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CMS Final Rules on Payment Impacts for Remote Therapeutic Monitoring

The [2023 Physician Fee Schedule](#) final rule (“Final Rule”), which became effective in January 2023, lists the services and rates for which Medicare will reimburse providers.

The Final Rule sets forth updates regarding several of Center for Medicare and Medicaid Service (CMS) key provisions relating to the delivery and reimbursement of Remote Therapeutic Monitoring (RTM), most notably allowing all RTM services to be furnished by clinical staff under general supervision for purposes of “incident-to” billing.

Remote Therapeutic Monitoring Services

RTM services provide the review and monitoring of non-physiological data related to signs, symptoms, and functions of a therapeutic response. RTM data can be objective data automatically generated by certain medical devices, or subjective data self-reported by patients, that provide practitioners with a comprehensive, functional measure of a patient’s response to therapeutic interventions. For example, practitioners can use remote sensors to track a patient’s use of “as-needed” medications, like inhalers or oral pain medication. This information allows practitioners to make more informed decisions regarding whether changes need to be made to a therapeutic regimen. RTM has focused primarily on monitoring of the musculoskeletal and respiratory systems, and recently broadened in the Final Rule to also include monitoring for cognitive behavioral therapy (CBT) via RTM.

RTM differs from remote patient monitoring (RPM) in significant ways. RPM collects patient physiological data, monitoring specific vital signs as they relate to established medical conditions. RPM allows health care professionals to track the overall health of a patient on short or long-term timeframes, while RTM allows for a remote assessment of a patient’s response to specific therapeutic interventions. RPM services are billed under different codes and

require different levels of supervision, so it is important to distinguish between these services in practice.

The six Medicare RTM codes are Current Procedural Terminology (CPT) codes: 98975, 98976, 98977, 98978, 98980, and 98981. Reimbursements under RTM are limited to an episode of care clinically related to the data transmissions that monitor the respiratory system (CPT 98976), the musculoskeletal system (CPT 98977), or cognitive behavioral therapy (98978). Under these primary CPT codes, physicians or other qualified health care professionals can bill for the collection and analysis of non-psychological data collected remotely via medical devices when used to monitor how patients are progressing under specific treatment plans. "Qualified health care professionals" are defined as those "qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service."^[1]

Response to July 2022 Proposed Rule

In its most significant update, CMS now allows RTM to be provided under general supervision for purposes of "incident-to" billing. The RTM codes, CPT codes 98980 and 98981, were originally created under the "General Medicine" category, rather than the Evaluation /Management (E/M) Services Category, under which RPM codes fall. As a result, qualified healthcare professionals were not permitted to order and bill for services provided by auxiliary staff under remote, general supervision. Requiring the physician to be physically present when the services were administered by auxiliary staff created a burden to patient access. This was causing practitioners to opt out of providing these services to their patients altogether.^[2]

In its Proposed 2022 Rule, CMS proposed to resolve this bottleneck by creating four entirely new codes allowing for general supervision to replace the two original codes (98990 and 98981). These proposed codes, GRTM1 through GRTM4, represented RTM treatment management services and RTM treatment assessment services. GRTM1 and GRTM2 provided for treatment management by physicians or nonphysician practitioners, and GRTM3 and

GRTM4 provided for RTM treatment assessment by a nonphysician qualified health care professional. Commenters across the health care industry responded negatively to these new codes, expressing concern that the codes were overly confusing or burdensome. Commenters also noted concern that these codes did not result in the appropriate levels of payment, based on the requirements for rendering these services under different levels of supervision and by different levels of clinical staff. Taking public commentary into consideration for these proposed codes, CMS rejected that proposal, instead opting to allow for general supervision under the original 98980 and 98981 codes.

Billing for RTM– General Supervision Changes

Under the final rule, which went into effect in January of 2023, physicians and certain non-physician practitioners (e.g., PAs and NPs) are permitted to bill for “incident to” RTM services under general supervision. However, the final rule does not give certain practitioners, such as physical therapists (PTs), occupational therapists (OTs), speech language pathologists (SLPs), and clinical social workers CSWs, the ability to bill for “incident to” services. In these cases, RTM services must be personally furnished by the billing qualified health care practitioner or, in the case of a PT or OT, by a therapy assistant under the PT’s or OT’s supervision.

In the wake of the final rule, various qualified health care practitioners have asked for more clarity from CMS regarding the required level of supervision under these rules, as there was widespread confusion about which providers must actually render services in order to be reimbursed. For example, the American Physical Therapy Association (APTA) followed up with CMS after the release of the Final Rule to determine the status of independent practice by physical therapist assistants (PTAs) in private practices under these codes. In response, CMS clarified that in private practice settings, PTAs must continue to be supervised under direct supervision when providing care under the RTM codes in the private practice setting. However, PTAs providing care in institutional facilities such as rehab agencies can furnish RTM services under general supervision. This indicates that there continue to be

ambiguities in the Final Rule regarding furnishing serviced under general supervision. Providers should ensure that they are utilizing the correct clinical staff to qualify for maximum reimbursement and to avoid billing errors.

What Services Can Be Billed for Under New RTM Rules?

The Final Rule rule does include some expansion of permitted services under RTM, though several commenters asked for additional updates that were not included. For example, the proposed rule considered the option of implementing a generic device code for the furnishing of RTM services. The inclusion of a generic device code, rather than the specific permitted devices as currently allowed, would have resulted in RTM for categories beyond respiratory system status, musculoskeletal system status, therapy adherence, and therapy response. After evaluation of public comments responding to such a proposal, CMS decided not to create a generic device billing code, citing concerns about assigning an appropriate reimbursement value for devices that have a wide range of costs and benefits. In this decision, CMS noted that they will continue to investigate the feasibility of such a generic device code, particularly as RTM is expanded to include additional bodily systems. CMS has already begun to include additional bodily systems, adding a code allowing for care of this kind in connection with cognitive behavioral therapy (CBT), to be billed at a contractor price set by the local Medicaid Administrative Contractor MAC. CMS has set several parameters for billing for RTM services that providers should be aware of. Even if a patient is being monitored under RTM through several medical devices, the services associated with these devices can only be billed by one provider, once per patient in each thirty-day period. In order to qualify, at least sixteen days of data must have been collected, and the services rendered must be reasonable

Preparing your Organization to Deliver RTM Services

Healthcare providers should be aware of the changes to RTM contained in the Final Rules. Due to the changes in the requirements to supervision, health care organizations may want to alter the way

they furnish these services to ensure that clinical staff is being utilized as efficiently as possible. Under the Final Rule, providers of cognitive behavioral therapy can utilize RTM to better understand how patients are complying with and responding to therapeutic interventions. Before offering this service, providers should determine reimbursement rates with their local MAC. RTM continues to be subject to very specific billing rules, including rules regarding timing of care and who is qualified to furnish care. To ensure timely and complete reimbursement, providers should ensure they provide RTM according to the Final Rule and other requirements from payors. In this final rule, CMS indicated that changes to RTM will continue to arise over subsequent rulemaking, so stakeholders should continue to pay close attention to this space.

For more information, please contact any member of Frost Brown Todd's [Health Care Innovation](#) industry team.

[\[1\]](#) American Medical Association

[\[2\]](#) Final rule, page 676

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