

THE VIVO CARE GUIDE

Remote Patient Monitoring

• RPM

Standing up and running a remote patient monitoring program in 2026: the clinical bar, the codes, and the operating model.

- 
- 01 Codes, rates & the 2026 changes
 - 02 Workflow, devices, evidence & compliance

FOR PROVIDERS, CLINICAL & OPS TEAMS

WRITTEN BY THE VIVO CARE CLINICAL TEAM · REVIEWED BY DR. AAMIR IQBAL, MD,
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INTRODUCTION

What RPM is, and what changed for 2026

Remote Patient Monitoring (RPM) is a Medicare-covered service in which patients use an FDA-defined connected device at home to capture physiologic data that transmits securely to their care team for review and treatment management between visits.

For 2026, the Centers for Medicare and Medicaid Services expanded RPM so it supports both long-term chronic monitoring and shorter, episodic monitoring, the most significant change to the program in years. This guide covers the codes, the 2026 rules, eligibility, workflow, the technology, the clinical evidence, and the compliance requirements that now draw federal scrutiny.

An effective program has four parts working together

01

Connected devices

Matched to the clinical use case the patient is being monitored for.

02

Software

Collects the data and presents it for clinical review and documentation.

03

Licensed clinical staff

Responsible for monitoring, outreach, and the documentation billing depends on.

04

Defined workflows

Eligibility, onboarding, engagement, and escalation, run the same way for every patient.

THE PROVIDER STAYS THE DECISION-MAKER

RPM extends the provider's reach between visits. **It does not replace clinical judgment.** The billing practitioner orders monitoring, supervises the program, and retains medical decision-making throughout.

ELIGIBILITY

Who qualifies for RPM, and who doesn't

RPM can be used for any patient with an acute or chronic condition who has an established relationship with the billing practitioner and a documented clinical reason to be monitored. It is not limited to specific diagnoses or specialties.

RPM is condition-agnostic. CMS does not restrict it to particular diagnoses, so it supports hypertension, diabetes, congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, weight management, and acute or post-acute situations. What it requires is an established patient relationship and an individualized clinical rationale.

RPM requires an initiating visit with the billing practitioner before services begin. That visit can be in person or via telehealth, and it can be an Annual Wellness Visit, an Initial Preventive Physical Exam, an evaluation and management visit, or another qualifying encounter.

THE BOUNDARY MATTERS

Patients with no prior relationship to the practice are a documented audit signal. A clear, individualized reason to monitor has to exist and be documented for each patient. RPM is not a blanket enrollment program, and enrolling patients without an individualized rationale is exactly what draws scrutiny.

"Rather than doing a one size fits all, we really look at our patients and tailor which programs would they benefit from."

DR. AAMIR IQBAL

Medical Director, Vivo Care, and Practicing Primary Care Physician

CODES & REIMBURSEMENT

The 2026 RPM CPT codes and rates

The 2026 code set covers setup, device supply and data transmission, and treatment management, with new short-duration and shorter-time codes added for 2026. The rates below are CMS national non-facility amounts and vary by locality.

CODE	WHAT IT COVERS	THRESHOLD	2026 RATE	VS 2025
99453	Initial device setup and patient education	One-time per episode of care	\$21.71	+10.1%
99445 / 99454	Device supply and data transmission (2+ days of readings)	99445: 2 to 15 days. 99454: 16 to 30 days. Mutually exclusive per patient per 30-day period.	\$52.10	new / +21.1%
99470	Treatment and management, first 10 to 19 minutes	New for 2026. Requires one live interactive contact. Exclusive with 99457 and 99458.	\$26.05	New
99457	Treatment and management, first 20 minutes	20 or more minutes. Requires one live interactive contact.	\$51.77	+8.2%
99458	Treatment and management, each additional 20 minutes	Add-on to 99457 only.	\$41.41	+7.7%

Rate basis: CMS 2026 Physician Fee Schedule, national non-facility, GPCI 1.0. Actual reimbursement varies by locality, Medicare Administrative Contractor, and payer.

READ THE TABLE THIS WAY

Three services stack into a monthly RPM claim: a one-time setup (99453), a single device-supply code (99445 or 99454), and one treatment-management code (99470 or 99457, with 99458 as the add-on). The billing rules on the next page keep those from being double-counted.

BILLING MECHANICS

Three rules, and what changed in 2026

Three rules to bill cleanly

1 Device supply is one combined service

99454 (16 to 30 days) and 99445 (2 to 15 days) are two thresholds of the same code, mutually exclusive in a 30-day period. Bill one, never both.

2 Treatment management is either-or

Bill 99470 (10 to 19 minutes) or 99457 (20 or more minutes), not both in the same month. 99458 only stacks on 99457.

3 A live contact is required every month

Every management code requires at least one real-time, interactive communication with the patient. A voicemail, a text, or a portal message does not count.

WHAT'S NEW IN 2026

Reimbursement now starts at 2 days of data, not 16

CMS expanded what RPM can bill. Device supply once required 16 days of readings in a 30-day window, which left short-term and episodic monitoring unbillable. For 2026, programs can bill after just 2 days of transmitted readings, opening RPM to far more clinical situations. Two new codes make it work.

New · 99445**Short-duration supply**

Reimburses device supply for 2 to 15 days of readings, at the same national rate as the 16-to-30-day code. Short-duration monitoring is not discounted RPM.

New · 99470**Shorter management**

Reimburses 10 to 19 minutes of treatment management, below the prior 20-minute floor, so brief but real clinical management is now billable.

The practical effect: programs can now support post-discharge recovery, medication titration, and other episodic use cases that did not fit the old thresholds, while the same documentation and non-duplicative billing rules apply.

HOW RPM EVOLVED

Two decades of policy catching up

RPM did not arrive with the 2026 codes. It is the result of two decades of Medicare and AMA policy catching up to the chronic-disease burden and the technology, each change widening who could deliver it and which patients it could reach.

NEW MEDICARE RPM ENROLLMENT

6x growth, 2019 to 2021

As the codes matured, RPM moved from a cardiology niche to a routine part of primary care.



- 2002** **CPT 99091 introduced**, the first code for collecting and interpreting remote physiologic data. It pays nothing on its own, is physician-only, and requires 30 minutes a month, so use stays mostly in cardiology.
- 2018** **CMS unbundles 99091** and pays for remote data review separately, classifying RPM as a communication-technology service rather than telehealth. RPM can now run in any patient's home, nationwide.
- 2019** **The modern code set arrives:** 99453, 99454, and 99457. Because 99457 can be performed by clinical staff under general supervision, scalable, team-based RPM becomes possible for the first time.
- 2020** **The COVID public health emergency** waives in-person initiation and extends RPM to acute conditions. New Medicare RPM enrollment jumps from about 20,000 patients in 2019 to more than 123,000 by 2021.
- 2021** **CMS adds 99458** (each additional 20 minutes), confirms general supervision, and formalizes the 16-day data rule for the device supply code.
- 2022** **Remote Therapeutic Monitoring (RTM)** codes are introduced for non-physiologic data such as therapy adherence. RPM and RTM cannot be billed for the same patient in the same month.
- 2025** **FQHCs and Rural Health Clinics** gain the ability to bill the individual RPM codes instead of one bundled code, extending RPM to safety-net populations.
- 2026** **The rigid 16-day floor ends.** New codes 99445 (2 to 15 days of device supply) and 99470 (10 to 19 minutes of management) make shorter, episodic monitoring billable, and the requirement for one live, interactive patient contact each month is formalized.

OPERATIONS

How an RPM program runs in practice

A working program moves a patient through eligibility, consent, device setup, daily data capture, clinical monitoring and outreach, and documented treatment management, with the provider supervising and the care team executing.

The workflow, step by step

<p>1 Verify eligibility Established relationship, a clinical reason to monitor, and benefit eligibility.</p>	<p>2 Document consent Including the patient's cost-sharing responsibility.</p>
<p>3 Set up and educate Supports the setup code and determines whether the patient actually uses the device.</p>	<p>4 Capture readings The patient takes readings at home; data transmits automatically and securely.</p>
<p>5 Monitor and reach out Care navigators review data, flag changes, and run the interactive outreach codes require.</p>	<p>6 Document and escalate Time, contacts, and decisions are documented; concerning trends escalate to the provider.</p>

CONNECTIVITY REMOVES A COMMON BARRIER

Patients can use connected devices that work over cellular networks with **no home internet**, or Bluetooth devices paired to a cellular hub. Cellular options matter for rural patients and anyone without reliable WiFi.

"We do the work in between visits."

KAT BAKER, RN
Director of Clinical Operations, Vivo Care

TECHNOLOGY

What an RPM program runs on

An RPM program runs on two pieces of technology working together: the connected devices in the patient's home, and the platform the clinical team works in. Each does a specific job, and a program is only as good as the weaker of the two.

The devices

Devices are matched to the clinical use case, and cellular options transmit with no home internet, which is what makes consistent readings possible for rural patients and anyone without reliable WiFi. The right device, chosen for the patient and simple to use, is what produces consistent daily readings, and consistent readings are what make a program both clinically useful and billable.



Connected devices shown are manufactured by **Tenovi**.

SIMPLE FOR THE PATIENT

Devices arrive ready to use. There is no smartphone, no app, and no Bluetooth pairing to set up. The patient takes a reading and it sends on its own, which removes the friction that keeps older patients from sticking with home monitoring.

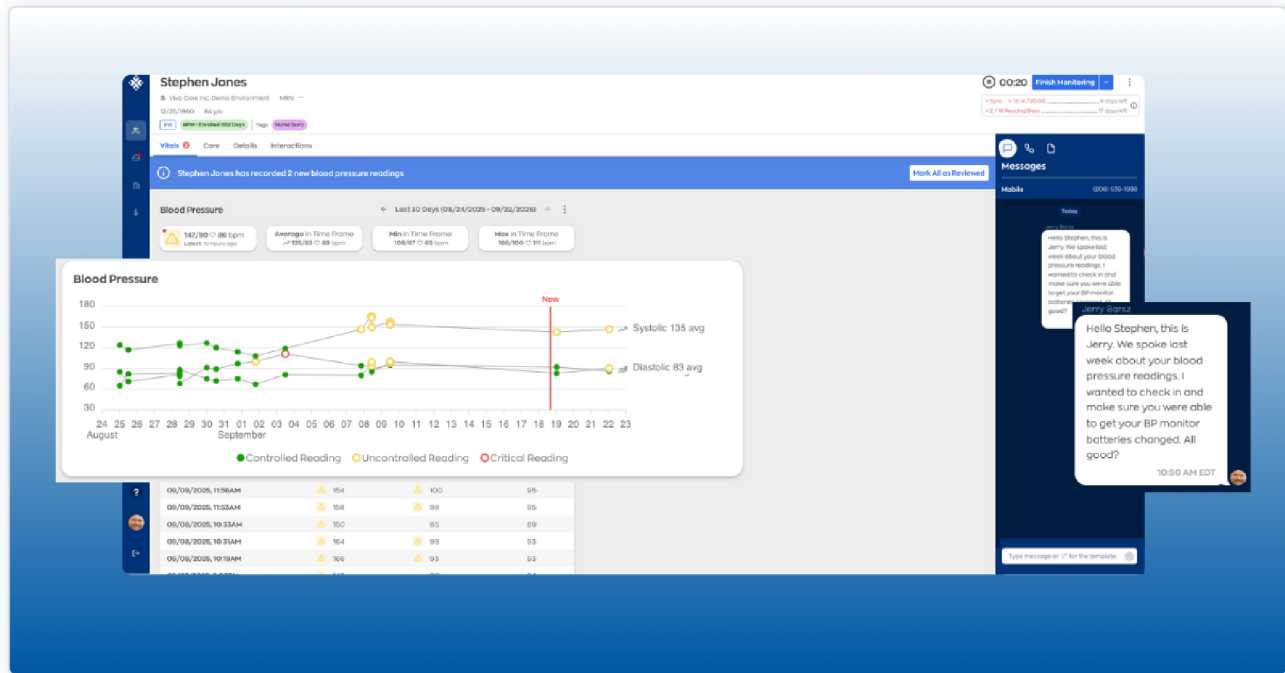
WHY AUTOMATIC TRANSMISSION MATTERS

In the **TASMINH4** trial, automated transmission outperformed manual patient reporting. Removing the friction of self-recording produces a more complete, timely dataset for the clinician to act on.

TECHNOLOGY

The platform does the triage

Getting a single reading into the chart is easy. Managing a whole panel against clinical thresholds every month is not, and that is what the platform exists for. Electronic health records were built for episodic visits, documentation, and claims, not for a continuous stream of physiologic data across hundreds of patients.



The Vivo Care platform: a patient's blood pressure trend with controlled, uncontrolled, and critical readings flagged, alongside the care navigator's message thread. **Demo environment shown.**

The platform ingests daily readings, triages them by urgency, tracks the interactive time each billing code requires, holds the audit trail, and flags which patients are about to fall below the billing floor.

THE VALUE IS IN THE TRIAGE, NOT THE DEVICE

Raw data at panel scale causes alert fatigue. A capable platform is what lets a small clinical team monitor a large panel **without the program quietly degrading the first time the clinic gets busy.**

COMPLIANCE & AUDIT

Where programs go wrong, and what auditors look for

Federal scrutiny has intensified as spending crossed half a billion dollars. The most common failure points are enrolling patients with no clinical rationale or prior relationship, billing management time without the required live contact, and weak documentation of setup and medical necessity.

THE SCRUTINY IS DOCUMENTED

\$500M+

Medicare RPM payments in 2024, the level of spending now drawing oversight.

~43%

of enrollees did not receive all three components of the service (OIG, September 2024).

What an auditor looks for

- A documented initiating visit and established relationship.
- An individualized clinical rationale, not template diagnosis coding.
- Proof a qualified person trained the patient before setup is billed.
- Transmission logs showing the number of days with recorded data.
- Time logs and at least one documented interactive contact per management code.
- Clear separation of RPM time from visits and other billable services.
- Documented patient consent, including cost-sharing responsibility.

THE TAKEAWAY

A defensible RPM program is built on documentation discipline. Every code billed should trace to an artifact an auditor can see.

BUILD VS PARTNER

Run RPM in-house, or with a partner?

The decision comes down to four things: clinical staffing, technology, compliance capacity, and time to a working program. Most practices underestimate the ongoing clinical monitoring load more than any other factor.

01 · Clinical staffing

Management codes require licensed staff doing real, documented monitoring every month. Can existing staff absorb that when the clinic gets busy?

02 · Technology

Connected devices, secure transmission, a review platform, and the data trail an audit requires.

03 · Compliance capacity

The documentation discipline has to hold every month, not just at launch.

04 · Time to live

In-house builds take longer to reach reliable monitoring and clean billing.

	SELF-MANAGED	MANAGED CLINICAL
Who monitors	Your own clinical staff, on the Vivo Care platform	Vivo Care licensed care navigators, as an extension of your team
Staying current with CMS	You track CMS coding and rule changes each year	Vivo Care tracks CMS changes and keeps the program compliant for you
The tradeoff	More control, more internal load	Provider supervises and retains medical decision-making

Many practices run RPM alongside Chronic Care Management (CCM), billed concurrently when each program's requirements are independently met.

"We are not a one-size-fits-all tech solution, and we are not a one-size-fits-all services solution."

RYAN CLARK
CEO, Vivo Care

CLINICAL EVIDENCE

What the evidence shows

The peer-reviewed evidence is consistent on one point: RPM improves outcomes when the data drives an active clinical response, and does little when it does not. The common thread across the strongest results is not the device. It is the team responding to the data.

HYPERLINK · JAMA

71.8% vs 30.0% usual care

of patients in blood pressure control at six months with home telemonitoring plus pharmacist-led medication management, roughly a 10 mmHg larger systolic reduction.

TIM-HF2 · THE LANCET

7.86 vs 11.34 usual care

all-cause deaths per 100 person-years in heart failure when daily monitoring is routed through a 24/7 telemedical center.

PASSIVE MONITORING DID NOT HELP

When monitoring was passive, a connected cuff with no clinical response loop (Mehta, 2024) or an automated phone check-in reviewed in a busy clinic (Tele-HF), outcomes matched usual care. RPM is only as effective as the clinical workflow behind it.

WHAT VIVO CARE SEES ON ITS PLATFORM

How a panel moves toward goal over the first three months

31.4% → 38.9%

Systolic readings in goal range

13.2% → 10.1%

High-critical systolic readings

61.7% → 66.3%

Diastolic readings in goal range

Vivo Care platform figures, not trial results; individual patient results vary. Sustained adherence is the mechanism: cellular devices transmit automatically, and 96.9% of billable patients meet the monthly threshold, which is what makes this movement possible.

A boundary worth naming. The same evidence shows RPM does not change outcomes in acute illness: remote pulse oximetry did not reduce hospitalizations in acute COVID-19. RPM is built to catch the slow drift of chronic disease, not an acute crisis.

FREQUENTLY ASKED

Remote patient monitoring FAQ

Q What are the requirements to bill each RPM code?

99453 covers setup and education, once per episode of care. Device supply requires either 2 to 15 days (99445) or 16 to 30 days (99454), billed as one or the other. Management codes (99470, 99457, 99458) each require at least one live, interactive communication that month, and the time must be documented.

Q Do RPM codes require 16 days of readings?

Not in every case anymore. The 16-to-30-day threshold (99454) still exists, but new for 2026, 99445 lets providers bill device supply for 2 to 15 days of readings in a 30-day period.

Q Can I bill the device supply code twice if a patient uses two devices?

No. The device supply code is billable once per patient per 30-day period by one practitioner, regardless of the number of devices.

Q Which insurance plans cover RPM, and who verifies coverage?

Traditional Medicare Part B covers RPM. Medicare Advantage and commercial plans vary by payer and plan, so coverage should be verified before enrollment. Vivo Care performs benefit eligibility verification as part of onboarding.

Q Will RPM create unexpected bills for patients?

RPM is a Part B service, so patients are generally responsible for 20 percent coinsurance unless they have supplemental coverage. Disclose cost-sharing clearly at consent, which is also a documentation requirement.

Q Does Vivo Care submit claims?

The billing practitioner remains the biller of record. Vivo Care supports the program with the documentation, transmission logs, time logs, and monthly reporting that billing depends on.

FREQUENTLY ASKED

RPM FAQ, continued

Q How do the devices connect, and is home internet required?

Patients can use cellular devices that work without home internet, or Bluetooth devices paired to a cellular hub. Cellular options are designed for patients in rural areas or without reliable WiFi.

Q What happens with lost, broken, or returned devices?

Device logistics, including replacement, warranty, and which returned devices can be redeployed to new patients, are handled as part of program operations. The specifics are covered in a consultation.

Q Does the platform integrate with our EMR?

Yes, the physiologic data can get into the EMR. Depending on your final program design and your EMR, the process and placement may vary. Vivo Care maps this out during program design and partnership planning.

Q Who can perform RPM monitoring?

RPM can be furnished by clinical staff under the general supervision of the billing practitioner. Who qualifies as clinical staff depends on state scope-of-practice law. The billing practitioner retains medical decision-making and oversight.

Q Can RPM be billed alongside other care management programs?

Yes, in most cases. RPM can be billed concurrently with APCM, CCM, PCM, and TCM when each program's requirements are independently met and time is not double-counted. RPM cannot be billed concurrently with RTM for the same patient in the same month.

Q Does RPM require an initiating visit?

Yes. RPM requires an initiating visit with the billing practitioner, which can be in person or via telehealth.

SOURCES & REVIEW

Sources and medical review

1	CMS Calendar Year 2026 Medicare Physician Fee Schedule Final Rule. <i>Rates, code definitions, and 2026 changes</i> .	7	Margolis KL et al. Home BP telemonitoring and pharmacist management (HyperLink). <i>JAMA</i> , 2013.
2	CMS Physician Fee Schedule Final Rules, CY2018, CY2019, and CY2021, and AMA CPT code set history. <i>Evolution of the RPM codes</i> .	8	Koehler F et al. Telemedical interventional management in heart failure (TIM-HF2). <i>The Lancet</i> , 2018.
3	HHS Office of Inspector General, <i>Billing for Remote Patient Monitoring in Medicare</i> , OEI-02-23-00261, August 25, 2025.	9	Chaudhry SI et al. Telemonitoring in patients with heart failure (Tele-HF). <i>New England Journal of Medicine</i> , 2010.
4	HHS Office of Inspector General, <i>Additional Oversight of Remote Patient Monitoring in Medicare Is Needed</i> , OEI-02-23-00260, September 19, 2024.	10	Mehta SJ et al. Remote blood pressure monitoring with social support. <i>JAMA Network Open</i> , 2024.
5	American Medical Association CPT 2026 code set.	11	Lee KC et al. Pulse oximetry for monitoring patients with Covid-19 at home. <i>New England Journal of Medicine</i> , 2022.
6	McManus RJ et al. Self-monitored blood pressure for titration of antihypertensive medication (TASMINH4). <i>The Lancet</i> , 2018.		



MEDICALLY REVIEWED BY

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Medical Director, Vivo Care · Board-Certified, Internal Medicine

A Physician Partner at AFP Health in Thousand Oaks, California, Dr. Iqbal has run a Remote Patient Monitoring program on the platform now known as Vivo Care since December 2020. Across a ten-month window on his own patient panel, average systolic blood pressure dropped 12 mmHg and readings in goal range climbed from 24 percent to 47 percent. He reviews Vivo Care's clinical and billing resources for accuracy against current CMS guidance.

ACROSS THE VIVO CARE PLATFORM

545 days

average RPM enrollment duration, a measure of sustained monitoring.

96.9%

billable patient adherence (2+ measurements per patient), year to date 2026.

Disclaimer. This guide is for general educational purposes and does not constitute legal, billing, or reimbursement advice. Coverage, coding, supervision rules, and reimbursement vary by payer, region, and Medicare Administrative Contractor. Confirm current CMS guidance and payer policy before billing. Reviewed by Dr. Aamir Iqbal, Medical Director, Vivo Care. Last updated June 2026. Platform figures: 120,000+ patients supported (cumulative), 350+ active healthcare organizations, 25.9M+ documented engagement minutes (2023 to 2025).

TALK THROUGH YOUR PROGRAM

Want your RPM program checked against the 2026 requirements? **A Vivo Care specialist will walk through eligibility, workflow, and compliance for your practice.**



RELATED READING

2026 Remote Care Billing and Coding Guide

vivocaresolutions.com/resource/2026-remote-care-billing-and-coding-guide/

CMS 2026 PFS: new RPM codes 99445 and 99470

vivocaresolutions.com/blog/2026-pfs-new-rpm-codes-99445-99470/

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