Now & Next
Healthcare Alert

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CMS finalizes 2027 Medicare RPM/RTM changes; direct employee rule delayed to 2029

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New remote monitoring rules require enrollment and billing updates for 2027, while giving practices until 2029 to address clinical staffing arrangements.

What's the impact?

- Effective January 1, 2027, remote therapeutic monitoring (RTM) may be furnished only to established patients, and both RTM and remote physiologic monitoring (RPM) require a face-to-face initiating visit with the billing practitioner before billing begins.
- The Centers for Medicare & Medicaid Services (CMS)'s direct employee requirement was finalized with a delayed start date of January 1, 2029. Third-party contracting will remain permitted through December 31, 2028, subject to "incident to" and other billing rules.
- CMS may issue sub-regulatory guidance before 2029 clarifying whether leased employees or independent contractors may provide remote monitoring services.

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On November 4, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Final Rule (the Final Rule), adopting changes to Medicare payment and coverage policies for RPM and RTM services. As we reported in July, CMS proposed these changes in response to two US Department of Health and Human Services (HHS) Office of Inspector General reports that identified potential fraud concerns in the RPM program.

For CY 2027, CMS proposed to (1) limit payment for RPM and RTM services to those performed by clinical staff who are direct employees of the billing practitioner, (2) extend to RTM services the established patient requirement that already applies to RPM, (3) require an initiating visit before RPM or RTM services begin, and (4) revise the valuation of RPM and RTM services under the PFS. CMS also sought comment about consolidating the RPM and RTM codes into new Healthcare Common Procedure Coding System (HCPCS) G-codes, which are billing codes used to identify certain services for Medicare payment.

CMS ultimately finalized some, but not all, of the proposed valuation changes and did not adopt the G-codes. The Final Rule does adopt the established patient and initiating visit requirements effective January 1, 2027, and finalizes the direct employee requirement with a two-year delay, to January 1, 2029.

Delayed clinical staff, direct employee requirement

The most significant of the proposed changes—that RPM and RTM services may not be billed to Medicare unless performed by clinical staff who are "direct employees" of the billing practitioner or the practitioner's practice—has been finalized, but CMS delayed the effective date until January 1, 2029. This means that practices will no longer be able to contract with third-party companies to supply clinical staff for RPM and RTM services.

CMS explained in the Final Rule that this does not require clinical staff to be physically located in the practice or the beneficiary to be on-site. It also does not prohibit practices from using outside vendors for devices, software, connectivity, data hosting, cybersecurity, technical support, or interoperability services, provided those vendors do not supply clinical staff time.

Practices may continue to contract with third-party companies through December 31, 2028, subject to existing "incident to" and other PFS billing rules. CMS cautioned that the billing practitioner must remain meaningfully involved in furnishing RPM and RTM services because the clinical staff time codes are valued to include ongoing practitioner work and supervision that cannot be delegated. Without adequate billing practitioner oversight or clinical integration with a third-party vendor, remote monitoring services will not meet Medicare billing requirements.

The Final Rule leaves an open question of whether clinical services may be performed by leased employees or independent contractors working under the billing practitioner's supervision, once

that part of the Final Rule takes effect in 2029. Commenters pointed out that the "incident to" requirements under §410.26 permit employees, leased employees, and independent contractors to provide services under general supervision. In response, CMS confirmed that clinical staff services may be provided under general supervision and that it is not changing the incident-to supervision requirements.

CMS did not directly address how the Final Rule's direct employee requirement fits with §410.26's recognition of leased employees and independent contractors but acknowledged that it may need additional time to specify other clinical staff arrangements that may be appropriate for remote monitoring services. This suggests that CMS may ultimately permit leased employees or independent contractors of the practice to provide these services, but their eligibility remains uncertain until CMS issues sub-regulatory guidance.

Established patient requirement for RTM services

Effective January 1, 2027, RTM services may be provided only to established patients, as is already required for RPM services. Under the PFS definition CMS adopted, an "established patient" is one who has received professional services from the physician or other qualified health care professional, or from another physician or qualified health care professional of the same specialty in the same group practice, within the past three years. For physical therapists, occupational therapists, and speech-language pathologists, an established patient is one receiving services under a therapy plan of care, which may extend through the episode of care. In response to concern about monitoring patients after discharge or injury, CMS clarified that a beneficiary who meets the new initiating visit requirements may qualify as an established patient.

Initiating visit requirement

Also effective January 1, 2027, practitioners must conduct an initiating visit before the onset of RPM or RTM services. The Final Rule does not define "onset" and did not impose a maximum interval between the visit and activation of RPM or RTM services. However, the regulations require that the initiating visit be face-to-face with the billing practitioner, in person or via telehealth. Remote monitoring does not have to be the sole purpose of the visit, but RPM or RTM must be discussed with the patient during the visit. For new patients, a patient relationship can be established as part of the initiating visit. An initiating visit is not required for a change of device, a clinical change, or a change of billing practitioner in the same practice. Beneficiaries receiving remote monitoring before January 1, 2027, do not need an initiating visit to continue services if all other requirements are met.

Valuation changes

The Final Rule revises the practice expense (PE) valuations for certain device supply and setup codes (CPT codes 99445, 99453, 99454, 98975, 98976, 98977, 98984, and 98985). Because these revaluations reduce total relative value units (RVUs) for the affected codes by 20% or more, CMS must phase them in over at least two years. The Final Rule did not provide more detail about how these changes will affect the reimbursement rates associated with these codes.

CMS separately addressed CPT codes 98978 and 98986. After considering public comment, CMS will price these codes in CY 2027 using the same practice expense valuation as CPT code 98977, giving all three codes the same PE RVU.

CMS also proposed eliminating direct PE inputs for certain treatment management codes, including CPT codes 99470, 99457, 99458, 98979, 98980, and 98981 but ultimately did not finalize that proposal, agreeing with commenters that clinical staff are often involved in providing these services and that eliminating clinical labor inputs would conflict with the direct employee requirement.

CMS also stated that further valuation changes are possible in future rulemaking, noting that the American Medical Association (AMA) informed CMS that its Relative Value Scale Update Committee (RUC) will review the PE valuations for all 19 RPM and RTM codes at its January 2027 meeting in response to CMS's concerns about a lack of data to support accurate valuation.

G-code consolidation

CMS had sought comment about consolidating the 17 existing RPM and RTM CPT codes into four new HCPCS G-codes. CMS did not adopt the G-codes and will consider the comments in possible future rulemaking.

Practical implications for stakeholders

The established patient and initiating visit requirements take effect January 1, 2027, and are conditions of payment. Practices should update enrollment workflows to confirm established patient status before monitoring begins and document the discussion of RPM or RTM in the record of the initiating visit. RTM providers, including physical therapists, occupational therapists, and speech-language pathologists, should also confirm that each patient is covered by an applicable plan of care or prior professional service.

Practices that rely on outsourced monitoring, and third-party companies that supply clinical staff, should identify each individual whose time is counted toward RPM or RTM codes, confirm that supervision is documented and meets current requirements, and review vendor agreements to

separate permitted technology and support services from clinical staff services that must be brought in-house by 2029.

Practices should complete enrollment and documentation updates before January 1, 2027.

Next steps

Nixon Peabody's Healthcare team will continue to monitor CMS guidance for remote monitoring services, including clinical staff arrangements before January 1, 2029, and any further changes to RPM and RTM valuations. We are available to help clients evaluate existing RPM and RTM arrangements, update enrollment, documentation, and billing workflows, and restructure vendor relationships before the 2029 deadline. If you have questions about how the Final Rule could affect your organization, please contact any of the authors of this alert or your regular Nixon Peabody attorney.

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