Providing and Billing Medicare for Remote Patient Monitoring

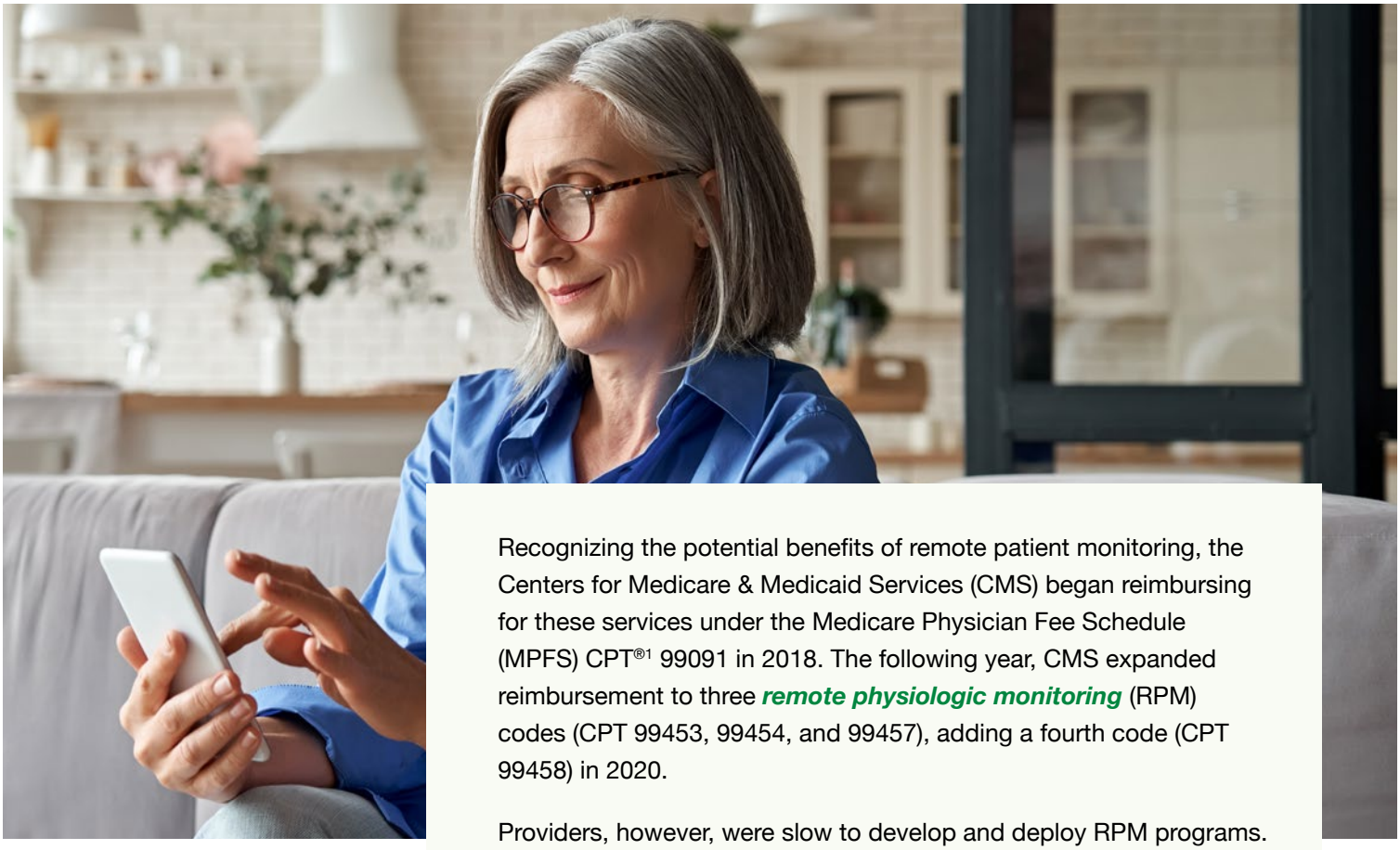
Updated February 2025



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Recognizing the potential benefits of remote patient monitoring, the Centers for Medicare & Medicaid Services (CMS) began reimbursing for these services under the Medicare Physician Fee Schedule (MPFS) CPT®[1] 99091 in 2018. The following year, CMS expanded reimbursement to three ***remote physiologic monitoring*** (RPM) codes (CPT 99453, 99454, and 99457), adding a fourth code (CPT 99458) in 2020.

Providers, however, were slow to develop and deploy RPM programs. In 2022, the most recent year for which CMS has made utilization data available, approximately 11,500 providers furnished these services to approximately 260,000 traditional Medicare beneficiaries.

To promote greater adoption, CMS in 2021 more fully defined the billing rules for the RPM codes, including the types of data and device capabilities required for RPM, the relationship between the CPT codes for the different components of RPM, and the required qualifications of individuals providing and billing for the services.

In 2022, CMS added reimbursement for ***remote therapeutic monitoring*** (RTM) under five CPT codes (CPT 98975, 98976, 98977, 98980, and 98981) and further refined its RTM billing rules in 2023, including the addition of a new RTM device code for cognitive behavioral monitoring, CPT 98978. RTM differs from RPM in that it involves non-physiologic data, which can be patient reported or digitally uploaded while RPM requires the data be digitally uploaded. In 2022, approximately 1,000 providers furnished RTM services to approximately 10,000 traditional Medicare beneficiaries.

1 Current Procedural Terminology® (CPT) is a registered trademark of the American Medical Association (AMA).

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I. Medicare Reimbursement for Remote Physiologic Monitoring



Q: Who can order and bill for RPM?

RPM can be ordered and billed only by physicians and non-physician practitioners (collectively, practitioners) who are eligible to bill Medicare for evaluation and management (E/M) services.

Q: Can Independent Diagnostic Testing Facilities (IDTFs) bill for RPM services?

Because RPM is not considered diagnostic testing, the service cannot be billed by IDTFs.

Q: What relationship between the practitioner and patient is required?

To bill for any RPM service, the practitioner must have an established relationship with the beneficiary. CMS has not defined "established patient" for purposes of RPM, but presumably the CPT definition would apply, i.e., a patient who has received professional services from the billing practitioner or another practitioner in the same group and the same specialty or subspecialty within the prior three years.

Q: Is consent required to provide and bill for RPM?

The practitioner must secure the beneficiary's consent to receive RPM either prior to or at the initiation of the service. Such consent must include an acknowledgment that the beneficiary will be responsible for the co-payment or deductible associated with the services. The beneficiary may consent verbally, but it must be documented in the medical record.

Q: Which beneficiaries are eligible for RPM?

CMS has not identified the specific circumstances in which Medicare will make payment for RPM other than to indicate the monitoring should be reasonable, medically necessary, and "used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition." Such justification for RPM should be documented in the patient's medical record.

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Q: Under what CPT codes does a practitioner bill for RPM?

CMS has clarified that RPM is a process for which each component is billed under a separate CPT code. These components include the following:

1. ***Service Initiation –*** billed under CPT 99453 *[remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment]*.
2. ***Data Transmission –*** billed under CPT 99454 *[remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days].*
3. ***Data Analysis and Interpretation –*** billed under CPT 99091 *[collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days]*.
4. ***Treatment Management Services –*** billed under CPT 99457 *[remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; (initial 20 minutes)* and CPT 99458 *(additional 20 minutes)]*.

Q: What are the 2025 reimbursement rates for RPM services furnished in the clinic setting?

The following reflects the 2025 MPFS national payment amounts; actual reimbursement will vary by geographic area. For 2025, the non-facility payment rate and the facility payment rate for these services are the same.

Code	Descriptor	Non-Facility Payment Rate
99453	Service initiation	$19.73
99454	Monthly data transmission	$43.02
99091	Interpretation and analysis, 30 min.	$51.75
99457	Treatment management services, clinical staff, 20 min.	$47.87
99458	Treatment management services, clinical staff, +20 min.	$38.49

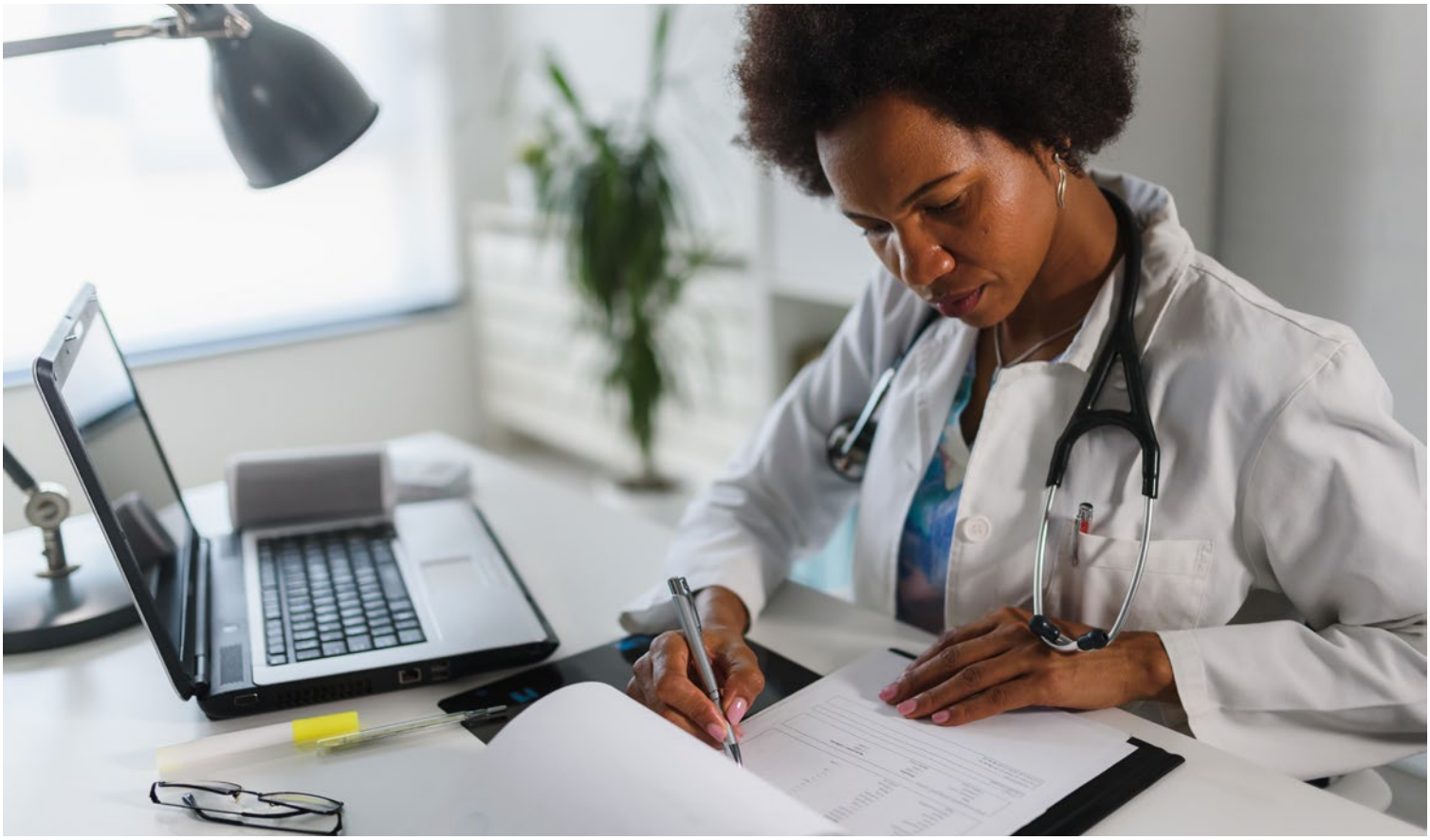
For CPT 99454, the 2025 rate represents a 9% cut from 2024, following a ~6% cut in 2024, a 10% cut in 2023, and a 12% cut in 2022.

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For RPM services billed as hospital outpatient department services, CMS has assigned CPT 99453 to APC 5012 (clinic visit and related services). The 2025 national payment amount for this APC is $128.87 (not adjusted for labor costs). CMS has assigned CPT 99454 to APC 5741 (Level 1 Electronic Analysis of Devices). The national payment amount for this APC is $37.29 (not adjusted for labor costs).

Also, for purposes of OPPS reimbursement, CPT 99454 has been assigned status indicator "Q1," which means no payment will be made for CPT 99454 if it is billed on the same claim as another service with status indicator "S," "T," or "V." For example, if the claim included CPT 99453, there would be no payment for CPT 99454, because the former has been assigned status indicator "V." Stated another way, payment for CPT 99454 is "bundled" into the payment for the other service.

CMS has not assigned CPT 99091, 99457, or 99458 to any APC. Thus, the payment for these services furnished in a hospital outpatient department is limited to the amount payable under the MPFS.



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II. Medicare Remote Physiologic Monitoring Billing Rules

A. Service Initiation and Data Transmission (CPT 99453 and CPT 99454)

Q: For what services do CPT 99453 and 99454 provide reimbursement?

The first two RPM codes, CPT 99453 and 99454, reimburse for the practice expense associated with furnishing RPM, including the cost associated with the monitoring device, its placement with the beneficiary, and the transmission of data.

Q: What practitioner work is required for these codes?

There is no wRVU assigned to either code. No practitioner work—supervision or otherwise—is required to bill for these services.

Q: What is included in CPT 99453?

CPT 99453 is used to report beneficiary education on the use of the device(s).

Q: Can CPT 99453 be billed more than once per patient? What if multiple devices are used?

According to CPT Guidelines, CPT 99453 can be billed only once per episode of care (defined as "beginning when the remote monitoring physiologic service is initiated and ends with attainment of targeted treatment goals") even if multiple devices are provided to the beneficiary.

Q: How many days of monitoring are required to bill 99453?

CPT Guidelines state (and CMS concurs) that CPT 99453 should not be reported "if monitoring is less than 16 days." Thus, if a beneficiary receives and is educated on the device(s), but data is not collected for a minimum of 16 days in a 30-day period, one could not bill for CPT 99453.

Q: What services are included in CPT 99454?

CPT 99454 is used to report the provision and programming of the device(s) for daily recording or programmed alert transmissions over a 30-day period, provided data is collected for at least 16 days during the 30-day period.

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Q: How often can CPT 99454 be billed? What if multiple devices are used?

CPT 99454 can be billed only once per 30-day period, even if multiple devices are utilized.

Q: How many days of monitoring/data collection are required to bill 99454?

CPT 99454 requires data be collected for at least 16 days during the 30-day period. For example, if the patient was educated and monitoring services for a beneficiary commenced on July 1, and data was recorded each day through September 12, one would bill CPT 99453 and 99454 in July and CPT 99454 in July and August (but not September).

Q: Are there other circumstances when CPT 99453 and 99454 cannot be reported?

CPT Guidelines state CPT 99453 and 99454 should not be reported "when these services are included in other codes for the duration of time of the physiologic monitoring service (e.g., 95250 for continuous glucose monitoring requires a minimum of 72 hours of monitoring)."

CMS has clarified that a practitioner who furnishes a global procedure cannot receive separate reimbursement for RPM furnished to the beneficiary during the global period unless RPM addresses an underlying condition that is not linked to the global procedure. There is no restriction on reimbursement for RPM furnished during a global period if the billing practitioner is not receiving the global service payment.

Q: Can two or more practitioners concurrently bill RPM for the same patient?

CMS will not pay more than one practitioner for CPT 99453 for an episode of care or CPT 99454 for a 30-day period, even if each practitioner is arguably furnishing a distinct service. According to CMS, "The medically necessary services associated with all the medical devices for a single patient can be billed by only one practitioner, only once per patient per 30-day period, and only when at least 16 days of data have been collected." CMS has offered no direction regarding the resolution of claims submitted by multiple practitioners for the same beneficiary for the same time period.



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Q: What types of devices can be used for RPM?

Regarding the device requirements for CPT 99453 and 99454, CMS has specified that any such device must:

- Meet the definition of "medical device" stated in Section 201(h) of the Federal Food, Drug and Cosmetic Act.
- Automatically upload patient physiologic data (i.e., data not self-recorded and/or self-reported by the patient).
- Be capable of generating and transmitting either (a) daily recordings of the beneficiary's physiologic data, or (b) an alert if the beneficiary's values fall outside pre-determined parameters.
- Be reasonable and necessary for the diagnosis or treatment of the patient's illness or injury or to improve the functioning of a malformed body member.
- Be used to collect and transmit reliable and valid physiologic data that allows an understanding of a patient's health status in order to develop and manage a plan of treatment.

Q: What documentation must be included in the beneficiary's medical record to support a claim for CPT 99453 and 99454? What date and place of service should be listed on such claim?

CMS has not stated any requirements, nor offered any guidance, regarding the documentation necessary to support a claim under CPT 99453 or 99454 or the appropriate date or place of service to be listed on the claim form. Absent such direction, we recommend the following:

- The documentation for CPT 99453 would include (a) a practitioner order for deployment of the device; (b) the condition for which the beneficiary is monitored and the medical necessity of the monitoring device; (c) the beneficiary's consent for RPM services, including acknowledgment of copayment responsibility; (d) identification of the device; (e) the date of delivery of the device to the patient/caregiver; and (f) the date(s) on which training is provided to the patient/caregiver.
- The documentation for CPT 99453 and 99454 would be sufficient to demonstrate monitoring occurred for at least 16 days in a 30-day period.
- The date of service for CPT 99453 would be the date on which the device records the 16th day of data in a 30-day period following initiation of the service (or the last date of that 30-day period).
- If the device records and transmits data for at least 16 days, but not more than 30 days, the date of service for CPT 99454 would be the last day the device records data and transmits it to the provider.
- If the device records and transmits data for more than 30 days, the date of service for the first instance of CPT 99454 for a given beneficiary would be 30 days following the delivery of the device or completion of training (whichever occurred later). The date of service for each instance thereafter would be 30 days from the prior date of billing, provided the use of the device continued at least 16 days after the prior date of service.
- Based on CMS' guidance regarding chronic care management (CCM), the place of service for both codes would be the location at which the billing practitioner maintains his or her practice (i.e., physician office vs. hospital outpatient department).

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B. Data Analysis and Interpretation (CPT 99091)



Q: For what services does CPT 99091 provide reimbursement?

According to CMS, "After the data collection period for CPT 99453 and 99454, the physiologic data that are collected and transmitted may be analyzed and interpreted as described in CPT 99091…."

Q: Who can perform CPT 99091 services? What level of supervision is required?

This work may be performed by a physician or non-physician practitioner or by clinical staff if the requirements for "incident to" billing are satisfied. Those requirements include **direct supervision** of the clinical staff by the billing practitioner—i.e., that practitioner must be physically present in the same suite of offices and immediately available to provide assistance and direction when the service is performed.

Through the end of the of 2025, direct supervision may be accomplished through the use of interactive audio/visual real-time communications technology.

Q: What work must be performed to bill for CPT 99091?

CPT 99091 is a time-based code, meaning 30 minutes of services furnished over a 30-day period must be documented to bill for this service. CMS notes the valuation for CPT 99091 is based on 40 minutes of work, including 5 minutes of pre-service work (e.g., chart review) and 5 minutes of post-service work (e.g., chart documentation). Stated another way, the pre- and post-service work cannot be counted toward the 30-minute requirement.

Q: Does a provider have to submit a claim for CPT 99453 and 99454 to bill for CPT 99091?

While a provider is not required to submit a claim for CPT 99453 and/or 99454 to bill for CPT 99091, a provider must have collected at least 16 days of data in a 30-day period to bill for this code. In the 2023 Medicare Physician Fee Schedule Final Rule, CMS stated RPM services "can be billed… only when at least 16 days of data have been collected." In the 2024 Final Rule, CMS clarified that the 16-day data collection requirement does not apply to the RPM treatment management codes, CPT 99457 and 99458, but did not include CPT 99091 in this clarification.

Note that a practitioner who bills for CPT 99091 without having billed for CPT 99453 and 99454 still would be subject to the established patient and consent requirements discussed in the previous section.

Q: What date of service should be used for CPT 99091? Place of service?

As with other time-based codes, the date of service for CPT 99091 would be the day on which the 30th minute of services is provided or any day thereafter up to and including the last day of the 30-day period. The place of service is the location at which the billing practitioner maintains his or her practice.

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C. Treatment Management Services (CPT 99457 and CPT 99458)

Q: What steps follow data collection and interpretation in RPM?

The next steps in the RPM process are the development of a treatment plan informed by the data and the management of that plan by clinical staff under the supervision of the billing practitioner until the targeted goals of that plan are attained. CMS refers to this as "treatment management services." CMS does not dictate the content or format of such treatment plan.

Q: Under what CPT codes are treatment management services billed?

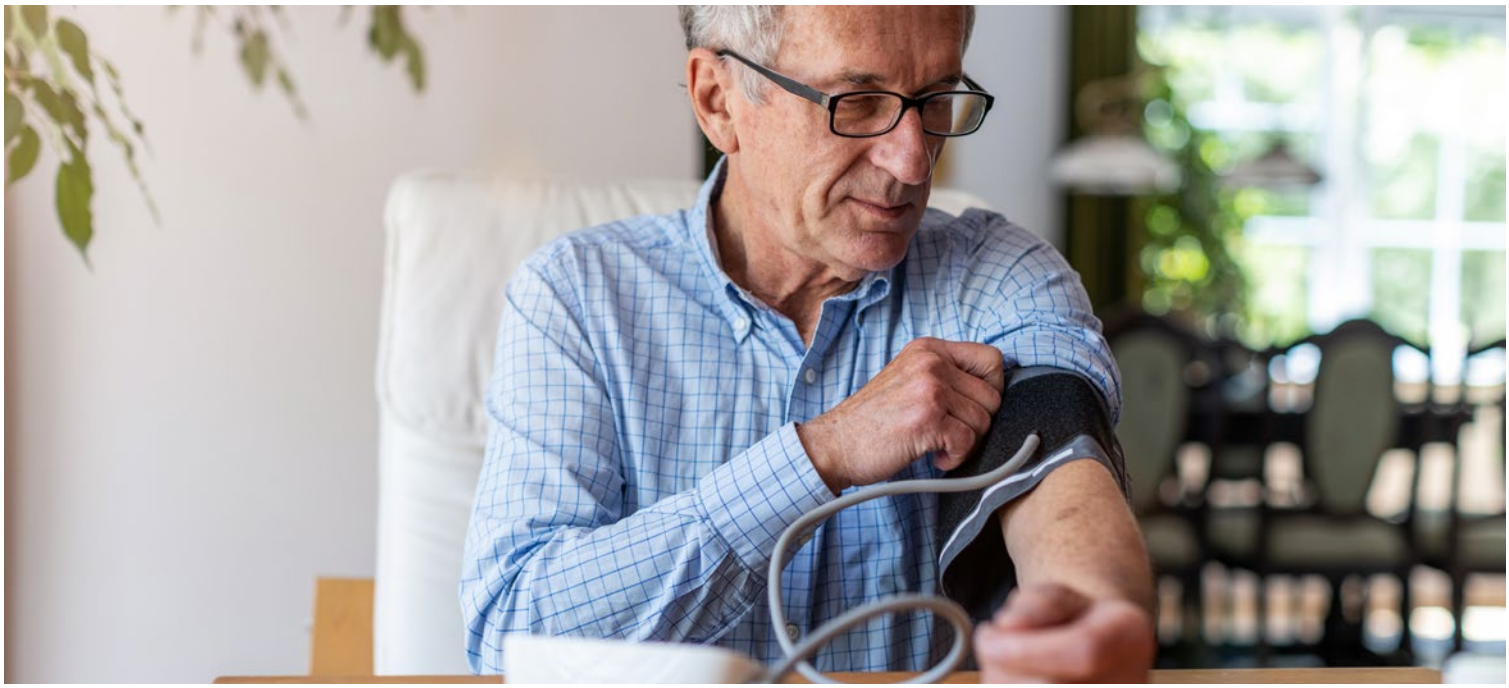
These services are billed under CPT 99457 (initial 20 minutes of services) and CPT 99458 (each subsequent 20-minute increment).

Q: Does the 16-day data collection requirement apply to treatment management services?

CMS has clarified this requirement does not apply to CPT 99457 and 99458, noting these codes "account for time spent in a calendar month and do not require 16 days of data collection in a 30-day period."

Q: How many units of CPT 99458 can be billed in a month?

As part of its National Correct Coding Initiative Program, CMS maintains a list of Medically Unlikely Edits (MUEs) to be applied by Medicare Administrative Contractors (MACs) in processing claims. An MUE for a specific code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Under the applicable MUE, only three units of CPT 99458 may be submitted with the same date of service. (Because CPT 99458 is an add-on code to CPT 99457, any claim for CPT 99458 must be submitted with the same date of service as CPT 99457.) If a claim is submitted with four units of CPT 99458 with the same date of service, the edit will force a denial of payment for all units (not just the fourth unit). When the claim is denied, the billing physician or practitioner has the opportunity to submit to the MAC documentation to demonstrate medical necessity.



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Q: What provider/patient interaction is required to bill these services?



CPT Guidelines specify that "[r]emote physiologic monitoring treatment management services are provided when clinical staff/physician/other qualified healthcare professional use the results of remote physiological monitoring to manage a patient under a specific treatment plan.…[CPT] 99457 requires a live, interactive communication with the patient/caregiver.…" CMS defines such communication as "real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission." According to the agency, the 20 minutes of time required to bill for CPT 99457 and 99458 can include time for furnishing management services as well as for the required interactive communication.

Q: What level of supervision is required for services furnished by clinical staff?

CPT 99457 and 99458 qualify as designated care management services under 42 CFR 410.26(b)(5), meaning these services can be furnished under the general supervision (as opposed to direct supervision required for CPT 99091) of the billing practitioner.

Q: Does the supervising physician or practitioner have to be the same individual as the care provider?

The supervising physician or practitioner does not have to be the same individual treating the patient more broadly. However, CPT 99457 and CPT 99458 must be billed under the National Provider Identifier (NPI) of the physician or practitioner who supervises the clinical staff performing the service.

Q: Can CPT 99457 and 99458 be billed concurrently with other care management services?

There is no prohibition on billing for other care management services—including CCM (CPT 99437, 99439, 99490, and 99491), complex CCM (CPT 99487 and 99489), principal care management (CPT 99424, 99425, 99426, and 99427) transitional care management (CPT 99495 and 99496), general behavioral health integration (CPT 99484, 99492, 99493, and 99494), chronic pain management (HCPCS G3002 and G3003), or advanced primary care management (HCPCS G0556, G0557, and G0558)—provided none of the time counted for treatment management services also is counted to support a claim for other care management services. RPM cannot be billed concurrently with RTM.

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Q: If a provider performs RPM (i.e., bills for CPT 99453 and/or 99454) in a given month, can the provider bill for CCM instead of CPT 99457 and 99458?

Until 2022, reimbursement for CPT 99457 and 99458 was greater than reimbursement for CCM, even though both required 20 minutes of care management services furnished by clinical staff. Thus, a provider was incentivized to bill for 99457 and 99458 rather than CCM.

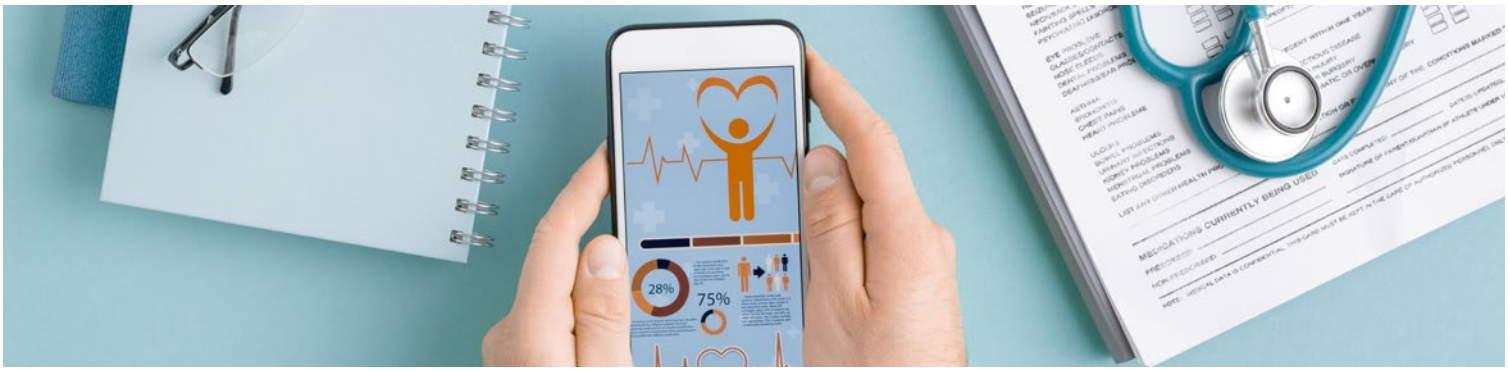
In 2022, however, CMS significantly increased the reimbursement for CCM so that it now pays more to provide these services than CPT 99457 and 99458. Specifically, the 2025 non-facility national payment amount for CCM billed under CPT 99490 is $60.49 compared to $47.87 for CPT 99457. Similarly, the reimbursement for the 20-minute add-on code for CCM, CPT 99439, is $45.93, compared to $38.49 for CPT 99458.

Assuming a provider can structure its program to satisfy the additional requirements associated with CCM (i.e., using a certified electronic health record for specified purposes, maintaining electronically a comprehensive care plan addressing all of the beneficiary's health conditions, ensuring beneficiary access to care, facilitating transitions of care, and coordinating care), it makes sense to bill the 20 minutes of care management services as CCM under CPT 99490 instead of CPT 99457. For a detailed explanation of the CCM billing rules, please see our separate white paper, Providing and Billing Medicare for Chronic Care Management and Related Services.

Back in 2014, CMS explained that "[p]ractitioners who engage in remote monitoring of patient physiological data of eligible beneficiaries may count the time they spend reviewing the reported data towards the monthly minimum time for billing the CCM code, but cannot include the entire time the beneficiary spends under monitoring or wearing a monitoring device." Now, with reimbursement for service initiation and monthly data transmission, providers can cover the costs associated with such monitoring used as part of the provider's CCM program.

Q: Can a practitioner bill CPT 99091 and 99457 for the same time period for the same beneficiary?

According to the CPT manual, CPT 99091 and 99457 cannot both be billed for the same time period for the same beneficiary. However, CMS has determined that "in some instances when complex data are collected, more time devoted exclusively to data analysis and interpretation by a [practitioner] may be necessary such that the criteria could be met to bill for both CPT codes 99091 and 99457 within a 30-day period." CMS cautions, however, that one cannot use the same time to meet the criteria for both CPT 99091 and 99457.



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Q: How does one count time for CPT 99457 and 99458?

While CMS has not provided specific guidance on counting minutes for RPM, CMS has provided the following rules with respect to counting 20 minutes for CCM. We assume CMS would apply the same rules to CPT 99457 and 99458.

1. Time spent providing services on different days, or by different clinical staff members in the same calendar month, may be aggregated to total 20 minutes.
2. If two staff members are furnishing services at the same time (e.g., discussing together the beneficiary's condition), only the time spent by one individual may be counted.
3. Time of less than 20 minutes during a calendar month cannot be rounded up to meet this requirement (e.g., if only 18 minutes, no billable service; if only 38 minutes, bill CPT 99457, but not 99458).
4. Time in excess of 20 minutes (but less than the 20 minutes necessary to bill CPT 99458) in one month cannot be carried forward to the next month.
5. One may count time a practitioner or clinical staff member spends with more than one beneficiary (e.g., educating two beneficiaries at the same time), but the total amount of time must be divided among the beneficiaries (e.g., 20 minutes spent with two beneficiaries would count as 10 minutes for each beneficiary).
6. Do not count any time on a day when the billing physician or practitioner reports an E/M service (office or other outpatient services [CPT 99202, 99203-99205, and 99211-99215]; domiciliary, rest home services [CPT 99324-99328 and 99334-99337]; or home services [CPT 99341-99345 and 99347-99350]) unless the documentation demonstrates such time is distinct and separate from the E/M service. Do not count any time related to other reported services (e.g., CPT 93290).

Q: How does one document time spent providing treatment management services?

CMS has not provided guidance regarding the way time spent providing treatment management services should be documented. For RPM, we recommend capturing the date and time spent providing the non-face-to-face services (including start and stop times), the name of the care team member providing services (with credentials), and a brief description of the services provided. The documentation also should clearly support the date and nature of live interaction with the patient.

Q: What date and place of service should be used to bill CPT 99457 and 99458?

Although CMS has not addressed the issue, we believe, based on CMS' guidance regarding CCM, that the date of service on the claim would be the date on which the 20th minute of work occurs or any date thereafter in the calendar month for CPT 99457. Because CPT 99458 is an add-on code, it must be billed with the same date of service as CPT 99457. The place of service would be the location at which the billing physician maintains his or her practice (i.e., physician office vs. hospital outpatient department).

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III. Medicare Reimbursement for Remote Therapeutic Monitoring

Q: What are the 2025 reimbursement rates for RTM?

For 2025, CMS reimburses RTM services under the following suite of codes:

Code	Descriptor	Non-Facility	Facility
98975	RTM (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	$19.73	$19.73
98976	RTM (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	$43.02	$43.02
98977	RTM (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	$43.02	$43.02
98978	RTM (e.g., therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days	Contractor priced	Contractor priced
98980	RTM treatment, physician/other qualified healthcare professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes	$50.14	$29.44
98981	RTM treatment, physician/other qualified healthcare professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes	$39.14	$28.79

For 2025, reimbursement for RTM services furnished in a hospital outpatient department under OPPS mirrors such reimbursement for RPM: (1) CPT 98975 is assigned to APC 5012 with a national payment amount of $128.87; (2) CPT 98976, 98977; and 98978 are assigned to APC 5741 with a national payment amount of $37.29, subject to certain limitations; and (3) CPT 98980 and 98981 are not assigned to any APC.

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Q: Is there an equivalent of CPT 99091 for RTM?

Reimbursement under CPT 99091 is limited to analysis and interpretation of *physiologic* data. There is no equivalent code for therapeutic data. Thus, there is no separate reimbursement available for analysis and interpretation of therapeutic data.

Q: How is RTM reimbursement similar to RPM reimbursement? How is it different?

Unlike RPM, which involves monitoring of physiologic data, RTM involves monitoring of data around indicators such as therapy/medication adherence, therapy/medication response, and pain level. Like RPM, RTM requires the use of a device that meets the definition of "medical device" stated in Section 201(h) of the Federal Food, Drug and Cosmetic Act and requires the collection of at least 16 days of data in a 30-day period. Unlike RPM, however, a device used for RTM does not have to automatically upload patient data; instead, the data may be uploaded to the device by the beneficiary and then transmitted to the provider.

CMS has explained that "[w]hile we have not specified in rulemaking whether RTM services require an established patient relationship, we believe that similar to RPM, such services would be furnished to a patient after a treatment plan has been established. Presently, a billing practitioner would establish such treatment plan after some initial interaction with the patient. We will work to clarify this policy in future rulemaking."

Q: Who can bill for RTM services?

Like RPM, RTM can be billed by physicians and non-physician practitioners. CMS has included CPT 98980 and 98981 as designated care management services assigned to general supervision.

Unlike RPM, the RTM codes are not E/M codes. Thus, CMS policy permits "therapists and other qualified healthcare practitioners to bill the RTM codes….[W]here the practitioner's Medicare benefit does not include services furnished incident to their professional services, the services described by the codes must be furnished directly by the billing practitioner or, in the case of a PT or OT, by a therapy assistant under the billing PT's or OT's supervision….RTM services that relate to devices specific to therapy services should always be furnished under therapy plan of care *regardless of who provides them*."

Q: Is RTM reimbursement limited to monitoring for certain conditions?

The three RTM data transmission codes (CPT 98976, 98977, and 98978) are similar to the RPM transmission code (CPT 99454), but not identical. CPT 99454 is not limited to monitoring of certain systems, although the data must be physiological. CPT 98976 is only for transmissions to monitor the *respiratory* system; CPT 98977 is only for transmissions to monitor the *musculoskeletal* system; and CPT 98978 is only for transmissions relating to cognitive behavior therapy. Thus, transmission of therapeutic data relating to other systems (e.g., vascular, digestive, neurological) is not reimbursed separately by Medicare.

Noting that monitoring technologies for cognitive behavior therapy are still evolving, CMS opted to make CPT 98978 contractor priced. This requires a provider to submit to the contractor supporting documentation (including invoices) from which the contractor will determine appropriate pricing.

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Q: Does Medicare reimburse for digital mental health therapy (DMHT)? How does DMHT differ from RTM for cognitive behavior therapy?

Beginning in 2025, CMS will separately reimburse for digital mental health therapy (DMHT) devices, where the digital software devices are the actual therapy/intervention, as opposed to therapeutic monitoring devices reimbursed under CPT 98978. Under HCPCS G0552, CMS will pay a practitioner for supplying a DMHT device and providing initial education after having diagnosed a patient with a mental health condition. Like CPT 98978, HCPCS G0552 is contractor priced under the MPFS. The reimbursement for G0552 billed under OPPS mirrors such reimbursement for CPT 98975: It is assigned to APC 5012 with a national payment amount of $128.87.

CMS also will pay for treatment management services directly related to a patient's therapeutic use of a DMHT device under HCPCS G0553 (first 20 minutes) and G0554 (each additional 20 minutes). The national payment rates for DMHT treatment management services are substantially the same as the rates for CPT 98980 and 98981. Unlike CPT 98980, however, HCPCS G0553 is reimbursable under OPPS, assigned to APC 5012.

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IV: Rural Health Clinic and Federally Qualified Health Center Billing for Remote Monitoring Services

Q: How are Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) reimbursed for RPM and RTM?

Prior to 2025, RHCs and FQHCs billed for general care management services (including the RPM and RTM codes, with the exception of CPT 98978) under HCPCS G0511. Between January 1 and June 30, 2025, RHCs may continue to bill for these services under HCPCS G0511 or bill under the appropriate CPT code. Effective July 1, 2025, RHCs and FQHCs must bill under the appropriate CPT code for the service provided; reimbursement under HCPCS G0511 will be discontinued. RHCs and FQHCs will be reimbursed for general care management services billed under the appropriate CPT code at the non-facility national payment rate (with Part B deductibles), not the RHC all-inclusive rate or the FQHC PPS rate. RHCs and FQHCs cannot bill for CPT 98978 or digital mental health treatment (HCPCS G0552, G0553, and G0554).

For more information about providing and billing Medicare for remote patient monitoring, contact:

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