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Remote Patient Monitoring Is At Regulatory Inflection Point

By **Howard Young, Rachel Lamparelli and Roshni Edalur** (February 6, 2026, 5:52 PM EST)

Howard Young

Rachel Lamparelli

The Centers for Medicare & Medicaid Services recently announced its latest foray into technology-enabled care delivery with its voluntary 10-year pilot program, the Advancing Chronic Care with Effective, Scalable Solutions model.

The ACCESS model, which is accepting applications through April 1 for a July 5 start date for the initial phase, will test an outcome-aligned payment approach for expanding access to technology-supported care for Original Medicare beneficiaries with certain chronic conditions.

By providing predictable, recurring payments tied to measurable health outcomes rather than specific services, the implementation of the ACCESS model signals yet another expansion of federal support for digitally mediated management of chronic disease to improve health and reduce costs.

In parallel to providers interested in the ACCESS pilot that are looking for technology partners to support patient monitoring, technology companies seeking to participate in ACCESS, whether directly or through provider partnerships, should be attuned to the U.S. Food and Drug Administration's recently adopted Technology-Enabled Meaningful Patient Outcomes program.

In collaboration with the ACCESS model, TEMPO is designed to facilitate the controlled, real-world use of certain digital health devices within CMS payment models, potentially allowing products to be deployed

prior to traditional marketing authorizations through an exercise of the FDA's enforcement discretion. While this alignment between CMS and FDA reflects a coordinated effort to accelerate innovation, it also introduces regulatory risk.

Roshni Edalur

The ACCESS model's rollout invites comparison to CMS' earlier embrace of remote patient monitoring, or RPM, services. As RPM has rapidly expanded across the U.S. healthcare system, federal policymakers and enforcement agencies have increased their focus on how these technology-enabled services are billed, reimbursed and monitored.

Against this backdrop, the U.S. Department of Health and Human Services' Office of Inspector General, through its Office of Evaluation and Inspections, released a report in August 2025 examining Medicare billing for RPM.

While acknowledging RPM's growing role in modern healthcare delivery, the OIG's 2025 report underscores the need for providers and the Medicare program to implement compliance-oriented safeguards when billing and paying for RPM services.

For RPM and digital health stakeholders, success under ACCESS will likely depend not only on clinical efficacy and scalability, but a sophisticated understanding of how CMS innovation models and OIG oversight intersect.

Growth in Remote Patient Monitoring

As the location of healthcare delivery increasingly shifts from the facilities to the home, RPM creates opportunities for greater access to preventive care at a more affordable cost, in turn leading to reductions in hospitalizations and emergency visits.

RPM refers to the collection and transmission of patients' physiological data (e.g., blood pressure, glucose levels, heart rate) from their home or another nonclinical setting to healthcare providers for assessment and intervention.

RPM often involves the use of digital devices, mobile apps, wearable and secure data platforms that enable continuous communication between patients and care teams, supporting early detection of changes in health status and more timely clinical decision-making.

Over approximately the past six years, healthcare providers have

increasingly integrated the use of RPM technologies into the delivery of their healthcare services: the OIG reports that in 2024 alone, Medicare payments for RPM surpassed $500 million, with Medicare coverage for RPM having only been first established in 2019.

The OIG's ongoing analysis of Medicare Part B Remote Patient Monitoring Services notes that since 2018 RPM billing has changed dramatically, with payments rising and new risks of fraud, waste and abuse emerging, including shipments of unsolicited devices, inadequate monitoring programs and inappropriate billing practices.

Although the OIG's final inspection report on RPM is not expected until later this year, this framing likely reveals that the OIG intends to carefully review RPM service delivery to ensure that Medicare is paying for claims that actually reflect a course of continuous clinical management, rather than business models focused on monitoring device distribution with limited provider engagement.

The OIG also explicitly tied its ongoing RPM reviews to its November 2023 consumer alert, which warned about companies signing up beneficiaries for RPM "regardless of medical necessity," using cold calls or clickbait ads and often billing for monitoring that never occurred. These findings underline a core policy concern: The significant growth and acceptance of RPMs can amplify access and abuse simultaneously.

RPM has measurable economic impact. A 2025 Health Affairs study of 754 primary care practices that began billing for RPM between 2019 and 2021 found that their Medicare revenue rose by approximately 20% compared with nonadopting peers, driven by both RPM claims revenues and increased outpatient visits. While this data demonstrates RPM's increased revenue potential, it may underscore the OIG's concern that financial incentives could drive adoption of RPM in lieu of clinical need.

And yet, the additional billings associated with RPM may be offset multiple times over if it means that chronic conditions can be managed and controlled, resulting in fewer exacerbations requiring acute care and more costly interventions and treatments.

Nearly 1 million Medicare enrollees utilized RPM services in 2024, representing a substantial uptick in the use of technology-based healthcare solutions. This growth in RPM reflects both the payor and provider communities' increasing belief in the clinical and fiscal benefits of RPM and an increasing reliance on technology to enhance patient care management.

As it frequently does, the OIG monitors Medicare coverage and payment trends related to new technologies and services. The OIG released its first report on RPM services in 2024, finding that nearly half of enrollees who

received RPM services did not receive all three of its components: education and setup, device supply and treatment management. This discrepancy led the OIG to question whether Medicare payments for RPM services were being used as intended.

Indeed, the OIG recommended in 2024 that CMS strengthen its oversight of RPM through the implementation of additional billing safeguards, inclusion of information about the ordering provider within claims and encounter data, and provider education.

In its August 2025 report, the OIG sounded a cautionary yellow flag yet again. However, actions by the Trump administration signal an interest in exploration of the use of technology-enabled care, particularly for chronic care populations.

The announcement of the CMS ACCESS model and FDA TEMPO pilot makes clear that RPM and other technology-enabled care is of keen interest to manage healthcare costs and improve outcomes.

RPM Improper Utilization Concerns

In light of the continued expansion of RPM use and associated program integrity concerns, the OIG's 2025 RPM report reiterated the recommendation from its 2024 RPM report, and again called for additional CMS oversight on the use and Medicare reimbursement of RPM services to protect the Medicare program from potential fraud, waste and abuse.

In furtherance of this recommendation, the OIG 2025 report outlines specific measures that CMS may use to identify RPM billing practices that require further scrutiny, including monitoring healthcare providers with:

- A high proportion of enrollees with no prior history with the medical practice;
- A high proportion of new enrollees with the medical practice that are receiving RPM services for the first time;
- A high proportion of enrollees that have never received any associated treatment management;
- An enrollee already receiving RPM services at another practice; or

- Multiple monitoring devices per month for a single enrollee.

If CMS adopts the OIG's recommendations, claims for RPM services — at least in the traditional Medicare fee-for-service program — will be reviewed with a more careful eye toward identifying patterns that signal potential program integrity concerns.

As a result of these recommendations, we can reasonably expect greater Medicare claims scrutiny for RPM services, perhaps through the enhanced data analytics and artificial intelligence tools CMS is using related to its program integrity measures. This would align with the algorithmic monitoring OIG is deploying in its 2026 audit initiative.

Scrutiny of Medicare RPM billing is not limited to CMS and the OIG. In its January 2025 civil False Claims Act settlement press release, the U.S. Department of Justice alleged that LiveCare Inc., a diabetic health coaching company that used RPM, had violated the Anti-Kickback Statute and FCA by paying a marketing service for Medicare Type 2 diabetes patient referrals to its RPM program. The FCA settlement resulted in LiveCare agreeing to pay up to $4.9 million to resolve the allegations.

This FCA investigation illustrates how RPM's low barriers to entry and ease of access can raise concerns about third-party referral schemes that bypass clinical judgment. By citing RPM as an emerging area of healthcare fraud, the OIG also made clear that its focus has shifted from education to accountability.

RPM Risk Mitigation Options

Providers utilizing RPM with their Medicare beneficiary population should reinforce appropriate training and processes to protect against RPM billing noncompliance and ensure that the provision of RPM services is medically necessary for the patients' conditions.

Although physician involvement in RPM services may not require intensive time, it should be sufficient to ensure the purpose and output of the RPM are clinically meaningful. CMS' future coverage and payment policy likely will focus on demonstrating active care coordination and documented clinical review rather than passive data collection.

To translate certain of the OIG's oversight themes into practice, providers can track several simple metrics each month related to RPM: (1) which patients have multiple devices associated with their care; (2) is the remote monitoring of abnormally short duration; (3) has the patient received a

qualifying evaluation and management visit within the last 12 months; and (4) does the provider engage in follow-up after instances of patient nonadherence.

These indicators, as well as others highlighted in the OIG's 2025 report, serve as early warning signals for improper billing and may help organizations self-correct before there is government scrutiny and intervention.

Conclusion

Taken together, these developments paint a composite picture of RPM at an inflection point. The OIG's findings confirm that Medicare's embrace of RPM has yielded both innovation and risk.

As AI and automation accelerate RPM's reach, along with innovative CMS programs like the ACCESS pilot, the next regulatory phase will likely evolve from verifying billing accuracy of RPM to assessing how such monitoring technology influences clinical decision-making.

Ensuring that RPM remains clinically driven rather than commercially optimized, while not chilling RPM's advancement, will be a central challenge for CMS, the OIG and the provider community alike.

Howard J. Young is a partner, and Rachel L. Lamparelli and Roshni Edalur are associates, at Morgan Lewis & Bockius LLP.

[1] Health Affairs, Practices That Adopted Remote Physiologic Monitoring Increased Medicare Revenue And Outpatient Visits (Nov. 2025).

[2] DOJ, LiveCare Inc. Agrees To Pay Up To $4.9 Million To Resolve False Claims Act Allegations (Jan. 31, 2025).
