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Client Alert: Centers for Medicare & Medicaid Services 2027 Physician Fee Schedule Proposed Rule Would Upend Third-Party Remote Patient Monitoring and Remote Therapeutic Monitoring Arrangements

The Centers for Medicare & Medicaid Services (CMS) Calendar Year (CY) 2027 Physician Fee Schedule proposed rule (CMS-1848-P, 91 FR 43842) spans a wide range of Medicare payment policies. Among those provisions are proposed changes to Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) that caught the industry off guard and that providers who do not closely track fee schedule rulemaking may have missed entirely. Not every specialty or practice offers RPM or RTM services, but for those that do, the arrangement frequently depends on a third-party company whose staff handles device setup, patient monitoring, data analysis, and communications on the billing provider's behalf. The proposed rule, if finalized without change, would effectively prohibit that model—requiring all

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clinical monitoring staff to be direct employees of the billing practitioner or practice. Providers who currently rely on third-party RPM or RTM vendors face a binary decision before January 1, 2027: restructure their programs to bring monitoring staff in-house and comply with the new requirements or discontinue RPM and RTM services altogether.

The Outsourcing Ban

The most impactful proposal would prohibit Medicare payment for RPM and RTM services performed by clinical staff members who are not direct employees of the billing practitioner or practice. Under current policy, many practices contract with third-party remote monitoring companies whose staff handles monitoring, data analysis, triage, and patient communications. This is often from centralized call centers with no direct clinical connection to the billing practice. CMS would end this arrangement, citing Office of Inspector General (OIG) findings that outsourced delivery fragmented care, weakened practitioner oversight, and led to billing for services not fully rendered. Practices could still purchase devices, software, and technology platforms from vendors, but the clinical work generating Medicare reimbursement must be performed by employed staff.

New Patient Relationship and Visit Requirements

CMS proposes extending the established patient requirement—already applicable to RPM—to RTM services. Additionally, both RPM and RTM would require a separately billable, face-to-face initiating visit (in-person or via telehealth) before monitoring services can begin. At that visit, the billing practitioner must discuss the monitoring plan with the patient, determine that RPM or RTM is clinically appropriate, and document patient consent. A visit at which remote monitoring is not actually discussed does not qualify. This mirrors the approach CMS takes with chronic care management services.

Ambiguity in the “Direct Employee” Definition

Notably, the proposed rule does not clearly define what qualifies as a “direct employee.” A W-2 employee of the billing practice is plainly inside the requirement, and a contractor supplied by an outside vendor is plainly outside it. However, common health care arrangements fall in between (for example, a multi-specialty physician group that employs clinical staff in a separate affiliated entity [such as a Management Services Organization] from the entity that holds the billing National Provider Identifier [NPI], or independent contractors who work exclusively on-site under the practice’s supervision). CMS has not addressed these scenarios, and the final rule may or may not provide additional clarity.

Lower Reimbursement Rates

CMS proposes downward revaluations of practice expense inputs for RPM and RTM setup, device supply, and treatment management codes. CMS believes current rates overstate what practices actually pay for monitoring devices and related services. We anticipate the final rates will depend on the record developed during the rulemaking process.

Possible Code Consolidation

While not formally proposed in the CY 2027 rule, CMS has solicited comment on replacing the current 17 RPM and RTM billing codes with four bundled Healthcare Common Procedure Coding System (HCPCS) G-codes. Each monthly code would require device supply, at least two days of data transmission, 20 minutes of treatment management, and at least one real-time patient interaction. If adopted in a future rulemaking, this would require practices to deliver a complete monthly monitoring service before billing, rather than billing individual components separately. Providers should monitor subsequent CMS rulemaking for developments on this front.

How to Prepare

Providers that offer RPM or RTM services, particularly those relying on third-party vendors, should promptly evaluate whether their programs need restructuring to comply and make necessary changes by year-end. Key steps include:

- Assess your staffing model. If your practice relies on third-party vendors for clinical monitoring staff, determine whether you can transition to a direct-employment model. If staff members are employed through an affiliated entity or serve as independent contractors, work with counsel to evaluate whether your arrangement satisfies the “direct employee” requirement or whether restructuring is necessary.
- Model the financial impact. Evaluate whether your RPM program remains viable at proposed reimbursement levels, factoring in the added cost of employing monitoring staff directly and lower practice expense valuations.
- Review patient intake workflows. Ensure your enrollment process includes a qualifying face-to-face initiating visit (in person or via telehealth) at which the billing practitioner discusses the monitoring plan and documents patient consent before RPM or RTM services begin.
- Monitor the final rule. The final CY 2027 PFS rule is expected later this fall. Watch for whether CMS clarifies the “direct employee” definition, modifies the outsourcing restriction, or moves forward with code consolidation.

If your practice offers RPM or RTM services, or you are a third-party vendor providing these services on behalf of a health care provider, Shumaker’s Health Law Service Line can help you evaluate your current program, assess compliance with the proposed requirements, and develop a path forward. Contact Mara Rendina or Aerin West to discuss your specific situation.