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WHITEPAPER

What the OIG's RPM Data Snapshot Actually Shows, and Why a Missing Claim Isn't Missing Care

A practical read of HHS-OIG's August 2025 Remote Patient Monitoring data snapshot, for practices that bill RPM in good faith

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Bottom Line Up Front

In August 2025, the HHS Office of Inspector General released a data snapshot on Remote Patient Monitoring billing, *Billing for Remote Patient Monitoring in Medicare* (OEI-02-23-00261). It followed OIG's earlier RPM report from September 2024 (OEI-02-23-00260). Both documents have circulated widely in compliance circles, and both have been read by many practices as a signal that RPM programs are under a fraud microscope.

Read the snapshot closely, though, and a different picture emerges. OIG did not pull a single medical record. It did not calculate an improper-payment estimate. It did not name one confirmed instance of fraud. And it says so itself, in its own words, in its Limitations section: its statistical measures *"do not confirm that a particular medical practice is engaging in fraudulent or abusive practices."*

What OIG actually built is a set of five billing-pattern measures, applied across 4,639 practices that billed RPM routinely in 2024. On every one of those five measures, somewhere between roughly 96 and 99 percent of practices fall inside what OIG itself treats as the normal range. That is not the profile of a benefit riddled with abuse. It is the profile of a small, clinically targeted service being billed conservatively, at scale, by practices that mostly understand the rules.

This whitepaper walks through why the snapshot's own architecture produces exactly the pattern it flags as suspicious, what the report concedes when read carefully, where the five measures individually fall apart under scrutiny, and, because the goal here is to help practices and not just win an argument, what OIG does get right and what your program should be doing regardless.

The Core Flaw: Confusing an Unbilled Service with an Undelivered One

RPM is not billed as one service. It is billed as three separate pieces, each with its own independent condition of payment:

- **Education and setup (CPT 99453)**: billed once per episode of care, when the patient is enrolled and taught to use the device.
- **Device supply (CPT 99454)**: billed monthly, but only if the device actually transmits physiologic data on at least 16 of the 30 days in that period.

- **Treatment management (CPT 99457/99458, or the physician-level alternative 99091)**: billed monthly, but only if clinical staff log at least 20 minutes of time on the case AND have at least one real-time, interactive conversation with the patient or caregiver that month.

Because each piece has its own threshold, a practice can do everything right (buy the device, ship it, pay a monitoring platform, staff a clinical team, call the patient repeatedly) and still be legally prohibited from billing one or more of those three codes in a given month. If the device transmits on only 12 days, 99454 cannot be billed. If the patient never picks up the phone despite five documented outreach attempts, 99457 cannot be billed. In both cases, the absent claim is what compliance looks like. It is the opposite of a red flag.

OIG's snapshot treats the gap between components (a month with device data but no management claim, or a patient enrolled but never billed for treatment management) as a pattern worth flagging. That instinct only makes sense if you assume the three codes should travel together as a package. They were never designed to. CMS confirmed as much in its CY 2024 Physician Fee Schedule, stating plainly that the 16-day data-collection requirement "does not apply" to the treatment-management codes, because those codes measure time and engagement, not device transmissions, on an entirely separate clock.

The clearest evidence that Medicare itself understood the gap: in the CY 2026 Physician Fee Schedule, CMS finalized two brand-new CPT codes: 99445, for device supply on as few as 2 to 15 transmission days, and 99470, for the first 10 minutes of treatment management, both effective January 1, 2026. Those codes exist because CMS recognized that real, clinically appropriate monitoring was routinely falling just short of the old 16-day and 20-minute thresholds and going completely uncompensated. In other words: the government's own payment fix is an acknowledgment that the very claim gaps OIG's snapshot flags as suspicious were, in a great many cases, legitimate care that simply had nowhere to be billed.

What OIG's Own Report Admits

It's worth stopping to note what the snapshot concedes in its own text, because those concessions carry most of the rebuttal on their own:

- **No finding of fraud.** *"We did not conduct a medical record review... the measures that we analyzed do not confirm that a particular medical practice is engaging in fraudulent or abusive practices... Any determination of fraud or an overpayment requires additional investigation."*
- **Growth could be legitimate.** On new-enrollee spikes, OIG writes that they "may represent legitimate growth," and that its fraud inference is imported from patterns seen in other, unrelated Medicare benefits, not from RPM claims data itself.
- **Not every patient needs full management.** OIG's own text allows that "all enrollees may not need treatment management or may not need the full 20 minutes... that is required to bill each month," which is precisely the mechanism this paper describes above.
- **The underlying data has known gaps.** OIG's footnotes acknowledge that Medicare Advantage encounter data is frequently incomplete, and that MA plans may apply different rules than fee-for-service, yet the snapshot's measures apply fee-for-service assumptions across pooled FFS and MA data anyway.
- **No dollar figure, anywhere.** The snapshot never estimates improper payments or ties any of its five measures to a single confirmed overpayment.

Taken together, this is a methods document describing analytics OIG intends to use going forward, not a fraud finding. The framing (the language, the pull quotes, the hotline number in the appendix) says one thing. The report's own evidentiary content says something considerably more modest.

The Numbers, in Full

OIG examined 4,639 practices that billed RPM routinely in 2024, out of 10,388 practices that billed it at all. Here is what its five measures actually flagged, in full:

OIG Measure	Practices Flagged	% of Routine Billers (4,639)	% of All Billers (10,388)
Sudden new-enrollee spike (≥150% and ≥100 new patients in a month)	32	0.69%	0.31%
No documented prior relationship for over 80% of enrollees	45	0.97%	0.43%
No treatment management billed for over 75% of enrollees	52	1.12%	0.50%
Over 25% of enrollees shared with two or more other practices	34	0.73%	0.33%
Multiple devices billed for the same patient over 100 times in a year	~20	0.43%	0.19%
Maximum flagged, assuming zero overlap between measures	**≤183**	**≤3.9%**	**≤1.8%**

Add up every practice flagged on every measure, with the generous assumption that no practice was flagged twice, and you still land at fewer than 4 in 100 routine billers, and under 2 in 100 of every practice that billed RPM at all in 2024. Put differently: on every single dimension OIG chose to examine, somewhere between 96 and 99 percent of billers look entirely normal. That is not a benefit in crisis. It's a program-integrity profile most parts of Medicare would be glad to have.

Working Through the Five Measures

1. Sudden new-enrollee spikes

RPM adoption typically doesn't ramp gradually; it launches. A practice signs a vendor contract, trains staff, and enrolls its eligible chronic-disease panel over a few weeks. Any group doing a genuine program launch, absorbing an acquired practice's patients, or switching RPM vendors and re-registering an existing panel will trip a 150%-in-one-month threshold as a simple byproduct of how the rollout works, not because anything improper occurred. Notably, OIG excluded the very largest practices from this measure, which means it is structurally weighted toward flagging exactly the mid-size groups most likely to be doing a legitimate single-site or single-panel launch.

2. No documented prior relationship

This measure is the most exposed to data artifacts. OIG searched claims back to January 2021 for evidence of an earlier in-person or telehealth visit with the billing practice. That search misses patients who aged into Medicare during the window (their decades-long relationship with the practice was billed to commercial insurance and simply isn't visible), practices whose Medicare Advantage encounter data is incomplete (which OIG itself concedes), practices that changed their billing TIN through a merger or reorganization, and Medicare Advantage arrangements that were never bound by the fee-for-service prior-relationship rule to begin with. A practice can be fully compliant and still fail this test on data-visibility grounds alone.

3. No treatment management billed

As covered above, this measure counts patients who never had a 99457/99458 claim billed by anyone all year, without accounting for patients who genuinely didn't need 20 minutes of monthly management, care time properly billed instead under Chronic Care Management, physician-level monitoring billed under 99091 instead (which the methodology doesn't clearly address), or patients enrolled late in the year with too little time left to accrue a claim. CMS's creation of the shorter 99470 code for 2026 is itself an admission that legitimate, shorter management encounters were going unbilled under the old all-or-nothing 20-minute threshold.

4. Enrollees shared across practices

The actual Medicare rule bars two practices from billing RPM for the same patient in the same 30-day period. OIG's measure instead looks at whether a patient appeared on two or more practices' rosters at any point across the entire year, a much looser test that a patient can trip simply by moving, changing doctors, or transitioning from a post-discharge monitoring program to a primary care chronic-disease program, with zero overlap in any single month. Snowbird Medicare beneficiaries alone will trigger this every year, entirely legitimately.

5. Multiple devices billed for one patient

Billed is not the same as paid. Medicare's own claims-processing system limits 99454 to one unit per patient per 30 days, so most "extra" device claims are simply denied on the back end; the safeguard is working exactly as intended, not evidence of a scheme. The snapshot counts what was billed, not what was paid, and never resolves the difference. It also doesn't account for replacement devices, corrected and resubmitted claims, or Medicare Advantage arrangements that legitimately pay for two devices when a patient is being monitored for two separate conditions.

The 2024 Report's 43% Statistic, Put in Context

OIG's earlier September 2024 report is frequently summarized in the trade press as finding that 43 percent of RPM enrollees "did not receive all three components" of the service, a statistic often read as proof that practices bill for fragments of care they never actually deliver. Broken into its parts, the picture looks different: roughly 28 percent of enrollees had no setup claim, 23 percent had no device-supply claim, and 12 percent had no treatment-management claim.

Each of those numbers has a mundane explanation. The setup code, 99453, is billable only once per episode, so a patient monitored continuously from 2021 through 2022 will correctly show zero 2022 setup claims, and a one-year claims window will mechanically generate a false positive for every continuing patient in the country. Many practices also simply never bill the roughly $19 setup code at all, choosing to fold patient education into their existing workflow at no charge, which, if anything, is Medicare getting free service rather than a shortfall. And as covered above, nothing in Medicare's own rules requires the three components to be billed together in the first place. The Alliance for Connected Care formally asked OIG to retract and republish the 2024 report over these characterizations; OIG declined, though CMS's own response identified no support for the report's underlying premise and committed only to "consider" its recommendations.

Scale: What $536 Million Actually Represents

Total Medicare RPM payments in 2024 were roughly $536 million, against total Medicare program spending of about $1.1 trillion; RPM represents roughly five one-hundredths of one percent of program spend. For comparison, CMS's own estimate of Medicare fee-for-service improper payments across the whole program was approximately $31 billion in FY 2022 alone, on the order of a hundred times larger than the entire RPM benefit.

The 31 percent year-over-year growth rate the snapshot highlights is also a function of a near-zero 2019 baseline; RPM's code set was built specifically to expand chronic-disease monitoring, so growth from that starting point is the program working as designed, not a warning sign. It's also worth noting the flip side of utilization: OIG's own 2024 report found that more than 60 percent of Medicare beneficiaries have hypertension, yet only about 1 million of Medicare's roughly 68 million enrollees (under 1.5 percent) received any RPM in 2024 at all. Relative to the population that could clinically benefit, RPM remains dramatically under-used, not overrun. That same report found 94 percent of RPM went toward chronic-condition management, and that Black, Hispanic, and dual-eligible beneficiaries received RPM at close to double the rate of white beneficiaries, an access pattern that Congress is actively trying to build on, with the RPM Access Act advancing through committee markup as recently as this month.

The Clinical Evidence the Snapshot Cites but Doesn't Follow

The snapshot's own first citation points to a 2023 Annals of Internal Medicine study finding that RPM helps control hypertension and reduce hospitalizations in the Medicare population, and then never circles back to ask whether the billing it scrutinizes is buying real clinical value. It is. A separate 2024 retrospective cohort found that after 90-plus days of RPM, the share of patients with uncontrolled hypertension fell from 66.3 percent to 40.2 percent, stage-2 hypertension fell from 37.5 percent to 19.1 percent, and average systolic blood pressure improved meaningfully, reductions large enough to matter for stroke and heart-attack risk at a population level. Any honest accounting of a $536 million benefit needs to weigh the avoided downstream hospitalizations against unproven, unquantified improper payments. The snapshot never attempts that comparison.

Where OIG Has a Legitimate Point

None of this means RPM fraud doesn't exist, and a credible response shouldn't pretend otherwise. The genuine outliers in this data deserve scrutiny: a practice with no documented relationship to 30,000 patients, or one billing duplicate devices over a thousand times a year, is worth a hard look, and if the underlying facts support it, worth prosecuting. Bad actors in RPM don't just steal from the program; they invite the code restrictions, prior-authorization hurdles, and payment cuts that end up landing on every compliant practice, and they damage the credibility that legitimate RPM programs have spent years building with referring physicians.

The right response isn't to argue that RPM fraud is a myth. It's to insist that OIG's statistical measures, as built, cannot tell the difference between a fraudulent shell and a compliant practice serving a hard-to-reach population, and that the honest fix is targeted, record-review-based enforcement against genuine outliers, not a framing exercise that puts a fraud-alert label on a benefit that is, by OIG's own numbers, behaving normally in 96 to 99 cases out of 100.

What This Means for Your Practice

Whatever you think of the snapshot's framing, it functions as a roadmap for what auditors and payers will be looking at next. That makes this a good moment to tighten up documentation, regardless of whether your program has anything to worry about:

- Document every outreach attempt to unengaged patients (the attempt, the date, and the outcome), so a low treatment-management billing rate is backed by a clear record of effort, not just a claims gap.
- Track device transmission days per patient per month, and be able to show at a glance why a 99454 claim was or wasn't submitted.
- If you run RPM alongside Chronic Care Management, keep clean records of which staff minutes were attributed to which program, so a reviewer can see why 99457 wasn't billed in a month CCM time was.
- For new program launches, acquisitions, or vendor transitions, keep the underlying business record (the contract date, the go-live date, the patient list being migrated) so a legitimate enrollment spike is easy to explain if it's ever questioned.
- Confirm your prior-relationship documentation practices, especially for Medicare Advantage patients, where encounter data is the most likely to be incomplete on Medicare's side, not yours.

Practices that can quickly produce this kind of documentation are practices that have nothing to fear from this snapshot, regardless of how it reads on the surface. Don Self & Associates works with practices on exactly this kind of program-level compliance and appeals readiness. Reach out through donself.com if you'd like a closer look at how your RPM documentation would hold up under this framework.

Sources

- HHS-OIG, Billing for Remote Patient Monitoring in Medicare, OEI-02-23-00261 (Data Snapshot, August 2025).
- HHS-OIG, Additional Oversight of Remote Patient Monitoring in Medicare Is Needed, OEI-02-23-00260 (September 19, 2024).

- Alliance for Connected Care, letter to HHS-OIG on the RPM report (September 24, 2024), and OIG's response.
- Fierce Healthcare, coverage of OIG's RPM findings and stakeholder reaction (September 2024).
- CMS, CY 2020, CY 2021, CY 2024, and CY 2026 Medicare Physician Fee Schedule Final Rules (conditions of payment for 99457/99454; clarification that the 16-day rule does not apply to treatment-management codes; creation of CPT 99445 and 99470).
- Tang et al., "Effects of Remote Patient Monitoring Use on Care Outcomes Among Medicare Patients With Hypertension," Annals of Internal Medicine (2023).
- Retrospective cohort study on RPM and hypertension outcomes, PMC11353537 (2024); real-world RPM adherence study in Medicaid diabetes patients, PMC10481216 (2023).
- CMS National Health Expenditure data (2024); CMS fee-for-service improper payment estimates (FY 2022).
- Alliance for Connected Care, statement on the RPM Access Act committee markup (July 2026).