TeleCARE

Remote Physiologic Monitoring (RPM)

BILLING GUIDE

Written by

Don Self

CPC, CMCS

Billing Guide Overview

This guide is written for physicians, advanced practitioners, clinic managers, and billing staff. It explains how Telecare-USA supports compliant RPM billing workflows and what clinics should verify before billing Medicare Part B, Medicare Advantage, commercial, and Medicaid RPM claims.

What RPM Really Is (and Isn't)

Remote Physiologic Monitoring (RPM) is clinical care performed remotely using FDA-cleared devices that automatically transmit physiologic data to the provider for review and management.

CMS and the AMA do not classify RPM as telehealth. RPM does not require audio/video, does not require rural status, and does not depend on temporary telehealth waivers. RPM falls under care management services, and is designed to support ongoing management of chronic conditions between visits. It should produce meaningful clinical review, patient engagement, and medical decision-making throughout the month

RPM Billing Codes (2026)

For 2026, the RPM code sequence used in this guide is:

99453, 99445, 99454, 99470, 99457 and **99458**

- Codes 99453, 99445, and 99454 are 30-day codes.
- Codes 99470, 99457, and 99458 are calendar-month codes.

Detailed Code Descriptions

99453

Initial device setup and patient education (30-day; one-time)
Covers the initial setup of the RPM device, patient education, and confirmation that the device is transmitting properly. This code is typically billed once per episode of care and requires at
least 16 days of transmitted data during the 30-day setup window.
Key points: one-time per episode of care; covers setup and education; requires 16+ days of data.

99445

Device supply for 2–15 days of data (30-day)
Used when the patient transmits between 2 and 15 days of automatically collected data during the 30-day cycle. CMS pays the same as 99454 because the device is still supplied for the entire 30-day period, so no reduction in payment is appropriate.
Key points: New code for 2026; 2–15 days of data; device supplied for full 30 days; Practices
must bill either 99445 or 99454 for a given cycle, not both.

99454

Device supply for 16+ days of data (30-day)
Used when the patient transmits 16 or more days of data.
Key points: 16+ days of data; one unit per 30-day cycle.

99470

RPM management, First 10 minutes (monthly)
Identical service description to 99457 but requires only 10 minutes of RPM management time in the calendar month.
Key points: New code for 2026; calendar-month code; 10-minute threshold; clinical review and management required.

99457

RPM management, first 20 minutes (monthly) Requires at least 20 minutes of RPM management time during the calendar month and one interactive communication with the patient.
Key points: 20 minutes required; one interactive communication; base code for 99458.

99458

RPM management, Each additional 20 minutes (monthly)
Add-on code to 99457. Medicare allows up to 3 units per month when time thresholds are met.
Key points: add-on to 99457; mid-point rule applies - must reach mid point to add on; up to 3 units allowed; refer to Telecare-USA RPM billing white paper for time details.

SCHEDULE A MEETING

TeleCARE

Patient Consent & Eligibility

PATIENT CONSENT

The patient must be an established patient of the practice. Patient consent must be obtained before RPM begins and may be verbal but must be documented in the medical record. TeleCARE's patient enrollment form serves as patient consent when completed and retained.

PATIENT ELIGIBILITY

Medicare does not publish LCDs for RPM. Coverage is based on medical necessity.
RPM is appropriate when physiologic monitoring will meaningfully influence clinical decision-making. Common uses include Hypertension, Diabetes, CHF, COPD, CKD, post-hospital monitoring, and other conditions where trends support active management.

RPM AND CCM IN THE SAME MONTH

RPM and CCM may be billed in the same month when the work and time are separate and not double-
counted.

DATES OF SERVICE (DOS)

• **99453, 99445, and 99454** are considered 30-day codes, which require a full 30-day service period between the date of service (DOS) used on an insurance claim.

• **99470, 99457, and 99458** are considered calendar-month codes, which only require a new calendar month to be reflected in the DOS on an insurance claim.
The DOS selected must fall on a date when the patient was eligible and not an inpatient or in a skilled nursing facility.

For convenience a **2026 RPM DOS Cheat Sheet** is included below....

TeleCARE

RPM Date of Service Cheat Sheet

Report Received At The Beginning Of:	For The Service Month Of:	Bill Applicable **99453, 99445, 99454** With a DOS Of:	Bill Applicable **99470, 99457, 99458** With a DOS Of:
January	December	December 30th	December 30th
February	January	January 30th	January 30th
March	February	March 1st	February 28th
April	March	March 31st	March 31st
May	April	April 30th	April 30th
June	May	May 30th	May 30th
July	June	June 30th	June 30th
August	July	July 30th	July 30th
September	August	August 30th	August 30th
October	September	September 30th	September 30th
November	October	October 30th	October 30th
December	November	November 30th	November 30th

Note that for the service month of February, 99453, 99445, and/or 99454 will require a different DOS than any applicable 99470, 99457, or 99458 due to the difference between 30-day codes and calendar- month codes. Clinics should follow the DOS cheat sheet and the recommended DOS listed on the TeleCARE billing report each month to help avoid denials.

POS, Hospitalization, Reporting, and Documentation

PLACE OF SERVICE (POS)

- Use POS 11 when the clinic has an office.
- Use POS 22 for hospital-owned outpatient clinics.
- Use POS 12 only when the provider exclusively performs home visits.

Place of service should reflect the billing provider's practice setting, not the patient's physical location at the time data is transmitted.

HOSPITALIZATION OR SKILLED NURSING (POS 21 OR 31)

If the patient is an inpatient hospital patient (POS 21) or in a skilled nursing facility (POS 31) on the DOS chosen for RPM, the clinic should not use that hospitalized or SNF date as the DOS for RPM billing.

In these situations, clinics should select a DOS that falls outside the inpatient or SNF stay and otherwise meets RPM billing requirements.

TELECARE BILLING REPORT

Each month, Telecare-USA sends each client a report showing, per patient: minutes, days of testing, supported RPM CPT codes (including 99458 units), recommended DOS, and suggested billing.

This report is intended to be used as a charge-posting reference to support accurate and consistent RPM billing.

It is the responsibility of clinics to post charges accurately and consistently.

Each "1" in a CPT column indicates that code should be billed for that patient using the listed DOS.

RPM DOCUMENTATION AND RECORD RETENTION

All RPM-related patient documentation is stored in Telecare-USA's HealthView portal for 10 years.

Clinic offices may: Export patient documentation at any time, or use the HealthView portal as a long-term documentation storage location.

Documentation may be accessed or exported in the event of payer inquiries or audit requests.

Billing staff who would like portal login credentials should reach out to Telecare-USA to have access established.

TeleCARE

Insurance & Medicaid Considerations

Insurance

Medicare Part B has not given TeleCARE clients trouble getting paid when RPM claims are properly supported and billed.

Medicare Advantage plans are required under 42 C.F.R. 422.100 to cover everything Part B covers, with hospice carved out separately. Currently, TeleCARE does not recommend assigning RPM devices to UnitedHealthcare patients (commercial or Medicare Advantage), because it is our belief UHC is not consistently following CMS RPM guidelines.

Most commercial plans and most Medicare Advantage plans are paying for RPM. Before issuing a device to any non-Medicare or non-Medicaid patient, clinic staff should verify coverage and payment amounts. Clinics should collect applicable patient copays or coinsurance for RPM services in accordance with their normal billing policies and payer requirements.

Medicaid

Many Medicaid programs prefer CPT 99091.
Code 99091 is considered a bundled code by most Medicaid programs.
Each clinic should confirm coverage and coding requirements with the Medicaid payer serving its area.

RPM Billing Guide
Written by Don Self, CPC, CMCS

Don Self, CPC, CMCS, is a healthcare reimbursement specialist and consultant with over 30 years of experience in medical billing, coding, and practice management. Known for his expertise in Medicare compliance and revenue optimization, he provides training and consulting services to healthcare providers across the U.S. Don specializes in maximizing reimbursement through accurate coding, including CPT, ICD-10, and HCPCS codes, and frequently speaks at national conferences on topics related to medical billing, chronic care management, and value-based care. He is also the founder of Don Self & Associates, a consulting firm dedicated to helping practices improve their financial performance and navigate complex reimbursement challenges.

Have Questions? Or Ready to Get Started? Contact us today!

scan me

CLICK TO SCHEDULE A MEETING

Email info@telecare-USA.com

Visit www.telecare-USA.com

1-888-563-6846