control" Requirements for a Remote Monitoring Arrangement

CMS has expressed concern about care fragmentation. A blanket employment restriction is an inadequate proxy for clinical integration. Instead, CMS should apply its longstanding care-management interpretation of general supervision. In the Chronic Care Management (CCM) context, CMS has explained that the billing practitioner must remain involved in ongoing oversight and management, collaboration, and reassessment, as appropriate. Where practitioner oversight or clinical integration with a third party is lacking, the service elements are not furnished and the practitioner should not bill Medicare (CY2017 MPFS final rule, 81 FR 80249).

The following guardrails are a logical outgrowth of the proposed rule because they directly address CMS's stated concerns and draw from existing care-management guidance. They would test whether integrated care is actually delivered:

- Ongoing oversight:
  - The billing practitioner must designate and document staff responsible for handling escalations and emergencies identified through monitoring.
  - The billing practitioner must maintain documented escalation pathways and shared clinical protocols with the individual or entity supporting monitoring.
  - The individual or entity supporting remote monitoring must designate clinical personnel responsible for the beneficiary's monitoring services who are available to communicate with the billing practitioner or designated practice staff.
- Collaboration:
  - Monitoring information must be shared promptly with the billing practitioner through the practice's electronic health record or another secure, documented workflow.
  - The record must demonstrate closed-loop responses to clinically significant alerts and practitioner instructions.
- Reassessment:
  - The billing practitioner must author and maintain a plan of care with defined remote monitoring goals and criteria for reassessment.

Adopt Key HHS OIG Policy Recommendations

As cited by CMS, the HHS OIG in 2024 made specific policy recommendations to address the outlined program integrity concerns that have not yet been addressed. These substantive recommendations would create the data and accountability pathways to resolve the "lack of information" held by CMS on these services. This approach would help CMS distinguish clinically integrated remote monitoring from arrangements that present genuine program-integrity risk without imposing a blanket employment restriction.

- **CMS should require that all remote patient monitoring services be ordered by a physician or other qualified health care professional and that information about the ordering provider be included on claims** and encounter data for remote patient monitoring. This ordering-provider requirement would not require a new modifier or reporting system. It is particularly appropriate in light of CMS's CY2027 proposal to require an initiating visit by the

billing practitioner. Requiring the ordering provider's National Provider Identifier (NPI) on the claim would create a claims-level record of the practitioner relationship that CMS is seeking to strengthen through the initiating-visit requirement. This requirement would help ensure that beneficiaries receive remote monitoring services that are medically necessary and clinically appropriate. It would also provide CMS and other oversight organizations with essential information needed to detect and prevent fraud, waste, and abuse.

- **CMS should require the use of a modifier to indicate "incident to" services on Medicare remote monitoring claims and encounters and to track RPM providers.** CMS is already implementing new claims modifiers in CY2027 that distinguish certain telehealth services furnished incident to a billing practitioner's professional services. Although remote monitoring is not itself a Medicare telehealth service, the new telehealth modifier demonstrates the feasibility and program integrity value of identifying incident-to delivery arrangements through claims data.

  In parallel with the telehealth platform modifier, CMS could establish a modifier for remote monitoring services offered through a contracted or centralized platform, providing CMS with greater visibility into how these services are delivered, including the use of centralized clinical staffing and vendor-supported care models. CMS could then use those data to identify unusual billing patterns, evaluate the effects of different staffing arrangements, and target oversight toward arrangements that present actual risks. This option would be far superior to prohibiting contracted staffing and consolidated staffing models (pooling staff within a clinically integrated network).

  These changes would give CMS full visibility into how these services are being delivered and greater visibility into how vendors and centralized staffing models are widely used to support difficult to operationalize remote monitoring programs.

Adopt the Proposed Initiating-Visit Requirement, With Narrow Exceptions Based on CMS Precedent

CMS has proposed a new requirement for a separately reportable initiating visit in association with the onset of RPM or RTM services in the CY2027 proposed rule, since these services require care coordination. We agree that an initiating visit can help ensure that remote monitoring follows a practitioner evaluation rather than algorithmic selection or vendor-driven outreach. We believe this CMS proposal is a reasonable guardrail if narrow modifications are made to reflect situations in which a strong, longitudinal patient relationship already exists.

- **CMS should leverage CCM precedent to define when a separate initiating visit is unnecessary because a strong, longitudinal practitioner-patient relationship already exists**. CMS should permit initiation during an otherwise qualifying E/M visit, annual wellness visit, or initial preventive physical examination *and should exempt patients seen by the billing practitioner within the preceding year*.

- **CMS should also recognize a care initiation pathway for specific post-acute situations in which a patient is provided a monitoring service as part of a coordinated plan of care post-hospitalization.** In these typically short-duration remote monitoring situations, the

provider initiating care (hospitalist) may not be the same provider managing the care plan (primary care).

- **CMS should also adopt a transition period for beneficiaries already receiving remote monitoring on January 1, 2027**. Applying the initiating-visit requirement prospectively during the first year would avoid an immediate volume of visits that primary and specialty practices would be unable to absorb.

Require Annual Recertification of a Remote Monitoring Order

Building on the initiating visit proposal, the Council recommends that CMS strengthen the requirement of an order for remote monitoring by requiring documented recertification of medical necessity if the patient's plan of care exceeds a year. The Council recognizes that there have been reports of patients staying on remote monitoring services after they are no longer needed. While copays and patient behavior typically resolve this concern, we believe that remote monitoring should only exist as part of a documented care plan treating a specific condition or conditions.

This additional visit, during which continued medical necessity would be documented, would serve to protect taxpayers from unnecessary utilization by creating an additional inflection point for ending patient care. As outlined by OIG, the additional data and documentation captured during both the initiating visit and the recertification of medical necessity with full documentation after a year would be useful for program integrity purposes and research.

ADDITIONAL RECOMMENDATIONS

Collect Information About the Physiologic Data and Devices Being Used

As recommended by OIG in 2024, CMS should implement methods to collect further information about the devices being used for remote monitoring and conditions it is treating**.** The current lack of information inhibits CMS's ability to conduct oversight and ensure the services are used appropriately. CMS should develop codes or modifiers identifying the physiologic information monitored and, where useful, the device type, manufacturer, or model. These data could improve program-integrity analysis, illuminate emerging use cases, and support more accurate valuation of remote monitoring device-supply services. The collection of this data would have multiple benefits. Device data would provide CMS with the information it needs to improve valuation calculations for the remote monitoring supply codes (a challenge described in the rulemaking). It would allow CMS to track growing remote monitoring use cases and understand them – making it clear how devices, costs, and utilization differ across widely varied conditions. Additionally, CMS should consider whether Medicare Advantage encounter data should eventually identify monitored physiologic information, devices, staffing arrangements, or contracted vendors.

Establish Broader Clinical-Access and Value-Based Payment Guardrails

CMS should evaluate whether selected CCM requirements or Advanced Primary Care Management standards and documentation —such as defined 24/7 care access and continuity of care requirements—should apply to remote monitoring. Purchasers of high-quality remote monitoring programs today often demand similar capabilities from remote monitoring providers.

Establish a Dedicated Enrollment Classification for Remote Monitoring Organizations

As recommended by OIG in 2024, CMS should develop a method to identify companies that specialize in remote patient monitoring. A new provider or supplier enrollment classification would improve visibility into organizations that primarily support remote monitoring. The Council welcomes the opportunity to create clear visibility into our practices and better demonstrate how high-quality remote monitoring services are able to drive saving for taxpayers through avoided hospitalizations and other outcomes.

Support a Market-Based Supplement to Government Requirements

Establish high-level clinical integration and oversight standards, and solicit applications from organizations capable of accrediting remote monitoring arrangements. While an accreditation pathway would need to be phased in over a period of time, it would be an effective way for industry to regulate problematic remote billing providers. The Council strongly support a quality and outcomes-focused barrier to entry for organization wishing to operate as remote monitoring vendors to ensure the integrity of the care delivered and the return on taxpayer dollars.

Accelerate the Pathway to Value-Based Payment (including the ACCESS Model)

CMS should also explore outcome-based payment options, appropriate quality measures, and additional model pathways for conditions and patient-intensity levels commonly managed through remote monitoring. While there is not yet a path to fully abandon fee-for-service for many Medicare patients, accelerating movement to value-based care resolves many CMS concerns in CY2027 proposal. More details can be found here.

- **Incorporate outcome-based payment options for remote monitoring services in any future alternative payment model.** We have concerns with the remote monitoring payment bundle as written in the proposed rule. We believe CMS should revisit this bundle with the goal of creating an opportunity for more flexibility and enhanced accountability for outcomes through a value-based payment. Remote monitoring providers are eager and ready to be paid for outcomes – we just need more payment pathways to capture necessary patient care.

- **Require all remote monitoring providers to begin reporting any appropriate ACCESS model measures as cited in the Outcome-Aligned Payment Measures List.** Outcome-focused data points (such as blood pressure reduction/control) for these services (alongside other documentation requirements above) could prove or disprove efficacy for specific conditions within a year. These reporting requirements would create a meaningful control group for ACCESS model participants to benchmark themselves against. The data generated by this comparison would yield incredible value for CMMI.

- **Build new/additional alternative payment model options for medical conditions and patient intensity levels that are currently treated through remote monitoring** (but are not currently represented in ACCESS model tracks).