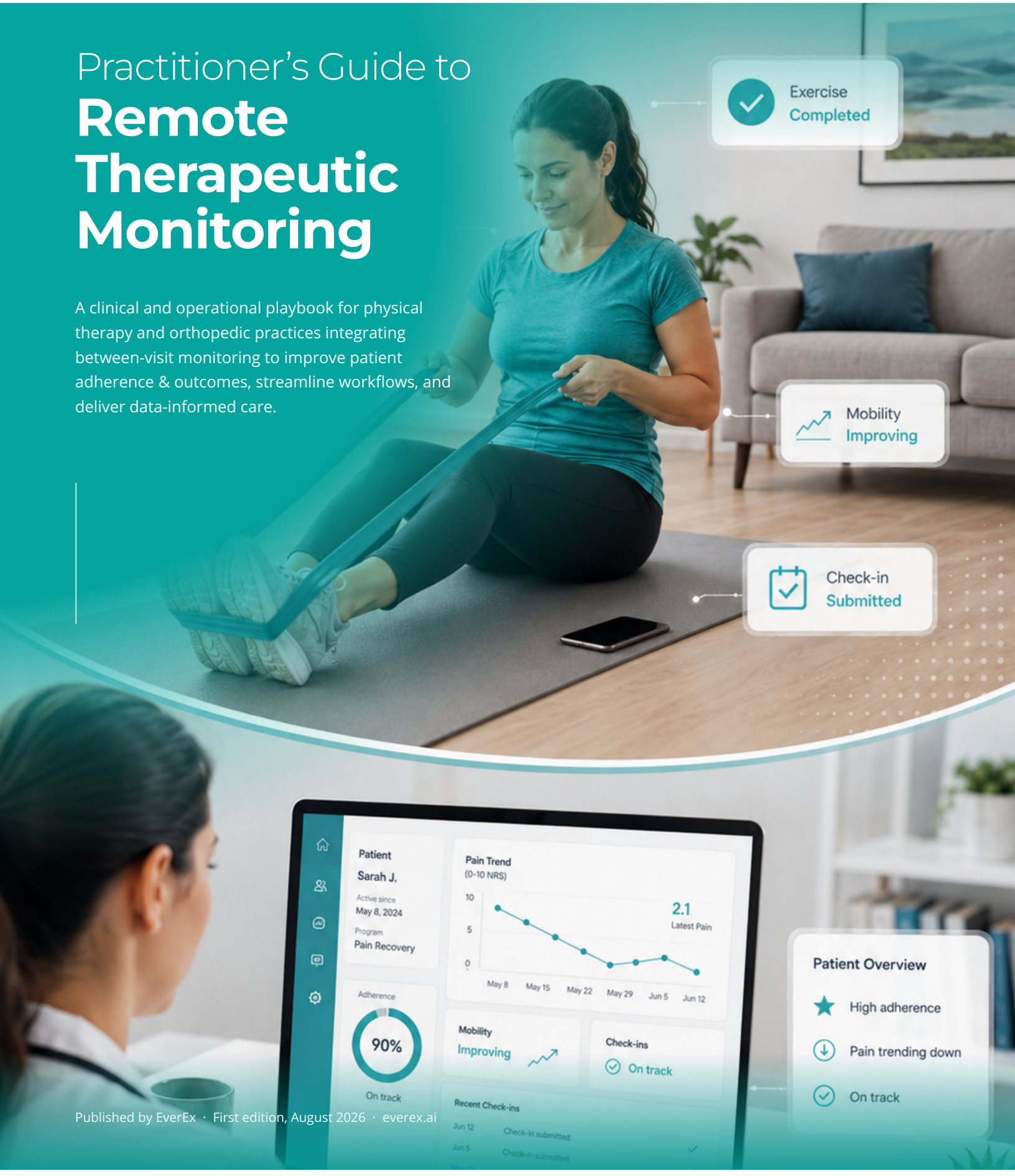
EverEx

Practitioner's Guide to

Remote Therapeutic Monitoring

A clinical and operational playbook for physical therapy and orthopedic practices integrating between-visit monitoring to improve patient adherence & outcomes, streamline workflows, and deliver data-informed care.



Published by EverEx · First edition, August 2026 · everex.ai

EverEx

Remote Therapeutic Monitoring

A Clinical & Operational Playbook

CONTRIBUTING AUTHORS

Drew Contreras, PT, DPT, SCS	Foreword
Ellen Morello, PT, DPT	Lead author, Chapters 1, 2, 3, 7
Alice Bell, PT, DPT	Billing specialist, APTA, Chapter 3 foreword
CJ Morrow, PT, DPT	Co-author, Chapter 4
Diana Diep, PT, DPT	Co-author, Chapter 5
Jerry Durham, PT	Co-author, Chapter 6

ABOUT THIS EDITION

First edition, published August 2026. Coding, threshold and payment parameters reflect the CY2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F) and CMS Transmittal R13431CP / MLN Matters MM14250 as of publication. The CPT panel and CMS revise these rules annually. CY2026 added two codes a physical therapy practice will bill, 98985 and 98979. **Re-verify every parameter each annual CPT and PFS cycle.**

This book is educational and does not constitute legal, billing or reimbursement advice. Federal law is a floor, not a ceiling: several states impose stricter requirements on consent, health data and supervision, and where state law is stricter it governs. Confirm requirements with qualified counsel for every state in which you treat patients before making operational decisions.

EverEx publishes this playbook as an educational resource for the rehabilitation profession. The guidance in these pages (including the vendor evaluation framework in Chapter 7) is written to apply to any RTM platform, including those that compete with ours.

© 2026 EverEx. Contributors retain rights to their individual chapters. EverEx, the EverEx flow mark and the EverEx wordmark are marks of EverEx.
everex.ai

Some Words from **the Experts**



Alice Bell, PT, DPT
Billing Specialist
Chapter 3 foreword

"Unlike traditional PM&R services, RTM utilizes a distinct reimbursement framework. **RTM CPT codes are generally based on cumulative patient monitoring activities and provider interactions that occur over a 30-day period or calendar month rather than a single encounter**, and require providers to adopt new workflows and compliance processes."



CJ Morrow, PT, DPT
Co-author, compliance
Chapter 4

"A practice can deliver clinically excellent monitoring and still generate auditable claims. **RTM compliance rarely turns on the quality of the care**; it turns on whether the right service was billed by the right person and supported by the right record."



Diana Diep, PT, DPT
Co-author, delivery models
Chapter 5

"One of the biggest decisions a clinic makes is determining **who will actually manage the program**. There is no one-size-fits-all answer, and that is good news, because there are real options."



Drew Contreras, PT, DPT, SCS
Vice President of Strategic Affairs
Foreword

"No single company, clinician or researcher has all the answers. But by bringing them together to build a community to address the challenges and provide innovation and solutions that leverage the strengths of one another, **that is how progress is made.**"



Ellen Morello, PT, DPT
Lead author
Chapters 1, 2, 3, 7

"Choosing an RTM vendor is not a procurement decision. **It is a partnership decision**, and the difference matters because of how deeply the platform embeds into your workflow and your compliance posture."



Jerry Durham, PT
Co-author, patient engagement
Chapter 6

"RTM isn't just a platform, it's an experience. And like all patient experiences, **it rises or falls with how well it's delivered at the front line.**"

Purpose of **This Playbook**

Remote Therapeutic Monitoring gives physical therapy something it has never had: a continuous view of the ninety-eight percent of the week the patient is not in your clinic.

RTM is a category of digital health services recognized by CMS that lets qualified health care professionals monitor non-physiologic, patient-reported data remotely and provide ongoing treatment management based on it. Pain. Function. Adherence. Response to therapy. The data your discipline has always relied on, captured on the days between visits.

The opportunity is real and so is the exposure. The code family changed materially in CY2026: two new codes you will actually bill, a restructured device-supply tier, and a widely-repeated rule that turns out not to apply the way most practices believe. Meanwhile the OIG has published an audit playbook for the sibling program, and a CY2027 proposal would reshape who is even permitted to furnish the service.



This playbook exists because between-visit care is now a billable clinical service, and **the billing follows the clinical activity, never the other way around.**

Practices that lead with revenue tend to run into trouble. They enroll indiscriminately, treat the monitoring workflow as an administrative checkbox, and miss the clinical intelligence the data was supposed to generate. When a payer audits those claims, the documentation tells the story. Practices that lead with clinical intent build something more durable, and the reimbursement follows because the clinical activity is real.

Throughout the book, **tangible workflows, decision frameworks, sourced code mechanics and self-audit checklists** are provided so a practice can move from reading to doing without a consultant in the room.

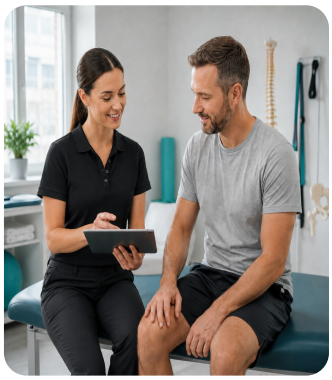
Four questions this **playbook answers**

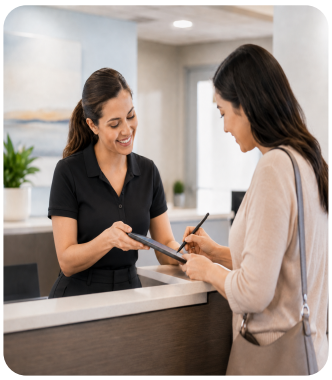
- What is RTM, how does it differ from RPM, and **which patients genuinely benefit** from between-visit monitoring?
- Which codes apply under the **CY2026 rules**, what thresholds govern them, and how do you document a claim that survives an audit?
- Who should **actually run the program**: your clinicians, a dedicated coordinator, or an outsourced team?
- What should you ask a vendor **before you sign**, and which answers should end the conversation?

By the end you will have a clear view of the opportunities, the obligations and the operational realities of running RTM in a rehabilitation setting.

Who Is **This Playbook For?**

This playbook is written for rehabilitation professionals and the teams around them, across private practice, hospital-based outpatient care, sports rehabilitation and community health.






Primary audiences include, but are not limited to:

- Physical therapists and physical therapist assistants
- Occupational therapists and occupational therapy assistants
- Speech-language pathologists
- Practice owners and clinic directors
- RTM coordinators and monitoring clinicians
- Front office and patient services teams
- Billing, revenue cycle and compliance staff
- Physicians, nurse practitioners and physician assistants referring into rehabilitation

The rules diverge by discipline. **Therapists and physicians follow different supervision and plan-of-care paths** for the same codes, and this book covers both.

How to **use it**

Starting a program	Read Chapter 1 for the clinical and regulatory foundation, then Chapter 5 to choose a delivery model, then Chapter 7 before you sign anything.
Program underperforming	Go to Chapter 6. Jerry Durham's argument is that RTM is an experience rather than a platform, and that it rises or falls at the front line. Then work §2.8 on burnout-resistant workflow design and §3.7 on the three revenue levers.
Preparing for audit	Chapter 4. Start with the four pillars in §4.1, then run the self-assessment in §4.8 against five to ten live patient files.
Training the team	§4.5 for scope of practice and the documented-training requirement, §6.3 and §6.4 for the enrollment conversation and the admin / clinical split, Appendix D for the script, Appendix A for the code card.

⚠ If you take one mechanical fact from this book

RTM runs on **two different clocks**. Device-supply codes are measured in unique days of data within a rolling 30-day window. Treatment-management codes are measured in cumulative minutes within a calendar month. The day thresholds do not govern the time codes, and practices that hold back management claims waiting on a day count are forfeiting compliant revenue over a prerequisite that does not exist.

Contents

Foreword · Drew Contreras 9

1 **What is RTM?** · Ellen Morello 10

2 **Clinical Best Practices** · Ellen Morello 15

3 **RTM Billing** · Ellen Morello, foreword by Alice Bell 21

4 **Compliance in RTM** · CJ Morrow 30

5 **RTM Delivery Models** · Diana Diep 42

6 **RTM Is the Front Door** · Jerry Durham 51

7 **How to Choose a Vendor** · Ellen Morello 56

Appendices A–E 62

In this playbook we cover a wide range of topics and **answer the questions practices ask most often**, including:

Jump to any section

The Two **Clocks**

Patient **Eligibility**

The Enrollment **Conversation**

Why Use **RTM at All?**

The CY2026 **Code Set**

Compliance **Self-Assessment**

SaaS, Outsourced or **Coordinator?**

Vendor **Scorecard**

Foreword

Why remote therapeutic monitoring matters for the profession.



Drew Contreras, PT, DPT, SCS
Vice President of Strategic Affairs
American Physical Therapy Association

The profession of physical therapy is no doubt synonymous with movement. The ability to help people move and interact with their world is what you can distill the profession down to at the most basic level. The APTA holds as a vision "transforming society by optimizing movement to improve the human experience." But what happens when the methods and tools to provide that transformation change from the traditional methods and techniques? The physical therapy professional must evolve, and the pathways to providing that movement optimization must also evolve. *"Change is the only constant"* — Heraclitus

The changes that must occur to support this evolution of care are here and are ready to be implemented.

Utilization of RTM in the clinical practice pathways has the potential to help the physical therapy profession **solve one of the biggest challenges our patients face: access to care.**

Leveraging the implementation of care methods that are rooted in science, data and goal oriented are exactly the type of tools the profession needs to empower clinicians to meet the challenges of a complex health care system.

The mission of the APTA is "Building a community that advances the profession of physical therapy to improve the health of society." No single company, clinician or researcher has all the answers. But by bringing them together to build a community to address the challenges and provide innovation and solutions that leverage the strengths of one another, that is how progress is made. Countless hours and effort went into this collaboration to bring this information to the clinicians who can make a difference in the lives of the patients they serve.

"Human progress never rolls in on the wheels of inevitability; it comes through the tireless efforts of people." — Martin Luther King Jr.

Dr Drew Contreras, PT, DPT, SCS

APTA, Vice President of Strategic Affairs

CHAPTER ONE

What is **RTM?**

Ellen Morello, PT, DPT

The regulatory definition, the distinction from RPM that everyone gets wrong, and why clinical intent has to come first.

The 30-second **definition**

- A CMS-recognized service category
- Non-physiologic, patient-reported data
- Billable treatment management on top

Where it **goes wrong**

- Enrolling indiscriminately
- Collecting data nobody reviews
- Leading with revenue, not care



1.1 Defining **Remote Therapeutic Monitoring**

RTM is a CMS-recognized service category that lets qualified health care professionals monitor non-physiologic, patient-reported data remotely, and bill for the treatment management they base on it.

In plain language: your patients report how they feel, how well they are keeping to their home program, and how their function is changing. You act on it as part of their care.

The data is **non-physiologic**. Not heart rate, blood pressure or glucose, which need a sensor. Pain, function, activity, adherence, response to therapy: the things patients can tell you themselves.

Mechanically it is simple. An app prompts brief check-ins between visits. Structured data flows to a dashboard. You review it, spot trends, act. The time you spend reviewing and managing care on the strength of that data is what the RTM codes pay for.

RTM is not a technology product or a set of codes.

It is a clinical service category, one that physical therapy is uniquely positioned to deliver.

What RTM is not

- Sending your patients a home exercise app
- Passive data collection that sits unreviewed
- A billing mechanism layered over care that has not changed

It is an active clinical service: a qualified provider monitors the data, interprets it against the plan of care, and makes decisions as a result. The billing follows the clinical activity, not the other way around.

1.2 RTM vs. RPM: **the critical distinction**

The acronyms differ by a letter and the confusion is constant. They are different programs, different code sets, different scope-of-practice rules.

	Remote Patient Monitoring	Remote Therapeutic Monitoring
Data type	Physiologic, device-measured	Non-physiologic, patient-reported
Typical inputs	Blood pressure, pulse oximetry, glucose, cardiac telemetry	Pain, function, mobility, adherence, response to therapy
Clinical home	Primary care, cardiology, chronic disease	Rehabilitation, musculoskeletal, respiratory, cognitive-behavioral
Who bills	Primarily physicians and NPPs	Physicians, NPPs, **and PTs, OTs, SLPs**

RTM exists to extend remote monitoring to disciplines that work from patient-reported data. Musculoskeletal function, pain, mobility, exercise adherence: that is precisely what it was designed to capture.

Two consequences. It is a **scope** issue, because PTs can furnish and bill RTM while RPM sits mainly with physicians. And it is a **platform** issue, because an RTM-appropriate tool is built around patient-reported outcomes, not continuous sensing.

> ⚠ **RTM and RPM cannot both be billed, by anyone**
>
> **They are mutually exclusive for the same patient in the same period.** It makes no difference who performs the services: not a second clinician, not a different discipline, not a separate practice. One practitioner may bill the device-supply and treatment-management codes from either family for a given patient in a 30-day period, and whoever bills first holds them.
>
> So the exposure is not only mis-matching data type to code family. It is enrolling a patient already monitored elsewhere. Overlapping claims are denied. **Check before you enroll, not after you bill.** *[CY2024 PFS Final Rule]*

1.3 The regulatory backstory

Before 2022, PTs who monitored patients between visits had no way to bill for it. The clinical value was understood; the payment infrastructure was not there.

The 2022 Medicare Physician Fee Schedule created the RTM code set and, critically, named physical therapists, occupational therapists, speech-language pathologists and clinical psychologists among the qualified providers. APTA pushed for that inclusion, submitting the clinical rationale for why non-physiologic monitoring belongs in rehab.

The rules have not stood still since. CMS has issued guidance on supervision, on how RTM sits alongside other remote care, and on documentation. Most significantly, **the CY2026 Final Rule restructured the code family**, adding short-duration device supply and a ten-minute management tier.

The 2022 fundamentals hold. The mechanics have changed, and will change again.

1.4 Patient eligibility and **appropriate use**

RTM is not right for every patient, and treating it as a universal add-on is both a clinical mistake and a compliance risk. The question is not who you *can* enroll. It is who will genuinely benefit.

CMS imposes no diagnosis requirement, which gives you real latitude. But the service must be medically necessary for that patient: the monitoring relevant to the plan of care, the data actionable, and you prepared to act on it.

A strong candidate

- Has meaningful between-visit variability in symptoms or function
- Has a home program central to recovery, where adherence is a real variable
- Can and will engage with a digital check-in
- Is someone whose off-days you genuinely need visibility into

Post-surgical patients are the clearest case. The first six to eight weeks change fast, and a pain spike or an adherence lapse can bend the whole recovery. Chronic pain patients are the other high-value group, particularly where fluctuation patterns are diagnostically useful.

Technology readiness is a clinical consideration, not an afterthought. Most platforms are a few taps, but not every patient has a reliable smartphone, and older adults often need setup support. That is a reason to assess and address barriers at enrollment, not to exclude people.

And some patients are simply not appropriate: medically unstable, unable to self-report reliably, or declining the service. An enrolled patient who never responds is getting no clinical benefit, and billing for them creates exposure.

▸ *Practical strategies for overcoming technology barriers at the point of care are in §6.4.*

1.5 RTM as a **clinical tool first**

Much of the industry talks about RTM as a revenue opportunity. That is not wrong. It is incomplete, and the incompleteness matters.

Practices that lead with revenue run into trouble. They enroll indiscriminately, treat the workflow as a checkbox, and never get the clinical intelligence the data was supposed to produce. When a payer audits, the documentation tells that story.

Practices that lead with clinical intent build something durable. They enroll patients monitoring genuinely helps. Their clinicians actually change treatment based on what they see. The record is coherent. The billing follows, because the clinical work is real.

When RTM is an extension of excellent care, the revenue is the outcome of doing good work.

That framing is not just ethical. It is the one that survives scrutiny.

The early evidence is encouraging. A 2025 retrospective case-control study across 95 private-practice PT clinics found patients receiving RTM alongside in-person care hit the Functional Status Benchmark more often than those with in-person care alone: 72% versus 63% (P=.004; adjusted OR 1.53, 95% CI 1.04–2.22), with higher engagement in the RTM group. Note the design: retrospective case-control, not a randomized trial. *[Marshall et al., Arch Rehabil Res Clin Transl, 2025;7(3):100466]*

Consider the arithmetic. A post-op patient at three visits a week spends about three hours in your clinic out of 168. Under two percent of their week. The other 98% is where outcomes are made or broken, and RTM is how you see into it.

KEY TAKEAWAY

RTM is a clinical service that happens to be billable, not a billing opportunity that happens to involve patients. Enroll for clinical reasons, document the reasoning, and the reimbursement holds up. Get the RPM distinction right, confirm nobody else is already billing the codes for your patient, and treat readiness as part of the assessment.

CHAPTER TWO

Clinical Best **Practices**

Ellen Morello, PT, DPT

Using RTM to drive outcomes: who to enroll, what to measure, how to read the data, and how to build a workflow that survives a full caseload.

Get this **right**

- Screen at evaluation
- Baseline before you monitor
- Respond to patterns, not points

Or pay for **it later**

- Under-engaged caseload
- Data that informs nothing
- A program that quietly collapses



2.1 Identifying the right patients

Patient selection is the single biggest factor in program quality. Get it right and everything downstream has something to work with. Rush it and you spend months managing a caseload whose data tells you nothing.

A strong candidate has real between-visit variability, a home program central to recovery, some motivation to participate, and access to a smartphone. Post-operative patients fit best: the weeks after a joint replacement or ACL reconstruction move fast, and a patient whose pain is escalating or who has quietly stopped exercising is someone you want to know about *before* the next visit.

Chronic musculoskeletal pain is the other strong fit. Fluctuating symptom patterns are hard to see in the snapshot of a visit. RTM turns a patient you see twice a week into one whose story you can follow continuously.

The enrollment conversation

How you introduce it shapes engagement from day one. Frame it as an extension of care you are already giving: a way to stay connected and adjust if something is not working. Skip the jargon. **Do not lead with the app; lead with the clinical relationship.** Patients who understand their provider is paying attention between visits engage far more consistently than patients handed a piece of software.

2.2 Setting goals and baselines

Before RTM can tell you whether someone is improving, you need to know where they started. This is the most frequently skipped step, and skipping it undermines everything after.

Measure	Best used for	Why it works in RTM
PSFS	Any condition; patient-nominated activities	Patient-driven, sensitive to between-visit change, trivial to administer digitally
NPRS / VAS	Any presentation with pain	Fast daily capture; establishes each patient's normal range
DASH / LEFS	Upper / lower extremity	Region-specific function across the episode
Oswestry	Lumbar conditions	Well-validated disability index for reassessment
STarT Back / MSK	Risk stratification at intake	Prognostic; helps target monitoring intensity

Collect the baseline at enrollment, ideally inside your initial evaluation workflow, so it is automatic rather than effortful.

Then document the RTM plan in the plan of care. It need not be elaborate, but it should be explicit: what data, how often, by what mechanism, and how it will inform decisions. That serves a clinical purpose and a compliance one, showing RTM is an intentional part of the plan rather than a billing add-on.

2.3 Interpreting patient-reported data

Your job is to extract signal from a stream: to tell meaningful information from normal variability.

Pain

The most common data type and the most misread. Between-visit variability is normal; a one- to two-point NPRS fluctuation over a week is expected. What warrants attention is sustained elevation above baseline, a spike that breaks the patient's established pattern, or a trajectory not improving when it should be. **Learn each patient's normal range before you read any single number.**

Adherence

Often more informative than pain. A patient who stops responding is telling you something without saying a word, and non-response frequently precedes deterioration or dropout. The conversation you have after three missed check-ins is far more productive than the one after they cancel.

Function

The most meaningful over time. Pain fluctuating while function improves is, on balance, progress. Pain stable while function declines warrants a closer look.

On over-interpretation

Not every deviation needs a response. **Respond to patterns, not to data points.** Document your reasoning when you act, and also when you decide to keep monitoring without intervening, because waiting is a clinical decision too. When you see a deviation, ask the patient what changed. The subjective data matters as much as the objective.

2.4 Making real-time adjustments

The value is realized in the moments it changes what you do. If review never produces an action, you are collecting data without using it.

Most often the action is a home program change: a patient reports an exercise consistently spiking their pain, you adjust dosage or substitute, and send it back through the platform with a note explaining why. The patient feels heard. The program improves. That is RTM working.

Direct outreach is the other common action. When check-ins suggest someone is struggling or drifting toward dropout, a proactive message changes the trajectory. Keep it specific: acknowledge what you saw, address the concern, reinforce the path forward.

Occasionally the data flags something beyond PT scope: new neurological symptoms, significant swelling, sudden unexplained loss of function. Prompt medical evaluation and document the reasoning. These early catches are the most compelling evidence for the program.

Document every clinical action taken on RTM data. It satisfies the treatment-management requirement and builds the record that shows the episode hangs together.

2.5 Communicating **between visits**

Done well, between-visit contact reinforces that the patient is being attended to, which drives adherence. Done poorly it gets ignored.

Be brief, specific and clinically grounded. Reference what you actually saw: “I noticed your pain scores have been higher this week.” That reads very differently from “How are you doing?”, and patients can tell.

Set expectations at enrollment. RTM messaging is not emergency communication; urgent concerns mean calling the clinic or seeking emergency care. But patients should know what to expect from you: a reasonable response time, consistent prompts, and proactive contact when something looks off.

Build the cadence into your workflow rather than leaving it to judgement. Some clinicians block fifteen minutes daily; others batch two or three times a week. What matters is consistency. Unreviewed data delivers no clinical benefit and leaves documentation gaps.

> ⚠ **Asynchronous messaging is not the required interaction**
>
> Portal messages, texts and automated prompts are clinically useful but do *not* satisfy the monthly interactive communication requirement. That needs a **real-time** contact: in person, by telephone or by video. Without it the entire month’s management service is unbillable, however many asynchronous minutes you logged. *[See §3.2 and §4.1]*

2.6 Measuring and **documenting outcomes**

RTM builds a longitudinal record that, used properly, becomes one of the most valuable clinical assets you have. The discipline is treating it as intelligence, not just billing documentation.

Reassess your baseline measures at regular intervals, typically every four to six weeks, and link them explicitly to the data collected in between. The goal is a coherent narrative: here is where they started, here is what the data showed, here is where they are, here is what it means for the plan.

At population level you can build an outcomes data set most practices have never had: pain trajectory by condition, adherence by diagnosis, functional improvement at discharge.

Share it. Send a quarterly summary to your referring physicians. Use it with health system partners and in value-based contract conversations. Practices that build and share RTM outcomes data will have a real advantage over the next decade.

2.7 Two case examples

Post-operative knee replacement: catching adherence early

A 68-year-old, six weeks post total knee replacement, enrolled at discharge from acute care. Good engagement initially. In week three her check-ins dropped from daily to every two or three days, with slightly elevated pain on the days she did report. Her PT messaged to ask how the exercises were going.

She had been avoiding them: the pain afterward felt "too much." A brief telehealth visit established she was performing quad sets with excessive effort and creating post-exercise inflammation. Coaching on exertion and icing followed. Daily check-ins resumed within a week, pain normalized, and she hit her functional goals on schedule. Without RTM the problem would have surfaced two weeks later.

Chronic low back pain: finding the flare pattern

A 44-year-old with two years of chronic low back pain and two previous unsuccessful episodes of PT. On the third referral his PT enrolled him specifically to understand the relationship between activity and flares. Over eight weeks a clear pattern emerged: pain spiked every Monday and Tuesday, following weekends of yard work.

That pattern was invisible in Wednesday and Friday appointments. Treatment shifted from pain management to activity pacing and load management, and the platform's trend graphs showed him the relationship directly. At six months his pain scores were the lowest in two years.

2.8 Building a workflow without burnout

Programs fail on burnout more than anything else. The workflow gets added to a full schedule, the review is never systematized, and three months later it has quietly collapsed. That is preventable, and prevention is a design problem.

Integration, not addition

Review should be woven into the rhythm of the clinical day, not bolted on after it. A dedicated fifteen to twenty minute block works better than reviewing in the margins between patients. Cancellations and no-shows are natural review windows.

Appropriate delegation

Support staff can manage check-in reminders, handle basic technology troubleshooting, run the enrollment and setup workflow, and pass the platform's inactivity report to the clinical team. What they cannot do is **monitor**.

Reviewing and interpreting patient-reported data is clinical work, and on the therapy side it cannot be delegated to unlicensed or administrative staff at all.

> ⚠ **Delegation has hard limits**
>
> There is no "incident-to" benefit on the therapy side: unlicensed clinical staff cannot furnish billable RTM minutes for a therapist, and administrative time is never countable toward the treatment-management codes. Keep admin activity out of the clinical time log entirely. The rules differ materially for physicians and NPPs. *[See §3.3 and §4.5]*

A platform that serves the workflow

A cluttered dashboard, buried alerts or manual data entry will erode even a motivated team. Chapter 7 covers the selection criteria, including the workflow factors easy to miss in a demo and critical in daily practice.

KEY TAKEAWAY

Build the workflow before you enroll the first patient. Establish baselines at intake, review on a fixed cadence, respond to patterns rather than points, and document the reasoning behind both action and inaction. Delegate everything that does not require clinical judgment, and nothing that does.

CHAPTER THREE

RTM **Billing**

Ellen Morello, PT, DPT · chapter foreword by Alice Bell, PT, DPT

The CY2026 code set, the two clocks that govern it, and how to capture every legitimate dollar without creating a single indefensible claim.

Device supply **clock**

- Unique dated days
- Rolling 30-day window
- 98985 or 98977

Treatment management **clock**

- Cumulative minutes
- Calendar month
- Plus one live contact



Chapter foreword

Alice Bell, PT, DPT · Billing Specialist, APTA

While the integration of Remote Therapeutic Monitoring (RTM) into patient management presents a significant opportunity to enhance patient engagement, improve adherence, address barriers to care, and support timely clinical intervention, it also introduces a range of operational and reimbursement challenges. Among the most significant of these are the unique documentation, coding, and billing requirements associated with RTM services.

Unlike traditional Physical Medicine and Rehabilitation (PM&R) services, RTM utilizes a distinct reimbursement framework. RTM CPT codes are generally based on cumulative patient monitoring activities and provider interactions that occur over a 30-day period or calendar month rather than a single encounter. As a result, the documentation, reporting, and billing requirements for RTM differ substantially from those associated with conventional therapy services and require providers to adopt new workflows and compliance processes.

Although Medicare has established relatively clear and consistent policies regarding RTM coverage and reimbursement, significant variability exists across Medicare Advantage, Medicaid, and commercial insurance plans. Coverage policies may differ considerably at both the payer and plan level, affecting provider eligibility, covered conditions, authorization requirements, reporting obligations, and documentation standards.

This chapter provides a comprehensive overview of RTM billing, including the CPT codes used to report RTM services, applicable documentation and supervision requirements, billing considerations, and coverage and reimbursement issues that providers should understand when implementing and managing RTM programs.

> ⚠ **This chapter was revised for CY2026**
>
> The RTM code family changed materially in the CY2026 Physician Fee Schedule Final Rule. **Two codes were added that a physical therapy practice will bill: 98985 and 98979.** The musculoskeletal device-supply code changed, and the widely-repeated "16-day rule" turns out not to gate the treatment-management codes at all. (CMS added a third code to the therapy list, 98984, but it is respiratory and sits outside PT scope. A fourth, 98986, is in the cognitive-behavioral family and is not a therapy service.) If you trained on RTM billing before 2026, several things you know are now wrong. Every parameter below is sourced; re-verify each annual CPT and PFS cycle.

3.1 The RTM CPT code set

Six codes make up the musculoskeletal RTM billing framework as of CY2026. Understanding what each one covers (and equally important, what it does not) is the foundation of compliant RTM billing.

98975	**Initial setup and patient education** Once per episode of care. Requires at least 2 days of monitoring data in the 30-day period.
98977	**MSK device supply, standard** 16–30 days of data transmission or access in a 30-day period.
98985	**MSK device supply, short duration *(new for CY2026)*** 2–15 days of data transmission or access in a 30-day period. Do not report for fewer than 2 cumulative days in the period.
98979	**Treatment management, first 10 minutes *(new for CY2026)*** 10–19 min qualified professional time **plus** at least one real-time interactive communication in the calendar month. **Not reportable with 98980 or 98981.**
98980	**Treatment management, first 20 minutes** At least 20 min qualified professional time **plus** at least one real-time interactive communication in the calendar month.
98981	**Treatment management, each additional 20 minutes** Add-on to 98980. Each additional cumulative 20 minutes in the calendar month.

CY2026 PFS Final Rule (CMS-1832-F); CMS Transmittal R13431CP / MLN Matters MM14250. The respiratory analogues are 98976 (16–30 days) and 98984 (2–15 days). A cognitive-behavioral family also exists (98978, 98986), but is not designated a therapy service.

98975 covers the initial setup of the RTM system and the education provided to the patient on how to use it. It is billed once per episode of care and captures the work of getting the patient enrolled, trained, and ready to begin monitoring. “Episode of care” follows the definition used in PT practice generally: a period of care for a specific condition with a defined beginning and end. If a patient is discharged and re-referred for a new condition, a new 98975 is appropriate. If they are re-referred for the same condition, it is not.

The code carries a minimum-days floor: **do not report 98975 unless the 30-day period produced at least 2 days of monitoring data**. The CPT 2026 codebook settled this at two days, the same floor that governs the short-duration device code 98985, which means setup is billable early in an episode rather than held back for a longer data history. *[AMA CPT 2026 codebook]*

98977 and 98985 are the two musculoskeletal device-supply codes, and the only difference between them is how many days of data the 30-day window actually produced. In the PT context, the “device” is typically the patient-facing application through which check-ins are delivered and data is collected. Note carefully that **98976 is the respiratory device-supply code, not the musculoskeletal one**, 98984 is its short-duration analogue. This has always been the case, but the two get transposed often enough in circulated training material that it is worth checking your own internal documentation against the descriptors above.

98979, 98980, and 98981 are the treatment-management codes, and they reflect the actual clinical work of RTM: reviewing the patient’s data, making clinical decisions based on it, communicating with the patient, adjusting the plan of care, and coordinating with other providers. Unlike the device codes, these are condition-agnostic: they are shared with the respiratory and cognitive-behavioral RTM families. The addition of 98979 in CY2026 changes the

everyday picture. It covers the 10–19 minute band and is **not** reportable alongside 98980 or 98981: once you cross twenty minutes you move to 98980 rather than adding to 98979.

3.2 The two clocks

RTM runs on two different clocks, and conflating them is the most consequential billing error in the field.

Device supply is measured in unique discrete days of data within a rolling 30-day window. Treatment management is measured in cumulative minutes within a calendar month. **The day thresholds do not govern the time codes.**

This is not a technicality. Practices that hold back 98979 or 98980 waiting for sixteen days (or even two days) of data are forfeiting compliant revenue over a prerequisite that does not exist. The minutes still need to reflect genuine, medically necessary monitoring, and the required synchronous contact still has to happen. But the device-day count is a device-code question. *[CY2026 PFS Final Rule; CMS Transmittal R13431CP]*

Counting a day

The operative unit is the **unique calendar date**, not the number of readings. RTM permits patient self-reported data, and a self-reported day counts the same as a device-captured day: provided the platform generates a discrete, date-stamped record. If a wearable collects seven days offline and syncs them as a single upload event, those days count only if the software resolves the import into seven distinct dated records. Otherwise the defensible posture is to count only the sync date.

Your platform's logging architecture therefore sets the ceiling on what you can bill. A system that batch-logs weekly cannot substantiate 98977. Treat logging behavior as a procurement criterion, not an implementation detail.

Counting time

Treatment-management minutes cover reviewing data, adjusting the home program or plan, and interacting with the patient. **No minute may be counted toward two services.** Time already billed to therapeutic exercise, manual therapy, or an evaluation and management visit is spent. Time cannot be double-counted with care management or other remote monitoring codes.

Time must also be documented contemporaneously. A log entry made at the end of the month summarizing "approximately 25 minutes of RTM management" will not hold up under audit. Build a time-tracking habit into your daily review workflow: note the date, the activity, and the minutes each time you engage in billable management. If your platform has built-in time tracking, use it. If not, a clinical note documenting the activity and time is sufficient provided it is created at the time of the activity.

The required synchronous contact

Each billing month requires at least one **real-time interactive communication** with the patient or caregiver. Real-time means synchronous, and it can occur in person, by telephone, or by video. Asynchronous portal messages, secure messaging, texts, and automated prompts do not qualify. Without the live touchpoint, the entire month's management service is unbillable. This is a requirement, not a component that extra asynchronous minutes can replace. *[CY2026 code descriptors; APTA Practice Advisory]*

Where the minutes actually come from

Reviewing a patient's dashboard typically takes two to five minutes. A patient attending therapy twice a week generates roughly eight visits in a month; two minutes of pre-visit review at each one accumulates sixteen minutes, enough for 98979. Add HEP updates based on patient-reported outcomes, a check-in call during a cancellation gap, and the required synchronous contact, and 98980 becomes realistic without adding a single new task to the day. RTM is largely about recognizing and capturing work you are already doing.

3.3 Who can bill, and how the paths differ

RTM is billable by physicians and other qualified health care professionals, including PTs, OTs, SLPs, NPs, PAs, and CNSs. All RTM codes carry a "sometimes therapy" designation, which splits the compliance path in a way that matters operationally.

For therapists (PT, OT, SLP), that "sometimes therapy" designation resolves to therapy in every case. The service must be furnished under an active plan of care with the discipline modifier: GP, GO, or GN. When a PTA or COTA furnishes the service in whole or in part, the CQ or CO modifier and the 15% assistant payment adjustment apply to 98975 and 98979–98981; the device-supply codes 98977 and 98985 are exempt. Private-practice assistants may work under general supervision. *[CMS Transmittal R13431CP; CY2025 PFS Final Rule]*

For physicians and NPPs, whether RTM sits inside or outside a therapy plan of care depends on *what is being monitored*. When the monitoring supports the physician's own medical management of a condition, it may sit outside a therapy plan of care. But when the MSK device codes monitor a therapy service (adherence or response to a therapeutic exercise program) CMS deems that a therapy service, so even a physician must furnish it under a therapy plan of care with the appropriate modifier. *[CMS Transmittal R13431CP]*

Personnel rules diverge sharply between the two paths, and this is where practices most often assume a flexibility they do not have.

Therapists PT / OT / SLP	There is **no incident-to benefit** under the Medicare therapy benefit. RTM must be furnished by the billing therapist personally, or by a **PTA or COTA** under the therapist's supervision with the CQ or CO modifier and the 15% assistant adjustment. **Unlicensed clinical staff cannot furnish billable RTM minutes for a therapist**, and neither can front-desk or administrative staff.
Physicians and NPPs	Clinical staff may furnish RTM **incident to** the billing practitioner. Since 1 January 2023 all RTM services may be furnished under **general** supervision rather than direct, so the practitioner need not be physically present. The practitioner remains responsible.
Both paths	Administrative time is **never** countable toward the treatment-management codes.

[CY2023 PFS Final Rule, general supervision for all RTM; CMS Transmittal R13431CP; APTA Practice Advisory. State practice acts sit on top of these rules and may be stricter. Confirm your own staffing model with counsel before relying on it.]

▸ *Full supervision, scope-of-practice, and state-law detail is in §4.5.*

3.4 Payer coverage landscape

Medicare is the payer to understand first, because Medicare established the RTM code set and its coverage policies set the floor for the broader landscape. Under traditional Medicare, RTM furnished by physical therapists is covered and reimbursable. Rates vary by geographic region and are updated annually; for current amounts, use the Medicare Physician Fee Schedule lookup tool with the relevant year and geographic modifier rather than relying on a figure printed in a book.

Payer type	Coverage posture	What to do before you bill
Traditional Medicare	Covered; annual fee schedule updates	Confirm current-year rates and geographic modifier
Medicare Advantage	Must cover the same services, but administers and prices with flexibility; adoption is uneven	Know your MA payer mix; verify coverage and prior authorization plan by plan
Medicaid	Highly variable by state; some programs have not addressed RTM at all	Verify with your state Medicaid office; monitor for policy updates
Commercial	Most heterogeneous; expanding but not universal, and can differ by product line and market within one carrier	Verify per payer; build authorization checks into enrollment
Self-pay	A growing option for uncovered patients	Disclose pricing clearly in writing before enrollment

One coverage question deserves separate mention: patient cost-sharing. Medicare Part B coinsurance, typically 20%, applies to RTM as billed every month. Recurring "surprise" copays are the leading driver of patient complaints,

and complaints invite audits. Explain the recurring charge before enrollment. Do not routinely waive it to smooth enrollment: that is a Beneficiary Inducements and Anti-Kickback problem, not a courtesy. *[See §4.1 and §4.3]*

3.5 Documentation requirements

RTM documentation must tell a coherent clinical story that supports every code billed. The requirements are not onerous, but they are specific, and gaps are the most common source of audit findings.

For **98975**, the record should establish that the patient was educated on the RTM system, understands how to use it, has access to the necessary technology, and has consented to participation. A note documenting the setup and education session plus a signed consent form satisfies this.

For **98977 or 98985**, the record should confirm the platform was supplied for the billing period and document the actual number of unique dated transmission days, supporting the specific tier billed. Retain the platform's exportable data-transmission report and link it to the claim.

For **98979, 98980, and 98981**, the documentation must establish three things: that the minute threshold for the specific code billed was met during the calendar month, that the time was spent on qualifying activities, and that the clinical work connected to the patient's ongoing plan of care. Be exact about the first one: **10–19 minutes for 98979, at least 20 minutes for 98980, and a further complete 20-minute increment for each unit of 98981.** A log showing 35 minutes supports 98980 and does not support a unit of 98981. A contemporaneous time log capturing date, activity, and minutes is the most defensible form. Supplement it with clinical notes reflecting the reasoning applied to the data and any care adjustments made. The required synchronous contact needs its own record: date, modality, duration, participants, and a brief clinical summary.

One principle applies across every code: the RTM service must be clearly connected to the plan of care for the condition being managed. A patient enrolled for post-operative knee rehabilitation should have RTM documentation that explicitly links the monitoring data to their knee rehabilitation goals. An auditor should be able to trace a clear line from diagnosis through plan of care to RTM data to management decision. If that line is not visible in the documentation, the claim is vulnerable.

3.6 Denial management and appeals

RTM denials cluster in the early stages of implementation, while billing and documentation workflows are still being refined, and in the commercial payer space, where coverage policies are less standardized. Building a systematic approach to denials is part of building a mature program.

Denial reason	Usual root cause	Response
Coverage not established	Commercial payer has no finalized RTM policy, or authorization was not obtained first	Verify current coverage; appeal with clinical documentation and a reference to the applicable policy
Threshold not met	A reporting gap between the platform and the claim, or the wrong device tier billed	Submit the platform's date-level transmission report as supporting documentation
Documentation insufficient	Missing time log, or no explicit link to the plan of care	Supplemental note or addendum plus a cover letter explaining the services provided
Missing interaction	No documented real-time contact for the month	Usually not appealable. Fix the workflow; this one is preventable
Eligibility / provider	Patient not eligible as billed, or biller not recognized as a QHP for RTM	Confirm insurance information and provider enrollment status
Concurrency	RTM and RPM billed for the same patient in the same month, or another practitioner billed first	Not appealable. Coordinate before enrolling

Track denials systematically. A log capturing payer, code, denial reason, appeal action, and outcome gives you the data to identify patterns, address root causes, and demonstrate program improvement over time. If a specific payer generates consistent denials for the same reason, that is a workflow problem to fix, not a claims problem to appeal one by one.

3.7 Maximizing reimbursement **compliantly**

Compliant RTM billing and maximum RTM reimbursement are not in tension: approached correctly, they are the same goal. The practice that captures every dollar of legitimate RTM reimbursement is the same practice that has clean documentation, consistent workflows, and a billing team that understands the codes.

Revenue per enrolled patient depends on payer mix, geography, and which tiers your actual patient behavior supports. Rather than print a figure that will be wrong by next January, build your projection from your own fee schedule: 98975 once per episode, one device-supply code per 30-day window at the tier your log supports, and one treatment-management tier per calendar month with 98981 where complexity warrants it.

The three levers

- **Enrollment rate**: what proportion of eligible patients actually get enrolled. Largely a function of the clinical and front-desk workflows in Chapter 2 and §6.3.
- **Retention rate**: how long patients stay actively engaged. A function of patient experience, check-in design, and clinical responsiveness.

- **Threshold attainment**: what proportion of enrolled patients reach a billable device tier and a billable management tier each month, *with* the required synchronous contact. A function of check-in frequency, engagement, and proactive outreach.

Improve all three and the revenue follows. The billing workflow should include a monthly calendar that tracks each enrolled patient's day count, minute accumulation, and synchronous-contact status *in real time*, not at month end when it is too late to address a gap. Your platform should surface this in an actionable dashboard. If it does not, that is a vendor selection consideration worth revisiting.

> ⚠ **Stratify honestly**
>
> CY2026 deliberately prices 98985 and 98977 identically: CMS finalized the same practice expense RVU for both, because the device is supplied for the full 30-day period either way. That parity tempts busy teams to hard-code one default device code. Resist it. Even when the payment is the same, a claim is a factual certification to the federal government. Billing the 2–15-day code for a patient whose log shows 22 days contradicts your own record and signals failed billing controls. Tally the log at the close of each 30-day window and output the code the facts support, neither inflated nor deflated. *[CY2026 PFS Final Rule]*

KEY TAKEAWAY

Learn the two clocks and stop gating time codes on day counts. Book the required synchronous contact as a deliberate monthly event, because without it nothing else in the month is billable. Log minutes the day you spend them. Select the device tier from the actual log at the close of each window. And track day count, minutes, and synchronous-contact status live, not retrospectively.

CHAPTER FOUR

Compliance **in RTM**

CJ Morrow, PT, DPT

The rules, the risks and the record, for therapists, physicians and the teams that support them.

Four **pillars**

- Coverage and coding
- Billing integrity
- Fraud and abuse
- Documentation and privacy

The audit **question**

Could a stranger reconstruct the service from your records alone?



A practice can deliver clinically excellent Remote Therapeutic Monitoring and still generate non-compliant, auditable claims. RTM compliance rarely turns on the quality of the care. It turns on whether the **right service** was billed by the **right person** and supported by the **right record**.

This chapter maps that terrain for both rehabilitation professionals (PTs, OTs, SLPs) and physicians and non-physician practitioners (NPs, PAs, CNSs), whose rules overlap but are not identical.

Scope note for this chapter

This chapter addresses federal requirements, focused on the musculoskeletal RTM codes where rehab professionals and referring physicians spend most of their time. Federal law is a floor, not a ceiling. Several states impose stricter rules on consent, health data, and supervision; where state law is stricter, it governs. Verify state-specific requirements with health-law counsel for every state where you treat patients. Billing mechanics, code descriptors, and payment rates are covered in Chapter 3 and Appendix A; this chapter covers the compliance logic behind them.

4.1 The RTM compliance landscape

RTM sits at the intersection of three regulatory systems: Medicare payment policy, federal fraud-and-abuse law, and documentation and privacy standards. A gap in any one can convert a sound clinical service into a liability. Four pillars organize the rest of this chapter.

Pillar	What it governs
1. Coverage & coding	Who may bill, under which codes, under what supervision, and within what plan of care
2. Billing integrity	The mechanical accuracy of each claim: data-day thresholds, time counting, required interactions
3. Fraud & abuse	Anti-Kickback, Stark, Beneficiary Inducements CMP, and the False Claims Act: vendor deals, referrals, patient incentives
4. Documentation & privacy	The record that proves the first three were satisfied, and the HIPAA obligations that follow RTM data out of your clinic

Pillar 1: coverage and coding

Two structural rules are easy to miss. First, only the device-supply codes are MSK-specific: 98977 and 98985 for musculoskeletal, 98976 and 98984 for respiratory. The treatment-management codes are condition-agnostic and shared across the RTM families. Second, the code family runs on two different clocks, as covered in §3.2.

Medical necessity is the baseline requirement. CMS is explicit that remote monitoring must be reasonable and medically necessary for diagnosis or treatment. No modifier discipline or time-tracking rigor can rescue monitoring

of a self-limiting condition that would resolve without intervention, and medical necessity is precisely where fraud-and-abuse enforcement begins. *[CY2026 PFS Final Rule]*

Pillar 2: billing integrity

In an audit, two questions do the heavy lifting: how many *days* of data does the claim have, and how much *time* did the clinician spend? The mechanics of both: unique dated records, honest tier stratification, no double-counted minutes, and the required monthly synchronous contact, are set out in §3.2 and §3.5.

> ⚠ **The physician day-level exclusion**
>
> Under CPT guidelines for the treatment-management codes, a physician or QHCP may not count any RTM time on a calendar day they report an E/M service for that patient. This includes ordinary office and inpatient E/M as well as telehealth E/M (98000–98015), and the brief virtual check-in (98016). Billing 98016 for the RTM phone call itself zeroes out that day's RTM time.
>
> The clean pattern for everyone: conduct the interactive communication as a dedicated, unbilled phone or video contact on a day with no other billed encounter. For therapists the logic converges from a different direction, since in-clinic minutes are typically already consumed by timed therapy codes. *[CPT RTM Treatment Management guidelines, as revised by the 2025 CPT errata; re-verify annually]*

Pillar 3: fraud and abuse

RTM's recurring per-patient revenue, vendor reliance, and outsourcing options are exactly the conditions federal enforcers scrutinize. Four regimes apply.

Regime	What triggers it in RTM	Who it reaches
Anti-Kickback Statute	Any exchange of value to induce or reward RTM referrals or orders, including volume-based vendor fees. Intent-based, criminal, penalizes both sides. *42 U.S.C. § 1320a-7b(b)*	Clinics, referring physicians, vendors
Beneficiary Inducements CMP	Routinely waiving copays or deductibles, or giving free devices, to drive enrollment. *42 U.S.C. § 1320a-7a(a)(5)*	The billing entity
Stark Law	A physician refers Medicare patients for RTM to an entity where they or family hold a financial interest, absent a fully satisfied exception. Strict liability; intent is irrelevant. *42 U.S.C. § 1395nn*	Physicians and physician-owned entities
False Claims Act	Knowingly submitting or causing claims that misrepresent the service: wrong day-strata, double-counted minutes, absent necessity	Whoever submits or causes the claim

Stark reaches RTM, and the code list matters. The original RTM codes entered the physician self-referral designated health services code list under the PT/OT/SLP category when the code family was established; CMS added 98979, 98984, and 98985 effective January 1, 2026, per the code list published December 1, 2025. Confirm

the current-year list rather than relying on a date printed here. Physician-owned therapy practices, joint ventures, and outsourced arrangements are precisely where Stark-relevant financial relationships form. Whether an exception applies is a legal determination for counsel. *[42 CFR § 411.351; CMS Annual Update to the List of CPT/HCPCS Codes, eff. Jan. 1, 2026]*

Vendor red flags

The OIG's Special Fraud Alert on telemedicine arrangements maps directly onto badly structured RTM programs. Watch for these three patterns:

- The vendor recruits or contacts *your* patients to drive enrollment
- The billing practitioner lacks meaningful patient contact to verify ongoing necessity
- Vendor compensation is tied to volume: "per patient enrolled," "per record reviewed"

RTM must be driven by a clinician's independent judgment for their own patient. Never by the vendor. Safe harbors, including the patient engagement and support safe harbor, can protect legitimate arrangements, but only if every statutory condition is met. *[OIG Special Fraud Alert, July 2022; OIG safe harbor final rule]*

The enforcement backdrop

RTM has no standalone OIG audit report yet, but its older sibling does. In its 2025 report on RPM billing, the OIG found Medicare RPM payments reached **$536 million in 2024**, up roughly 31% from $408 million the prior year. In a separate 2024 oversight report covering earlier claims years, the OIG found that **43% of RPM enrollees did not receive all three required components** of monitoring: education and setup, device supply, and treatment management.

RTM shares that exact three-part architecture: 98975, then 98977 or 98985, then 98979–98981. Auditors already have a playbook for verifying a corresponding proof of each component. A management claim with no data transmission that month, or a device claim with no setup on file, matches the published fraud profile. *[$536M and 31%: HHS-OIG OEI-02-23-00261, 2025. 43% figure: HHS-OIG OEI-02-23-00260, Sept. 2024.]*

Settled versus unsettled

The code structure, the two clocks, the sometimes-therapy rules, no-double-counting, medical necessity, and the four fraud statutes are **settled law**. Three areas remain genuinely unsettled and warrant MAC or counsel confirmation before you rely on them:

1. How auditors will count **passively batched data** that syncs in bulk.
2. The **established-patient question**. CMS has stated the formal requirement applies to RPM, not RTM, but expects RTM to follow an established treatment plan and has flagged future rulemaking to reconsider, and the CY2027 proposed rule would in fact extend the established-patient requirement to RTM. The conservative posture remains a documented initial evaluation and plan before enrollment. *[CY2024 PFS Final Rule, 88 FR 78883–84; CY2027 PFS proposed rule]*
3. How closely **commercial payers** will mirror Medicare's rules.

Where this chapter marks something unsettled, that reflects the state of federal authority, not a research gap. Treating a grey area as settled (or assuming an aggressive shortcut is safe because no rule expressly bans it) is how practices absorb risk without knowing it.

4.2 HIPAA considerations in **remote monitoring**

RTM moves protected health information outside your walls: onto patients' phones, across public networks, and into a vendor's cloud. HIPAA applies wherever the data travels. Three obligations follow.

Your RTM vendor is a business associate

Any vendor that creates, receives, maintains, or transmits ePHI on your behalf is a business associate, and a **Business Associate Agreement must be executed before the first byte of patient data flows**. The BAA must obligate the vendor to implement Security Rule safeguards, flow equivalent terms down to its subcontractors, and report security incidents to you. Business associates also carry direct HIPAA liability of their own, in addition to yours. *[45 CFR §§ 164.308(b), 164.314, 164.502(e)]*

A signed BAA is a contract, not due diligence. Ask for evidence of the vendor's actual security posture: a SOC 2 report, HITRUST certification, or controls mapped to NIST guidance. Keep it in your vendor file. NIST SP 800-66r2 is the practical federal roadmap for what "reasonable and appropriate safeguards" look like in operation. *[NIST SP 800-66r2, Feb. 2024]*

Update your risk analysis when you start RTM

The Security Rule requires an accurate and thorough assessment of risks to *all* ePHI you hold. Launching RTM without re-running your risk analysis leaves the analysis deficient. Map the full flow (patient device or app, to transmission, to vendor cloud, to clinic access and EHR integration), then confirm the technical safeguards along that path: unique user IDs and role-based access, audit logging, transmission security. Encryption is an "addressable" specification, but transmitting ePHI unencrypted is practically indefensible after a breach.

This is not a theoretical exposure. In OCR's HIPAA audit program, **risk analysis was the most-failed element** for covered entities and business associates alike. It is required whether you are a clinic of one or a clinic of hundreds. *[45 CFR §§ 164.308(a)(1)(ii)(A), 164.312; OCR 2016–2017 HIPAA Audits Industry Report]*

Breach notification readiness

- **Business associate to you:** without unreasonable delay, no later than 60 days from discovery. Negotiate a much shorter contractual window (five to ten business days is common), so you can meet your own deadlines. *[45 CFR § 164.410]*
- **You to your patients:** without unreasonable delay, no later than 60 days from discovery. HHS notification is required at 500 or more affected; an annual log covers smaller breaches; media notice is required for 500 or more in a state or jurisdiction. *[45 CFR §§ 164.404–408]*

> ⚠ **The FTC layer clinicians should know**
>
> A consumer wellness app that is not acting as your business associate is generally outside HIPAA, but it is inside the FTC's Health Breach Notification Rule, which the FTC substantially expanded in 2024 to cover most health apps. If your program, or your advice, steers patients toward consumer apps outside the RTM platform, do not assure them HIPAA protects that data. It usually does not. *[16 CFR Part 318, as amended 2024]*

Finally, remember the state layer: a growing number of states regulate consumer health data more strictly than HIPAA. Where your patients or data cross state lines, have counsel confirm which regimes attach.

4.3 Informed consent for RTM

RTM involves two different consents that practices routinely conflate: **program consent**, agreeing to be monitored and billed, and **HIPAA authorization**, permission for data uses beyond treatment, payment, and operations. Most programs need the first for every patient and the second only for secondary data uses.

Medicare has not codified an RTM-specific consent requirement. The parallel RPM framework requires consent obtained at the time services are furnished and documented in the record, and many state telehealth laws independently require documented consent. Written consent is the defensible standard for RTM even where not expressly required. Re-confirm annually, or whenever the device, vendor, or cost-sharing changes. *[CY2021 PFS Final Rule; APTA Practice Advisory]*

A defensible RTM consent covers

- What is being monitored, with which device or app, and for what clinical purpose.
- The right to decline or withdraw at any time without affecting other care.
- How often data is reviewed and, explicitly, that RTM is **not continuous emergency surveillance**. Patients must understand that concerning symptoms still mean calling the clinic or 911, not waiting for someone to notice a data point. This expectation gap is a genuine liability exposure, not boilerplate.
- Who sees the data: the care team, the technology vendor as business associate, and any monitoring service.
- **Cost-sharing.** Explain the recurring monthly charge before enrollment. Do not routinely waive it to smooth enrollment; hardship waivers must be individualized, documented, and vetted by counsel.

Secondary uses of patient data

If the vendor contract lets the vendor use patient data for product improvement, analytics, or AI model training, that use sits outside treatment, payment, and operations. It requires either valid de-identification under the HIPAA standard or the patient's written authorization, and it should be disclosed in your consent conversation either way. Read the vendor's data-use terms before you sign, not after a patient asks. *[45 CFR § 164.514]*

Many states impose their own telehealth consent requirements (some before billing, some once per episode, some in writing) based on where the patient is located. Confirm with counsel for every state in your patient population; the stricter law governs.

► *Sample patient consent language appears in Appendix B.*

4.4 Documentation **standards**

Every claim is a factual certification. The documentation test is simple and unforgiving: could a stranger reconstruct the service from your records alone? Six evidence elements answer that question.

1. Medical necessity & plan linkage	Why *this* patient is being monitored, tied to functional goals. Therapists: an active, signed plan of care that includes RTM. Physicians and NPPs: a documented treatment plan and rationale. Reassess and re-document necessity as the episode progresses; indefinite monitoring without reassessment is an audit magnet.
2. Consent record	Dated consent in the chart before the first billable service.
3. Device qualification	Evidence the platform meets the FDA definition of a medical device, per the CPT requirement, which is distinct from FDA clearance or registration. Keep the vendor's written classification statement on file.
4. Date-discrete data log	An exportable, unalterable log of unique calendar dates of transmission or access, supporting the exact code billed for each 30-day window.
5. Time log	Contemporaneous minutes by date, person, and activity, segregated from every other timed code, with assistant time flagged for CQ/CO. Recorded at the time of service, not reconstructed later. Identical auto-generated entries ("20 minutes: reviewed data" every month, every patient) read as fabrication to an auditor even when the work happened.
6. Interactive communication record	Date, modality, duration, participants, and a brief clinical summary of the required monthly synchronous contact.

Retrievability is part of the standard

Audit lookbacks arrive years later; vendor contracts end sooner. If your data logs live only in the vendor's system, you must be able to export or retrieve them after the relationship ends. Build export rights and log retention into the contract before signing. Retain records per Medicare and your state's medical-record retention rules, and note HIPAA's separate six-year retention requirement for policies and security documentation. A summary dashboard that cannot regenerate date-level and minute-level logs is a documentation gap wearing a nice interface. *[45 CFR § 164.316(b)]*

The strongest records don't just log data; they show the data changing care. A flagged pain trend leading to a program adjustment, documented in the note.

That clinical narrative is the best defense to a medical-necessity challenge.

4.5 Staff training and scope of practice

Role	What they may furnish
Therapists (PT/OT/SLP)	RTM must be personally furnished by the billing therapist or, for PT and OT, by a PTA or COTA under the therapist's supervision, general supervision in private practice since 2024. Therapists' Medicare benefit does not include incident-to services, and unlicensed clinical staff cannot furnish billable RTM minutes. *[CMS Transmittal R11118CP; CY2024 PFS Final Rule]*
Physicians and NPPs	Since 2023, clinical staff may furnish RTM under general supervision consistent with incident-to rules: a materially different staffing model than the therapy side. The supervising practitioner remains responsible for the service.
Administrative staff	Essential to enrollment, scheduling, and tech support, but administrative time is **never** countable toward the treatment-management codes, and admin staff cannot perform the clinical data review those codes describe. Keep admin activity out of the clinical time log entirely.

State practice acts sit on top of Medicare rules. Medicare's general-supervision allowance does not override a state act that requires direct supervision, sets assistant ratios, or restricts remote delivery. Licensure also matters when the patient is physically in another state during monitoring. Confirm compact privileges or licensure for every state where enrolled patients reside. The stricter rule governs, always.

Train every role on the piece it owns

- The two-clock code logic and honest stratification *(billing)*
- Contemporaneous time capture and the no-double-counting rule *(clinicians)*
- The consent conversation and cost-sharing disclosure *(enrollment staff)*
- Escalation pathways for concerning data: who responds, how fast, what gets documented *(everyone)*
- HIPAA handling of RTM data *(everyone)*

Then **document the training itself**: dates, content, attendance. Auditors ask for it, and a training record is a core element of an effective compliance program. Refresh at least annually: the CPT panel and CMS change these rules every year, and CY2026 alone added 98979, 98984 and 98985 to the therapy code list.

▸ *Front-desk workflows and the enrollment conversation are covered in §6.3 and §6.4.*

4.6 Audit triggers and preparation

Multiple entities can review RTM claims: your MAC, including Targeted Probe and Educate, the Supplemental Medical Review Contractor, Unified Program Integrity Contractors, Recovery Audit Contractors, and the OIG. They increasingly use data analytics, which means **patterns** trigger audits before any human reads a chart.

Patterns that draw attention

- Every enrolled patient billed the standard device code every month. Real patient populations produce variance between the 2–15 and 16–30 day tiers; its absence suggests default coding.
- Treatment management billed without a documented interactive communication, or in months with no data transmission on file.
- Identical time entries across patients and months. Uniform “20 minutes” logs read as templated, not contemporaneous.
- Indefinite monitoring with no documented reassessment of medical necessity.
- Enrollment spikes correlated with a vendor relationship, or RTM billed for nearly 100% of a caseload.
- RTM and RPM billed for the same patient in the same month. CMS does not permit both; concurrent claims are denied and flagged for review.

Audit yourself first

Quarterly, pull five to ten RTM files and test them against the §4.8 checklist, including a live test of whether you can regenerate the platform’s date-level and minute-level logs. If you cannot do it now, you will not be able to do it under audit. Assign a named owner for audit correspondence with a calendar for response deadlines; a strong file that misses the deadline still loses. Engage counsel early for UPIC or OIG contact, since those reviews concern program integrity rather than routine documentation.

> ⚠ **The 60-day overpayment clock**
>
> If your internal audit identifies an overpayment (billing the standard device code when the log does not support it, or double-counted minutes) federal law requires you to report and return it within 60 days of identifying and quantifying it. Knowingly retaining it past that window converts a billing error into False Claims Act liability. **The clock starts with your own finding, not an audit letter.** Work with counsel on quantification and lookback scope. *[42 U.S.C. § 1320a-7k(d); 42 CFR § 401.305]*

4.7 Building a culture of compliance

Everything in this chapter fails without a practice culture that treats compliance as clinical quality rather than paperwork. The OIG’s General Compliance Program Guidance describes seven elements of an effective program,

explicitly scaled to organizations of every size, including small practices where roles are worn as hats rather than job titles.

1. **Written policies and procedures** for RTM: enrollment criteria, consent workflow, time capture, code selection, escalation.
2. **A designated compliance lead with real authority.** In a small practice, a named owner with protected time, reporting to leadership.
3. **Training and education**, documented and refreshed annually.
4. **Open lines of communication.** Staff can raise a billing concern without retaliation, and the concern goes somewhere.
5. **Internal monitoring and auditing**, per §4.6.
6. **Consistently enforced standards.** The rules apply to owners and top producers, not just staff.
7. **Prompt response and corrective action.** Fix the system that produced the error, not just the entry; report and return overpayments on the 60-day clock.

Culture shows up in small behaviors: the biller who asks "does the log support this?" is rewarded, not shushed. A near-miss becomes a workflow fix instead of a blame exercise. Vendor compliance claims are verified against primary sources rather than accepted from a sales deck. The incentives align more than teams expect: the same date-discrete log that defends a claim is the record proving your patient actually engaged with their care. A practice that can show its work has nothing to fear from the enforcement backdrop in §4.1. *[HHS-OIG, General Compliance Program Guidance, Nov. 2023]*

KEY TAKEAWAY

Compliance failures in RTM are almost never clinical failures: they are record failures. Get a BAA signed before data flows, re-run your risk analysis, obtain written consent that names the recurring copay and states plainly that RTM is not emergency surveillance, log minutes contemporaneously, stratify device codes from the actual log, and self-audit quarterly including a live log regeneration test.

4.8 Compliance self-assessment checklist

Use this quarterly and before launching or changing an RTM program. Any "no" is an action item; recurring "nos" in the same domain are a system problem. This is a self-assessment aid, not a substitute for legal review.

Item	Question	
	PROGRAM FOUNDATION	
Medical necessity	Every enrolled patient has a documented clinical rationale and, for therapists, a signed plan of care that includes RTM; necessity is reassessed during the episode.	☐
Consent	Written, dated consent including recurring cost-sharing disclosure is in the chart before the first billable service, and re-confirmed annually or on program changes.	☐
Device qualification	The vendor's written FDA device / SaMD classification statement is on file.	☐
	CODING AND BILLING INTEGRITY	
Stratification	Device-supply codes (98977 vs. 98985) are selected from the actual date-stamped log at the close of each 30-day window. There is no default code.	☐
Time capture	Treatment-management minutes are logged contemporaneously by date, person, and activity, and never overlap other timed or E/M services.	☐
Interactive communication	Every management month includes a documented synchronous phone or video contact, held on a day with no billed E/M (physicians) and outside billed therapy time (therapists).	☐
Modifiers	GP / GO / GN applied for therapy claims; CQ / CO applied when assistants furnish applicable codes.	☐
Concurrency	No patient is billed RTM and RPM in the same month; time for other care-management services is kept separate.	☐
	HIPAA AND VENDOR MANAGEMENT	
BAA	A signed BAA predates any data flow, with subcontractor flow-down and a short contractual incident-reporting window.	☐
Risk analysis	The security risk analysis has been updated to cover the RTM data flow end to end, with encryption in transit and at rest confirmed.	☐
Vendor diligence	Independent evidence of vendor security posture (SOC 2 / HITRUST / NIST-mapped) is on file, along with data-use terms for any secondary use.	☐
Breach readiness	Your notification workflow can meet the 60-day individual-notice deadline, including the vendor's reporting step.	☐
	FRAUD AND ABUSE	

Item	Question	
Vendor compensation	No vendor or marketer payment varies with enrollment volume, orders, or claims; counsel has reviewed the arrangement.	☐
Patient inducements	Copays are not routinely waived; any hardship waiver is individualized, documented, and counsel-vetted.	☐
Stark screening	Any physician financial relationship with the entity billing RTM has been screened against the code list and exceptions by counsel.	☐
	STAFFING AND TRAINING	
Furnishing rules	Only permitted personnel furnish RTM per discipline, consistent with state practice acts and licensure for each patient's location.	☐
Training records	Role-specific RTM training is documented (dates, content, attendance) and refreshed at least annually.	☐
	AUDIT READINESS	
Internal audits	Files are self-audited quarterly against this checklist, including a live regeneration of platform logs.	☐
Log retrievability	Export rights and log retention survive the vendor contract; records meet Medicare, state, and HIPAA retention rules.	☐
Overpayments	A documented process reports and returns identified overpayments within 60 days.	☐

SOURCES REFERENCED IN THIS CHAPTER

CMS, CY2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F) · CMS, CY2027 Medicare Physician Fee Schedule Proposed Rule (July 2026) · CMS MLN Matters MM14250, Therapy Code List 2026 Annual Update · CMS, CY2021 Medicare Physician Fee Schedule Final Rule (85 FR 84472) · CMS Manual System, Transmittal R13431CP / CR 14250, 2026 Annual Update to the Therapy Code List (Nov. 2025), and Transmittal R11118CP (2022 Therapy Code List update) · CMS, Annual Update to the List of CPT/HCPCS Codes (Physician Self-Referral), eff. Jan. 1, 2026; 42 CFR § 411.351 · AMA, CPT Professional Edition, Remote Therapeutic Monitoring Treatment Management Services guidelines (re-verify each CPT cycle) · AMA, CPT 2025 Corrections and Errata, RTM Treatment Management guideline revisions (Mar. 2025) · APTA, Practice Advisory: Remote Therapeutic Monitoring Codes Under Medicare (updated Jan. 2026) · HHS-OIG, OEI-02-23-00260 (Sept. 2024) and OEI-02-23-00261 (Aug. 2025), Remote Patient Monitoring oversight reports · HHS-OIG, Special Fraud Alert: Practitioner Arrangements With Purported Telemedicine Companies (July 2022), and Safe Harbor / Beneficiary Inducements final rule fact sheet · HHS-OIG, General Compliance Program Guidance (Nov. 2023) · 42 U.S.C. § 1320a-7b(b); 42 U.S.C. § 1320a-7a(a)(5); 42 U.S.C. § 1395nn; 42 U.S.C. § 1320a-7k(d) and 42 CFR § 401.305 · 45 CFR Part 164, Subparts A, C, and D, including §§ 164.308, 164.312, 164.314, 164.316, 164.404–410, 164.502(e), 164.514 · 16 CFR Part 318 (FTC Health Breach Notification Rule, as amended 2024) · NIST SP 800-66r2 (Feb. 2024) · HHS OCR, 2016–2017 HIPAA Audits Industry Report.

CHAPTER FIVE

RTM Delivery **Models**

Diana Diep, PT, DPT

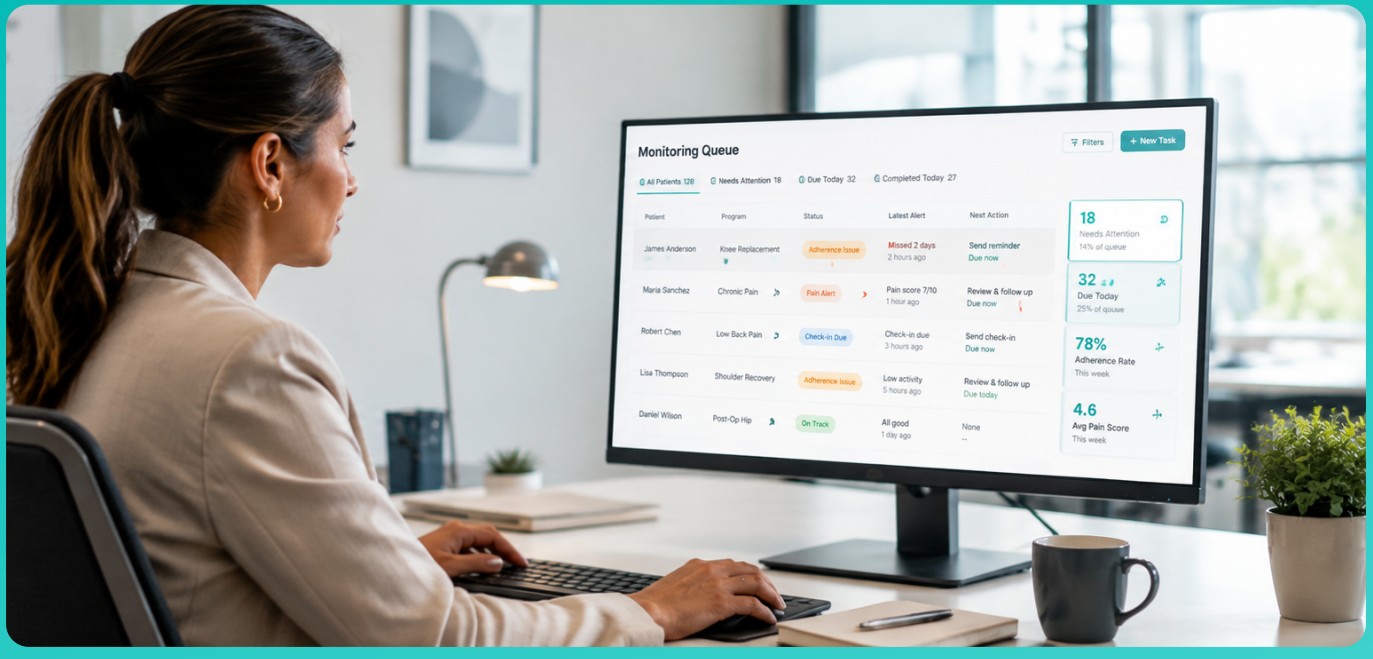
SaaS-only, outsourced, or a dedicated internal coordinator: three models, their real costs, and how to tell which one fits your practice.

Three **models**

- SaaS-only: you run it
- Outsourced: they run it
- Coordinator: one owner, in-house

One **warning**

A CY2027 proposal would require monitoring staff to be direct employees.



One of the biggest decisions a clinic makes when implementing Remote Therapeutic Monitoring is determining **who will actually manage the program**.

There is no one-size-fits-all answer, and that is good news, because there are real options. Some clinics prefer complete control over their RTM workflows. Others would rather shift the day-to-day responsibilities to a third-party team. Others land in the middle by assigning a dedicated team member to run RTM internally.

Understanding the advantages and limitations of each model helps your clinic choose the approach that fits your staffing, patient volume, financial goals, and operational capacity.

> ⚠ **Read this before you evaluate the outsourced model**
>
> As of this writing, the content in this chapter reflects current RTM regulations and industry practice. However, the **CY2027 Medicare Physician Fee Schedule proposed rule, published July 16, 2026, would require that RPM and RTM services be furnished exclusively by clinical staff who are direct employees of the billing practitioner or practice.** If finalized as proposed, that would effectively eliminate outsourced and contracted monitoring as a compliant delivery model, not only for treatment management, but across RPM and RTM.
>
> Three companion proposals in the same rule compound the effect: extending the established-patient requirement to RTM, requiring a separately reportable face-to-face initiating visit, and reducing practice expense valuations. CMS also solicited comment on collapsing all seventeen RPM and RTM CPT codes into four G-codes.
>
> **None of this is final.** The content below remains accurate under current rules and is offered for educational purposes. But if you are evaluating outsourced RTM as part of a long-term strategy, weight this proposal heavily, follow the rulemaking, and consult reimbursement counsel before committing. *[CY2027 PFS proposed rule, July 2026]*

5.1 The three primary models

Model	Who does the daily work	Best fit
SaaS-only	The clinic's existing clinicians and staff, using a purchased platform	Practices with existing staff capacity, established workflows, and internal RTM expertise
Outsourced	A third-party team of RTM clinicians or coordinators, under the treating provider's oversight	Practices that want to launch or scale quickly without hiring
Clinic-managed coordinator	A dedicated internal employee who owns the program	Medium to large practices wanting internal control without burdening every clinician

1. The Software-as-a-Service (SaaS) only model

The clinic purchases an RTM platform and manages the entire program internally. The software provides the tools to prescribe home exercise programs, collect patient data, facilitate communication, and track billing eligibility, but the clinic's own staff performs all patient monitoring, engagement, documentation, and billing. Everything is in-house, and the clinic has full control.

That means clinic staff are responsible for enrolling patients, monitoring adherence, reviewing data, messaging patients, updating the HEP, documenting the monitoring services, meeting the CPT requirements, and billing the codes.

2. The outsourced RTM model

The clinic partners with a third-party company that provides dedicated RTM clinicians or coordinators to perform the day-to-day monitoring and patient engagement. The clinic still prescribes RTM and maintains oversight of patient care; the outsourced team handles routine monitoring, patient communication, documentation, and coordination according to the clinic's and the rendering clinician's protocols. The treating provider maintains oversight and bills under the appropriate clinician, while much of the administrative workload shifts away from the clinic.

3. The clinic-managed RTM coordinator model

The clinic designates or hires an internal RTM coordinator responsible for managing the program. Rather than distributing responsibilities across multiple therapists or relying on an external vendor, one dedicated staff member oversees enrollment, monitoring, communication, documentation, and coordination with treating providers. This combines the efficiency of a dedicated specialist with the control of keeping the program entirely in-house.

5.2 The SaaS-only model

Typical workflow

1. The provider prescribes RTM and educates the patient on the rationale and benefits.
2. The patient is enrolled on the RTM platform.
3. The home exercise program is prescribed.
4. The patient completes exercises and reports symptoms.
5. Clinic staff review patient engagement.
6. Staff communicate with patients based on the reviewed data.
7. Billable monitoring time is documented in the clinic's EMR.
8. The clinic bills the RTM CPT codes.

Advantages

Lower overall cost. Instead of paying for outsourced monitoring or hiring dedicated RTM staff, the clinic invests in a software platform and leverages its existing team. Lower overhead makes this attractive for organizations introducing RTM without a significant upfront financial commitment.

Full control. The clinic owns every aspect of the patient experience: communication, clinical decision-making, documentation, workflow, scheduling, and billing. That lets clinics tailor RTM to their existing operations rather than adapting to someone else's process, and patients often receive a more personalized, consistent experience as a result.

Strong integration with existing staff. RTM becomes a natural extension of the care patients are already receiving. Because the treating therapist already has an established relationship with the patient, introducing RTM feels seamless rather than like an add-on service. Patients are more likely to engage when the recommendation comes from a provider they know and trust. Questions get addressed during scheduled appointments, programs get modified immediately based on progress, and therapists have direct access to both in-clinic and remote data.

Greater flexibility. Clinics decide who owns enrollment, monitoring, communication, and documentation. Responsibilities can be shared among clinical staff, front office staff, or other team members based on the clinic's staffing model, and workflows can be refined as volume grows and requirements change.

Higher revenue retention. Because the clinic performs all billable services internally, it keeps a larger share of the reimbursement after software costs. There are no ongoing service fees or revenue-sharing agreements. Billing runs through the existing EMR and billing workflow, which reduces administrative cost and keeps oversight of documentation and claims in-house.

Challenges

Increased staff workload. RTM takes time, and it introduces responsibilities that occur outside scheduled appointments: patient education and enrollment, ongoing monitoring of activity and exercise compliance, responding to messages, updating home exercise programs, documentation, and tracking billing requirements. Each task may take only a few minutes, but they add up quickly across dozens or hundreds of patients. Without protected time, RTM falls behind: engagement declines, documentation becomes inconsistent, and reimbursement opportunities are missed.

Staff training is required, and it is not a one-time event. Staff need to understand RTM regulations and eligibility, patient onboarding, CPT requirements, documentation standards, and platform navigation. As regulations change, features update, and new employees join, clinics need ongoing education and standardized workflows to maintain consistency and compliance.

Requires internal buy-in. Even the best platform cannot succeed without support from the clinical team. Common barriers: therapists forgetting to enroll eligible patients, staff viewing RTM as an extra task rather than an extension of patient care, inconsistent software use between providers, and clinicians who are unmotivated or not comfortable with technology. Clinics that succeed establish clear workflows, assign ownership of specific tasks, provide regular performance feedback, and communicate the clinical and financial value to the whole team.

Difficult to scale. Many clinics manage RTM well with a small number of patients, but scaling introduces new operational challenges. Without dedicated staffing or efficient workflows, therapists end up balancing RTM against a full patient schedule, leading to delayed follow-up, inconsistent engagement, burnout, and missed reimbursement. As the program grows, many clinics eventually need protected staff time, an RTM coordinator, or a transition to a hybrid or outsourced model.

5.3 The outsourced model

The outsourced model lets clinics offer RTM without placing most of the day-to-day responsibility on their internal team. Instead of managing monitoring, communication, and documentation in-house, the clinic partners with an external RTM service that provides dedicated clinicians or care coordinators.

The treating provider remains responsible for the plan of care and makes all clinical decisions; the outsourced team supports the program. This lets clinics expand RTM without significantly increasing the workload of existing staff.

Typical workflow

1. The provider prescribes RTM for an eligible patient.
2. The patient is referred to the outsourced RTM team, which assumes responsibility for the day-to-day monitoring process.
3. The patient is onboarded and educated on the platform and their prescribed home program.
4. Monitoring clinicians track adherence, review progress, and identify barriers to recovery.
5. Patients receive ongoing communication through secure messaging, phone calls, or other approved methods.
6. Billable monitoring time and clinical interactions are documented per RTM requirements.
7. Regular reports and clinically relevant updates are shared with the treating provider.
8. The clinic submits RTM claims using the documentation and billing support provided.

Advantages

Minimal clinic staff burden. Patient onboarding, adherence and symptom monitoring, routine patient questions, time documentation, and routine follow-up are handled by a dedicated external team, letting therapists and front-office staff stay focused on in-person care.

Faster program launch. Building internally requires developing workflows, training staff, assigning responsibilities, and creating documentation processes. With an outsourced model, much of that infrastructure already exists, shortening implementation timelines considerably.

Consistent patient follow-up. Patient engagement is one of the strongest predictors of RTM program success. Dedicated monitoring teams use standardized workflows to ensure patients receive regular communication throughout the episode of care, which supports adherence and keeps patients connected between visits.

Easier to scale. Whether a clinic enrolls 50 patients or 500, the external team can typically absorb the increased volume without the clinic hiring additional staff or significantly changing internal operations.

Higher therapist efficiency. In-house clinicians spend more of their time on work that requires their clinical expertise (evaluations, treatment sessions, clinical decision-making) while the outsourced team keeps patients engaged between visits and supplies meaningful updates and documentation.

Challenges

Higher overall cost. In addition to the platform, clinics pay for the clinical monitoring service: a monthly fee, per-patient pricing, or a revenue-sharing arrangement. Clinics retain a smaller portion of the reimbursement than they would managing the program in-house. That said, because the model scales more easily, clinics can often enroll more patients, creating greater overall revenue despite sharing a portion of each claim.

Less direct control. Another organization is interacting with your patients. Vendors work closely with clinics to develop communication protocols and align with standards of care, but differences in communication style, response times, or workflow may not always reflect your preferred approach.

Requires strong communication. Success depends on seamless coordination among treating providers, outsourced monitoring clinicians, billing staff, and administrative teams. Clinical updates, plan-of-care changes, patient concerns, and billing documentation must move promptly and accurately. Without well-defined workflows, information gets delayed, duplicated, or overlooked, affecting both care and reimbursement.

Vendor dependence. You rely on the vendor's responsiveness, staffing capacity, clinical expertise, documentation quality, and ability to consistently engage patients. If the outsourced team experiences staffing shortages or inconsistent service, your program feels it. Evaluate a vendor's clinical experience, communication processes, reporting capabilities, compliance practices, and track record carefully.

> ⚠ **Structure the arrangement carefully**
>
> Outsourcing is legitimate, but the OIG's telemedicine fraud alert maps directly onto poorly structured RTM vendor deals. Three specifics to get right: the vendor must not recruit or contact your patients to drive enrollment; the billing practitioner must maintain meaningful patient contact sufficient to verify ongoing necessity; and vendor compensation must not vary with enrollment volume, orders, or claims. Have counsel review the arrangement before signing. *[See §4.1]*

5.4 The clinic-managed coordinator model

Some clinics find that neither a fully internal SaaS model nor a fully outsourced approach fits. Instead they designate a dedicated employee to oversee day-to-day management of the program while the treating provider remains responsible for clinical care.

Rather than distributing RTM responsibilities across every therapist, one individual becomes the primary owner of the program and the central point of contact for monitoring, communication, documentation, and coordination. Depending on the size and structure of the practice, that coordinator may be a PT or PTA for physical therapy patients, an OT or OTA for occupational therapy patients, or a PA, NP, or PT in a physician group.

Typical workflow

1. The treating provider identifies appropriate candidates and introduces the program during an in-person visit.
2. The coordinator onboards the patient, provides education, and confirms the patient can use the application and complete their home program.
3. The coordinator monitors adherence and engagement by reviewing exercise completion, patient-reported outcomes, and other RTM data.
4. Patients receive ongoing communication through secure messaging or phone calls.
5. Clinical concerns are escalated to the treating provider whenever plan-of-care changes or additional clinical decision-making are required.
6. The coordinator documents billable monitoring time and patient interactions.
7. Billing reports and supporting documentation are prepared for accurate claim submission.

Advantages

Dedicated program ownership. When responsibilities are divided among multiple therapists, enrollment, follow-up, documentation, and billing preparation easily become inconsistent or overlooked. A dedicated coordinator creates clear accountability, standardized workflows, and consistency across the organization. Because they are embedded in the clinic, they can collaborate with providers directly, understand clinical priorities, and adjust workflows to the clinic's specific needs. They become the internal expert.

Reduced therapist workload. The coordinator manages onboarding and education, adherence monitoring, routine patient questions, follow-up with inactive patients, time tracking, and billing documentation, allowing therapists to support more patients without a significant increase in administrative work.

Greater control than outsourcing. The coordinator is part of your internal team, so you retain direct oversight of patient communication, documentation standards, workflows, and quality assurance. Communication is faster, treatment plans adjust more efficiently, and patient concerns get addressed without going through an outside organization.

Easier staff training. Training every therapist to become an RTM expert is time-consuming and hard to maintain as regulations evolve and staff turn over. With a coordinator model, you develop one highly knowledgeable specialist who understands billing requirements, documentation standards, compliance, engagement strategy, and the platform, and who serves as an internal resource for everyone else.

Scalable with growth. Clinics can expand gradually by increasing the coordinator's administrative time or adding coordinators as demand grows, maintaining consistent engagement and operational quality without redesigning workflows.

Challenges

Requires dedicated staffing resources. The model requires protected staff time or a specific hire. If RTM duties are simply added to someone's existing workload without reducing their other responsibilities, the coordinator experiences the same competing priorities and inconsistent follow-up as a treating clinician. Successful programs intentionally allocate sufficient time.

Ongoing personnel costs. Eliminating outsourcing fees introduces internal expense: salary and wages, benefits, initial and ongoing training, administrative support, and software licensing. For smaller practices with limited volume, these costs may be hard to justify until the program grows.

Coverage planning. A successful program should never depend on one individual. If the coordinator is out for vacation, illness, parental leave, or turnover, another trained staff member must be able to continue monitoring, documentation, and communication without disrupting care or billing. Standardized workflows and cross-training reduce that operational risk.

5.5 Choosing your model

Work through these questions honestly before committing. The answers usually point clearly in one direction.

Question	What your answer indicates
Do clinicians have protected, non-treating time today?	If no, SaaS-only will stall regardless of platform quality
How fast do you need to launch?	Weeks favors outsourced; a quarter or more allows internal build
What patient volume do you expect at month 12?	Under ~40 favors SaaS-only; a few hundred favors coordinator or outsourced
Is there a clinical leader available for genuine oversight?	Required for all three, but non-negotiable for outsourced
How much reimbursement are you willing to share?	Revenue-share tolerance is the main economic dividing line
Could you absorb a rule change banning contracted monitoring?	If not, weight heavily against outsourced given the CY2027 proposal

Real-world patterns

- **Solo or small practice, 3 clinicians.** SaaS-only with a part-time RTM coordinator role carved out of existing admin time.
- **Multi-site group, 12 clinicians.** Coordinator model, or outsourced with a documented clinical oversight protocol.
- **Hospital-based outpatient.** Hybrid: in-house billing with outsourced or centralized monitoring.
- **Private equity-owned group.** SaaS at scale with a centralized internal RTM team, which is the coordinator model multiplied.

KEY TAKEAWAY

Choose **SaaS-only** if your team has the time, expertise, and appetite to manage RTM internally while maximizing revenue retention. Choose **outsourced** if your priority is reducing staff workload, launching quickly, and leveraging external expertise, even at the cost of sharing more of the program economics, and only after weighing the CY2027 proposal that would require monitoring staff to be direct employees. Choose the **coordinator model** if you want the control of an internal program without burdening every treating clinician.

There is no universally best model. The most successful RTM programs align with the clinic's staffing capacity, operational workflow, patient population, and commitment to consistent patient engagement.

CHAPTER SIX

RTM Is the **Front Door**

Jerry Durham, PT

How to boost patient success (and business) with the right engagement strategy.

Engaged admin **teams mean**

- Higher RTM enrollment
- Better data collection
- Fewer patient drop-offs

What patients **want in 2026**

- “Make it fit into my life”
- “Let me manage it on my phone”
- “Show me it’s working”



In 2026, Remote Therapeutic Monitoring has become more than a billing code. For physical therapy practices, it is the most scalable way to extend care, improve outcomes and differentiate in a crowded market.

But most clinics miss the point: RTM isn't just a platform, it's an experience. And like all patient experiences, it rises or falls with how well it's delivered at the front line.

That's where patient engagement strategy meets business strategy. When you operationalize RTM through a well-trained, patient-centric front desk, and connect it to clear mobile workflows and transparent value, you unlock not just better adherence, but stronger retention and growth.

RTM isn't just a platform, it's an experience. **And like all patient experiences, it rises or falls with how well it's delivered at the front line.**

6.1 The front desk makes or breaks RTM adoption

Patients don't sign up for RTM because of a CPT code. They sign up because someone they trust (often the front desk) explains how it helps them feel better and faster.

Yet in many clinics, the admin team isn't looped in. That's a strategic miss.

Engaged admin teams mean

Higher RTM enrollment · better data collection · fewer patient drop-offs.

The front desk is your first sales funnel. When staff confidently pitch RTM as part of the care experience ("this is how we'll keep you progressing between visits"), it frames it as value, not as a cost.

6.2 Shifting the mindset: admin as care team members

If your front desk sees themselves as schedulers and gatekeepers, RTM will underperform. But when they see themselves as **care extenders**, patient outcomes shift.

What this looks like

- Asking the right questions during check-in: "how's your home exercise going?"
- Reframing RTM as support between visits, not a tech add-on
- Following up when a patient misses digital check-ins, like they would for a missed appointment

Patient success isn't just about exercises. **It's about being seen, heard and supported, by everyone on your team.**

▸ *A re-engagement script for patients who stop checking in appears in Appendix D.*

6.3 The enrollment conversation at check-in

You only get one shot to make RTM feel valuable, and it happens when the patient is still forming their expectations.

High-performing practices script the enrollment conversation like this:

> "As part of your care, we'll stay connected between sessions using our app. You'll get reminders, track your progress, and we'll be able to adjust if anything's off. **It helps you get better, faster, with fewer trips.**"

Then they pair that with transparency. Three questions every patient is silently asking:

- **What's the cost?**
- **What do I get?**
- **Who will check in with me?**

This is where **"Arrive, Pay, Stay"** starts. If patients aren't clear and confident at check-in, they won't opt in, or worse, they'll opt out mid-plan.

> ⚠ **Editorial note: the cost answer is a compliance control**
>
> Answer "what's the cost?" explicitly and every time. Medicare Part B coinsurance, typically 20%, applies each month the patient is enrolled, and recurring surprise copays are the leading driver of patient complaints. Complaints invite audits. Equally important: **never offer to waive the copay to close an enrollment.** Routine waivers are a Beneficiary Inducements and Anti-Kickback problem, not a courtesy. Route genuine hardship cases to whoever owns your documented, individualised waiver process. *[See §4.1 and §4.3]*

▸ *A full enrollment script, objection responses and a warm-handoff line appear in Appendix D.*

6.4 The onboarding handoff: **what admin owns**

You don't need your clinical team to do everything. That's the beauty of smart RTM workflows.

Your admin team can own	• Confirming RTM setup: app installed, login successful • Explaining how to use it: what to expect and when • Troubleshooting tech basics: forgotten password, stuck video • Collecting initial PROMs during check-in if needed
Clinicians must own	• The decision to enroll, and its clinical rationale • Reviewing and interpreting patient-reported data • All clinical decision-making and escalation • The monthly real-time interactive contact • Every minute entered in the billable time log

This frees up providers to focus on higher-value clinical conversations, while keeping patients moving forward in the background.

▸ *A before-they-leave-the-building setup checklist appears in Appendix D.*

> ⚠ **Editorial note: keep administrative time out of the clinical log**
>
> Everything in the left column above is necessary and valuable. None of it is billable under the treatment-management codes. On the therapy side there is no incident-to benefit, unlicensed staff cannot furnish billable RTM minutes for a therapist. Keep the two logs physically separate so there is no opportunity for them to blend. *[See §4.5]*

6.5 What patients want **from RTM in 2026**

Now let's zoom out. Patients in 2026 are telling us three things loud and clear.

"Make it fit into my life."
Fewer clinic trips, real-time support, and flexibility.

"Let me manage it on my phone."
One app. One login. Two-way messaging. Video demos. Progress graphs.

“Show me it’s working and what I’m paying for.”
Visual feedback, clear ROI, and upfront pricing.

Your front desk is **the launchpad for all of this.**

6.6 Business impact: why this strategy wins

Strategy lever	Patient outcome	Business impact
Front desk leads RTM onboarding	Higher engagement, fewer dropouts	More completed plans of care, better data
RTM enrollment built into check-in	Higher perceived value	Increased RTM revenue capture
Mobile-first tools plus admin support	Ease of use, better feedback loops	Stronger adherence and outcomes
Transparent pricing and dashboards	Greater trust and retention	More referrals, stronger payer relationships

6.7 Final takeaway: RTM is the front door to better business

You don’t need more tech. You need smarter deployment.

RTM, when grounded in patient-first strategy and delivered through your front desk, becomes an engine for success:

- Patients feel seen, supported and empowered
- Clinicians stay focused on care, not admin
- Admins become engagement drivers, not just schedulers
- The practice grows, because patients stay

KEY TAKEAWAY

In 2026, RTM isn’t just a back-office decision. **It’s your front door, and your front desk holds the key.**

CHAPTER SEVEN

How to Choose **a Vendor**

Ellen Morello, PT, DPT

Five evaluation categories, the questions that separate a partner from a supplier, and what to verify before you sign.

Five **categories**

- Clinical and regulatory
- Patient experience
- Billing and compliance
- Integration and technology
- Partnership and support



7.1 Vendor selection is a strategic decision

Choosing an RTM vendor is not a procurement decision. It is a partnership decision, and the difference matters because of how deeply the platform embeds into your clinical workflow, your documentation, and your compliance posture.

Consider what you are actually handing over. Your patients' protected health information will live in the vendor's cloud. Your billable time will be logged in their system. The date-discrete data log that defends your claims in an audit three years from now will be generated by their software. Your clinicians' daily experience (and therefore your program's sustainability) depends on their dashboard design.

Switching costs are real. Patient re-enrollment, staff retraining, workflow redesign, and data migration are each substantial on their own. Practices that choose badly frequently stay badly chosen for years, and the program underperforms the entire time.

Give the evaluation the time it deserves. Two demos and a reference call is not an evaluation; it is a formality. The framework in this chapter is designed to be worked through deliberately, with the scorecard in Appendix C, across a defined evaluation window.

7.2 Device qualification and FDA status

There are two distinct questions here, and practices routinely collapse them into one.

The CPT requirement. The RTM device codes require that the platform meet the FDA *definition* of a medical device. That is a definitional question, and it is distinct from FDA clearance or registration. What you need in your file is the vendor's **written classification statement** confirming the platform meets that definition. Ask for it in writing. Keep it in your vendor file. It is one of the six evidence elements an auditor will look for. *[See §4.4]*

FDA clearance. Separately, some RTM tools carry FDA clearance: typically 510(k) clearance, occasionally de novo authorization for a genuinely novel device type. Clearance is not required for every RTM platform, but where a vendor claims it, verify it. The FDA maintains a public, searchable 510(k) database; a clearance that cannot be found there does not exist. Be specific about what was cleared: clearance for one module of a product line does not extend to the whole platform.

> ⚠ **Questions that produce useful answers**
>
> - Will you provide a written statement that the platform meets the FDA definition of a medical device, for our vendor file?
> - Do you hold FDA clearance? For which specific product or module, and under what K number?
> - What is your regulatory posture if the classification of software-as-a-medical-device changes?

7.3 Patient experience and **engagement design**

Patient experience is the most underrated factor in vendor selection, and it has the most direct line to revenue. Here is why: the device-supply tier you can bill is determined entirely by how many unique days your patients actually engage. Engagement is a function of how easy, fast, and unannoying the patient-facing app is. **UX quality is a billing variable.**

What to look for: simplicity above all, accessibility as a genuine design commitment rather than a compliance claim, and reliability on older devices and poor connections. A check-in that takes more than a minute will not be completed daily. An app that requires a password reset every two weeks will lose your older patients entirely.

Consider your actual patient demographic, not the demographic in the vendor's marketing. If a meaningful proportion of your caseload is over 70, ask specifically about font sizing, tap target size, offline behavior, and what happens when a patient loses their phone. Ask what in-app help and patient support resources exist, and who answers when a patient calls confused: your front desk, or theirs.

Test it yourself. Enroll as a test patient and use the app daily for two weeks before you commit. Then have two or three staff members who are not enthusiastic about technology do the same. Their frustration is the most predictive data in the entire evaluation.

7.4 Code tracking and **billing support**

This is where the CY2026 restructuring changes what you should be asking for. A platform built for the pre-2026 code set will show you a single day counter and a minute total. A platform built for the current rules should show you considerably more.

Capability	Why it matters now
Date-discrete day log, exportable	Determines whether you can substantiate the device tier you billed; a batch-logging system caps what you can claim
Automatic tier stratification	Outputs 98977 vs. 98985 from the actual log at the close of each 30-day window, with no default code
Minute-level time log by person and activity	Contemporaneous capture, segregated from other timed codes, with assistant time flagged for CQ/CO
Synchronous contact tracking	Records date, modality, duration, participants, and summary: the requirement that voids the month if missed
Live threshold dashboard	Shows day count, minutes, and contact status *during* the month, while gaps can still be closed
Concurrency awareness	Helps you avoid billing a patient another practitioner is already monitoring
Audit-ready export	Regenerates date-level and minute-level records years later, after the contract has ended

Ask about built-in billing automation versus bolt-on billing tools, and be specific about what "integration with your billing team" actually means in practice. A report you have to re-key is not integration.

> ⚠ **The question that separates good platforms from marketing**
>
> "Show me, in the live product, how you would regenerate a date-level transmission log and a minute-level time log for a patient discharged eighteen months ago." If the answer involves a support ticket, a CSV you have to reconstruct, or a summary dashboard that cannot drill down, you have found a documentation gap wearing a nice interface. Then ask whether your export rights and log retention survive contract termination, and get it in the contract before you sign. *[See §4.4]*

7.5 EHR integration and workflow compatibility

The integration question is not "does it connect to our EHR?" It is "how well, and what specifically flows?" Vendors describe a wide range of things as integration, from a genuine bidirectional interface to a link that opens their web app in a new tab.

Be concrete. Ask which fields flow in which direction, whether documentation auto-populates into the chart or has to be copied, whether the integration is native or runs through middleware, and who supports it when it breaks. Native integrations tend to be more reliable but less flexible; middleware is more adaptable but adds a vendor and a failure point.

Evaluate integration claims skeptically. Two questions that cut through: *which specific version* of our EHR is this live in today, and *which named practice* using our EHR can we call? A roadmap commitment is not an integration.

If full integration is not available, that is not automatically disqualifying, many practices run RTM successfully alongside their EHR rather than inside it. But you need to know before you sign, and you need to design the documentation workflow around the gap rather than discovering it in month two.

7.6 Data, reporting, and clinical insight

At the patient level, the platform should show you what you need to make a clinical decision in under a minute: pain trajectory, adherence pattern, functional trend, and anything that has broken the patient's established range. Alerts should be clinically calibrated rather than hair-triggered; alert fatigue kills programs.

At the population level, ask what cohort reporting exists. The ability to track average pain trajectory by condition, adherence rate by diagnosis, and functional improvement at discharge across your RTM population is the foundation of the outcomes data set discussed in §2.6, the data referral sources and payers increasingly ask for.

Two non-negotiables. First, **exportable data**: can you take your data with you, in a usable format, at any time, including after termination? Second, **secondary-use terms**: read what the contract permits the vendor to do with patient data for product improvement, analytics, or AI model training. Any use outside treatment, payment, and operations requires valid de-identification or written patient authorization, and it should be disclosed in your consent conversation either way. Read those terms before you sign, not after a patient asks. *[See §4.3]*

7.7 What to expect after go-live

Implementation support is where the partnership is either real or theatrical. A strong onboarding includes workflow design help before enrollment starts (not just platform training) role-specific training for clinicians, front desk, and billing, and a named person accountable for your launch.

Understand the difference between customer service and customer success. Customer service answers your ticket. Customer success notices your activation rate has dropped and calls you about it. Ask which one you are buying, and ask for the specific mechanism: what does the vendor monitor on your behalf, and how often do they proactively reach out?

Set response time expectations explicitly, and distinguish clinical urgency from administrative questions. A patient locked out of their app during a post-operative week is not a routine ticket.

7.8 The vendor evaluation scorecard

Five categories. Score each vendor independently, then weight the categories according to your practice's actual constraints rather than a generic template.

	Category	What you are scoring
1	Clinical & regulatory	Written device-definition statement, FDA clearance where claimed, clinical validity, appropriateness to your scope
2	Patient experience	App simplicity, accessibility, reliability on older devices, in-app support, tested engagement
3	Billing & compliance	Date-discrete logging, tier stratification, minute-level time log, synchronous contact tracking, audit-ready export
4	Integration & technology	EHR connectivity verified in your version, security posture evidence, uptime history, data portability
5	Partnership & support	Onboarding depth, customer success mechanism, response times, roadmap transparency, reference quality

Weighting by practice type

- **Small practice, no dedicated RTM staff.** Weight patient experience and partnership support heavily, you have no capacity to absorb friction.
- **Multi-site group.** Weight billing and compliance plus integration, inconsistency across sites is your main risk.
- **Hospital-based or health system.** Weight integration and security posture: procurement and IT review will gate everything else.
- **Any practice with existing audit exposure.** Weight billing and compliance above everything, and treat the log-regeneration test in §7.4 as pass/fail.

► *A printable scoring matrix with space for notes and vendor comparison appears in Appendix C.*

KEY TAKEAWAY

Test the patient app yourself for two weeks before you commit, and have your least tech-enthusiastic staff do the same. Demand a live demonstration of date-level and minute-level log regeneration for a long-discharged patient.

APPENDICES

Tools You Can **Use on Monday**

A code card, consent language, a vendor scorecard, an enrollment script and a glossary, built to be printed and handed to the person who needs it.

Print **these**

- A. Code quick-reference
- B. Consent language
- C. Vendor scorecard

Then **run these**

- D. Enrollment script
- E. Glossary
- §4.8, Self-assessment

APPENDIX A

RTM CPT code **quick-reference**

Print this. Tape it above the billing desk. Re-verify it every January.

98975	**Initial setup and patient education** Once per episode of care. Do not report for fewer than 2 days of monitoring data in the period
98977	**MSK device supply, standard** 16–30 days of data transmission or access in a 30-day period
98985	**MSK device supply, short duration *(new CY2026)*** 2–15 days of data transmission or access in a 30-day period. Do not report for fewer than 2 cumulative days
98979	**Treatment management, first 10 minutes *(new CY2026)*** 10–19 min QHP time **+** ≥1 real-time interactive communication, per calendar month. **Not reportable with 98980 or 98981**
98980	**Treatment management, first 20 minutes** ≥20 min QHP time **+** ≥1 real-time interactive communication, per calendar month
98981	**Treatment management, each additional 20 minutes** Add-on to 98980. Each additional cumulative 20 minutes in the calendar month

CY2026 PFS Final Rule (CMS-1832-F); CMS Transmittal R13431CP / MLN Matters MM14250. This card lists the **musculoskeletal** RTM codes, the set a physical therapy practice bills. The same family also contains respiratory and cognitive-behavioral device-supply codes, which sit outside PT scope and are not listed here. The treatment-management codes are condition-agnostic and shared across all three. Rates are geographically adjusted and updated annually: use the CMS Physician Fee Schedule lookup tool for current amounts rather than any figure printed here.

⚠ Five rules that decide most claims

1. **Two clocks.** Device supply = unique dated days in a rolling 30-day window. Treatment management = cumulative minutes in a calendar month. Day counts do not gate the time codes.
2. **One real-time contact per management month**: in person, by phone, or by video. No contact, no billable management month. Asynchronous or secure messaging does not count.
3. **No double-counted minutes.** Time billed to therapeutic exercise, manual therapy, or E/M is spent.
4. **One biller per patient per 30 days**, across RTM and RPM combined.
5. **Modifiers.** GP / GO / GN on therapy claims; CQ / CO with the 15% adjustment when assistants furnish 98975 or 98979–98981. Device codes are exempt.

APPENDIX B

Sample patient **consent language**

A starting point, not a form. Have counsel review before use, and confirm state-specific requirements for every state in which your patients are located.

PURPOSE AND DESCRIPTION OF SERVICES

Your care team has recommended Remote Therapeutic Monitoring as part of your plan of care. This means that between your in-person visits, you will use [platform name] on your smartphone or computer to report information about how you are doing: such as your pain level, how you are functioning, and whether you have completed your prescribed home exercise program. Your care team reviews this information and may adjust your treatment plan based on it.

WHAT IS COLLECTED AND HOW IT IS USED

The information collected includes your responses to check-in questions, your reported pain and function scores, and your completion of prescribed exercises. It is used solely to support your treatment, except as separately authorized by you in writing. Your treating provider and their clinical care team will review it. [Platform name] operates the technology on our behalf under a Business Associate Agreement and is required to protect your information under HIPAA. [If applicable: Our monitoring partner, (name), also reviews your information as part of your care team.]

THIS IS NOT EMERGENCY MONITORING

Remote Therapeutic Monitoring is not continuous or emergency monitoring. Your information is reviewed periodically, not in real time. If you experience a medical emergency, worsening symptoms, or a concern that needs immediate attention, call our clinic at [phone] during business hours, or call 911 or go to your nearest emergency department. Do not wait for someone to notice something in the app or respond to a message.

COST

Remote Therapeutic Monitoring is a billable service. It is billed to your insurance each month you are enrolled. **If you have Medicare Part B, standard coinsurance (typically 20%) applies each month**, and you may also be responsible for amounts applied to your deductible. This is a recurring monthly charge for as long as you remain enrolled. If you have questions about your specific cost, please ask us before you enroll.

YOUR RIGHTS

Participation is voluntary. You may decline to enroll, or withdraw at any time, without affecting any other care you receive from us. To withdraw, tell any member of your care team or call [phone]. We will confirm your withdrawal and stop billing for the service.

ACKNOWLEDGMENT

I have read and understood the information above. I have had the opportunity to ask questions. I understand what is being monitored, who will see my information, that this is not emergency monitoring, that a recurring monthly charge applies, and that I may withdraw at any time.

Patient signature _____ Date _____

Printed name _____ Staff obtaining consent _____

Note on secondary data use: if your vendor contract permits use of patient data for product improvement, analytics, or AI model training, that use sits outside treatment, payment, and operations. It requires valid de-identification under the HIPAA standard or a separate written HIPAA authorization, not this consent form. See §4.3.

APPENDIX C

Vendor evaluation **scorecard**

Score 1–5 in each row. Set your category weights first, before you see any demos, so the weighting reflects your practice rather than the last sales call.

Criterion	Weight	Vendor A	Vendor B
1. CLINICAL & REGULATORY			
Written FDA device-definition statement provided for our file			
FDA clearance verified in the public database, where claimed			
Measures and data types appropriate to our scope and caseload			
2. PATIENT EXPERIENCE			
Check-in completes in under one minute			
Works reliably on older devices and poor connections			
Accessibility: font sizing, tap targets, screen reader support			
Passed our two-week internal test, including skeptical staff			
In-app help and patient support, and who answers the phone			
3. BILLING & COMPLIANCE			
Date-discrete, exportable day log (not batch-logged)			
Automatic 98985 / 98977 tier stratification from the actual log			
Minute-level time log by date, person, and activity; CQ/CO flagging			
Synchronous contact tracking with modality and duration			
Live in-month threshold dashboard			
Live log-regeneration test passed (18-month-old patient)			
4. INTEGRATION & TECHNOLOGY			

Criterion	Weight	Vendor A	Vendor B
EHR integration verified live in *our* version, with a named reference			
Documentation auto-populates rather than requiring re-keying			
SOC 2 / HITRUST / NIST-mapped security evidence on file			
BAA executed, with subcontractor flow-down and short incident window			
Data export rights and log retention survive termination, in contract			
Secondary-use terms reviewed and acceptable			
5. PARTNERSHIP & SUPPORT			
Onboarding includes workflow design, not only platform training			
Role-specific training for clinicians, front desk, and billing			
Customer success with a defined proactive monitoring mechanism			
Response time commitments distinguish clinical from administrative			
Roadmap transparency; no roadmap answers to launch-critical questions			

Notes:

APPENDIX D

Front desk **enrollment script**

Scripts supporting Chapter 6. Adapt the wording to your team's voice, and keep the beats from §6.3: the relationship, the small ask, the boundary, and the three questions every patient is silently asking.

INTRODUCING RTM AT CHECK-IN OR CHECKOUT

"Before you head out, [clinician] mentioned she'd like to keep an eye on how you're doing between your visits. It's a program called remote monitoring. Basically, you'll get a quick check-in on your phone most days, just a couple of questions about your pain and whether you got your exercises in. She reviews it and can adjust your program if something isn't working. Takes under a minute a day.

A couple of things I want to be upfront about. It's not monitored around the clock, so if something feels urgent, call us or call 911, don't wait on the app. And there is a monthly charge that goes through your insurance, so you'll see coinsurance on it each month you're enrolled. I'd rather tell you now than have it surprise you.

Want me to get you set up before you go? Takes about two minutes."

OBJECTION RESPONSES

If they say...	Try...
"I'm not good with technology."	"That's exactly why I'd like to set it up with you right now, together, before you leave. Once it's on your phone it's just two taps a day. And if it ever stops working, call me directly."
"Is this going to cost me more?"	"Yes, and I want to be straight with you about it. It bills monthly, and with Medicare that usually means about 20% coinsurance each month you're enrolled. If that's a concern, let's talk about it before we start rather than after."
"Who sees my information?"	"Your care team here, and the company that runs the app, they're bound by a HIPAA agreement with us. If you want more detail than that, let me get [name] to walk you through it properly."
"I already come in three times a week."	"True, and that's about three hours out of your week. This is about the other hundred and sixty-five, which is where most of the progress actually happens."
"Let me think about it."	"Of course. Can I put a note on your chart so [clinician] can answer any questions at your next visit? No pressure either way."

WARM HANDOFF TO THE CLINICIAN

"Heads up before you go in, [patient] mentioned at the desk that she's been having trouble getting her exercises done at home. Might be a good RTM conversation."

BEFORE THE PATIENT LEAVES THE BUILDING: THE CHECKLIST THAT MATTERS

Supports §6.4, confirming RTM setup and login before the patient goes.

- Consent signed, dated, and filed
- App installed **and the patient has logged in successfully**

- Phone number and email verified in the platform
- Patient has completed one practice check-in with you watching
- Patient can state, in their own words, what to do if something feels urgent
- Patient knows the monthly charge applies

RE-ENGAGEMENT OUTREACH: AFTER THREE MISSED CHECK-INS

Supports §6.2, following up on missed digital check-ins the way you would a missed appointment.

"Hi [name], it's [you] from [clinic]. I noticed you haven't been checking in on the app the last few days and wanted to make sure nothing's gone wrong with it. Is it working okay on your phone? … Great, and you've got an appointment Thursday at 2, so I'll see you then."

If there is no response after two attempts, escalate to the clinical team rather than continuing administrative outreach.

APPENDIX E

Glossary

AKS	Anti-Kickback Statute. Federal criminal law prohibiting exchange of value to induce or reward referrals for federally reimbursed services. Intent-based; reaches both sides of a transaction.
BAA	Business Associate Agreement. Required HIPAA contract with any vendor that creates, receives, maintains, or transmits ePHI on your behalf. Must be executed before data flows.
CMS	Centers for Medicare & Medicaid Services. Establishes the RTM code set and coverage policy through annual Physician Fee Schedule rulemaking.
CQ / CO	Modifiers indicating a PTA (CQ) or COTA (CO) furnished the service in whole or in part; triggers the 15% assistant payment adjustment on applicable RTM codes.
CPT	Current Procedural Terminology. The AMA-maintained code set; RTM descriptors and guidelines are revised annually.
ePHI	Electronic protected health information. Subject to the HIPAA Security Rule wherever it is created, stored, or transmitted.
FCA	False Claims Act. Liability for knowingly submitting or causing claims that misrepresent the service furnished.
GP / GO / GN	Discipline modifiers for physical therapy, occupational therapy, and speech-language pathology services furnished under a therapy plan of care.
HEP	Home exercise program. In the RTM context, the prescribed program whose adherence and response are monitored.
HIPAA	Health Insurance Portability and Accountability Act. Governs privacy, security, and breach notification for PHI.
MAC	Medicare Administrative Contractor. Processes claims and conducts reviews, including Targeted Probe and Educate.
MSK	Musculoskeletal. The RTM device-supply family most relevant to physical therapy (98977, 98985).
OIG	HHS Office of Inspector General. Issues fraud alerts, compliance program guidance, and oversight reports; publishes the audit playbooks enforcement follows.
PFS	Physician Fee Schedule. The annual CMS rule that sets RTM coverage parameters and payment rates.

PSFS	Patient-Specific Functional Scale. Patient-nominated functional outcome measure well suited to digital administration in RTM.
QHP / QHCP	Qualified health care professional. For RTM, includes physicians, NPs, PAs, CNSs, PTs, OTs, and SLPs.
RPM	Remote Patient Monitoring. Physiologic, device-transmitted data; primarily physician-driven. Cannot be billed concurrently with RTM for the same patient.
RTM	Remote Therapeutic Monitoring. Non-physiologic, patient-reported data (pain, function, adherence, response to therapy) with billable treatment management based on that data.
SaaS	Software as a Service. In this book, the model in which the clinic licenses a platform and performs all monitoring internally.
SaMD	Software as a Medical Device. Relevant to the CPT device-definition requirement for RTM device-supply codes.
SOC 2	Independent audit report on a service organization's security controls; acceptable evidence of vendor security posture.
Stark Law	Physician self-referral prohibition. Strict liability; RTM codes are on the designated health services code list.
Interactive communication	The real-time (synchronous) contact with the patient or caregiver required at least once per calendar month to bill any RTM treatment-management code. May occur in person, by telephone, or by video. Asynchronous and secure messaging do not qualify.
510(k)	FDA premarket notification pathway demonstrating substantial equivalence to a legally marketed device. Verifiable in the FDA's public database.

Between-visit care, **done properly.**

Remote Therapeutic Monitoring gives physical therapy something it has never had: a continuous view of the ninety-eight percent of the week the patient is not in your clinic.

This playbook is what six contributors wish they had been handed on day one: the clinical logic, the CY2026 code mechanics, the compliance record that survives an audit, the three delivery models and what each really costs, the front-desk workflow that decides whether any of it happens, and the vendor questions worth asking before you sign.

The billing follows the clinical activity. Never the other way around.

EverEx

Published by EverEx · First edition, August 2026 · everex.ai
Coding parameters current as of the CY2026 Physician Fee Schedule Final Rule, re-verify each annual cycle.