PROPOSED RULE

CMS wants to hit rewind on RPM & RTM

After years of expanding remote monitoring, the proposed CY2027 rule would make these services **harder to bill and pay less**, and would end the outsourced clinical-staff model that let programs scale. Here's what you need to know.

01 Employed staff only

CMS would pay for RPM/RTM only when clinical staff employed by the practice furnish the monitoring and treatment management. **Outsourced/third-party clinical staff would no longer be payable**; the single most disruptive change in the rule.

PROPOSED

02 17 Codes bundled into 4

CMS is seeking comment on **collapsing 17 RPM & RTM codes into 4 new HCPCS G-codes** for setup and monthly monitoring. This is not yet a formal proposal; comments can shape whether it becomes one.

CONSIDERING

03 Established patients only

RPM could be furnished **only to established patients** as a condition of payment.

PROPOSED

04 Face-to-face initiating visit required

Practitioners would have to furnish a **separately reportable initiating visit** tied to the onset of RPM/RTM services.

PROPOSED

05 Practice-expense inputs revalued down

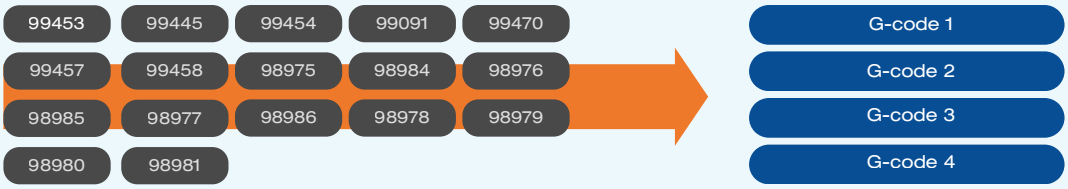
CMS believes RPM/RTM may be overvalued. It says it lacks real device pricing data and proposes to crosswalk the practice-expense inputs for setup and device-supply codes to lower-valued self-measured-BP and ECG-monitoring codes, and to **strip practice-expense inputs entirely** from the treatment-management codes (keeping their work RVUs). The net effect is lower payment and CMS is expressly asking commenters for real device cost data.

PROPOSED

The Code Collapse

CONSIDERING

17 existing CPT codes → 4 proposed HCPCS G-codes. **CMS cites concern over the "administrative burden"** and"proliferation" of remote-monitoring codes. (Seeking comment — not yet proposed.)



Why the pullback?

20x

Medicare RPM payments were roughly **20 times higher in 2022 than 2019.** The growth is what CMS is reacting to.

2024

An **HHS OIG report** called for greater oversight of RPM, flagging risks CMS says the current code structure can't fully resolve.

All

CMS wants assurance beneficiaries receive **all components** of the service, questioning third-party oversight and clinical integration.

WHAT YOU CAN DO

The comment period is your window

This is a proposed rule, not final — and the bundling piece is only out for comment. Nothing takes effect yet, and **public comments genuinely shape the outcome.** Before the window closes:

Submit a comment

Speak to the employed-staff-only proposal and the 17→4 bundling — the two changes with the biggest operational impact.

https://www.regulations.gov/document/CMS-2026-2377-0002/comment

Bring evidence, not opinion

Spell out how your monitoring team works under the billing practitioner, how flagged readings get routed back to the practice, and what the program has done to keep patients out of the clinic and the ER.

Rally others

Encourage partner practices and clinicians to comment too — volume and specificity both matter.

Deadline to comment

SEPT

14

Source: CY2027 Physician Fee Schedule proposed rule, Federal Register, published July 16, 2026. Some figures were summarized from that rule and a secondary write-up — confirm the exact code list and "proposed" vs. "seeking comment" language against the rule text before relying on this. Not legal or billing advice.

YOUR NEXT STEP

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