2026 Remote Therapeutic Monitoring Implementation Guide

For chiropractic offices using ChiroPlus

This guide explains the 2026 musculoskeletal Remote Therapeutic Monitoring code pathway, the documentation needed to support each service, and a practical office workflow.

Important payment notice. The dollar amounts below are 2026 Medicare Physician Fee Schedule national non-facility averages for reference. They are not a promise of payment. Coverage, provider eligibility, scope-of-practice rules, payer contracts, patient benefits, modifiers, bundling edits, locality adjustments, and documentation all affect payment. Original Medicare generally limits covered chiropractic services to "manual manipulation" of the spine to correct a subluxation; therefore, a published Medicare rate does not by itself establish that Medicare will pay a chiropractor for RTM. Verify each payer's policy and the billing provider's eligibility before implementation.

RTM at a glance

RTM uses a qualifying medical device to collect nonphysiologic information related to treatment, such as home-exercise adherence, therapy response, pain or functional status. For chiropractic home care, the most relevant pathway is musculoskeletal monitoring.

Service stage	What happens	2026 code path
Set up	The patient is enrolled and educated on use of the device.	98975
Collect data	The device makes musculoskeletal treatment data available during a rolling 30-day period.	98985 for 2–15 days OR 98977 for 16–30 days
Manage care	A qualified professional reviews the data, adjusts care as needed, and completes real-time patient or caregiver communication.	98979 for 10–19 minutes OR 98980 for first 20 minutes; add 98981 for each full additional 20 minutes

2026 musculoskeletal RTM code reference

Code	Plain English	Reporting threshold and key rule	2026 national non-facility average
98975	Initial device setup and patient education	Once per episode of care; do not treat as monthly setup. The 2026 code structure requires at least 2 days of monitoring in the 30-day period.	$21.71
98985	Musculoskeletal device supply and data access for 2–15 days in a 30-day period	New for 2026. Use only when cumulative qualifying data days fall between 2 and 15. Do not report with 98977 for the same 30-day period.	$40.08
98977	Musculoskeletal device supply and data access for 16–30 days in a 30-day period	Revised for 2026. Use when at least 16 qualifying data days are achieved. Do not report with 98985 for the same period.	$51.44
98979	RTM treatment management, first 10 minutes in a calendar month	New for 2026. Requires 10–19 total minutes and at least one real-time interactive communication. Do not report with 98980 or 98981 in the same month.	$26.39
98980	RTM treatment management, first 20 minutes in a calendar month	Requires at least 20 total minutes and at least one real-time interactive communication. Report once per calendar month when met.	$54.11
98981	Each additional full 20 minutes of treatment-management time in the same calendar month	Add-on to 98980 only. Count only complete additional 20-minute increments. Do not append to 98979.	$41.42

Rate basis: CY 2026 Medicare PFS national non-facility amounts, standard non-QP conversion factor, current through the October 2026 release. Geographic and payer adjustments apply.

How the codes work together

Patient result during the period	Device code	Management code
8 qualifying data days; 12 documented management minutes including live communication	98985	98979
22 qualifying data days; 18 management minutes including live communication	98977	98979
18 qualifying data days; 26 management minutes including live communication	98977	98980
27 qualifying data days; 43 management minutes including live communication	98977	98980 + one unit of 98981
1 qualifying data day; 14 management minutes	No device-supply code	Evaluate independently whether management requirements are met; do not assume device-code failure automatically decides management-code eligibility

Patient qualification checklist

- The patient has a condition and treatment plan for which remote monitoring is medically necessary.
- The monitoring is permitted within the clinician's state scope of practice and the payer recognizes the billing provider for the service.
- The patient consents to RTM; document the consent method and date.
- The technology meets the applicable medical-device requirement and captures the information needed for the selected RTM code.
- The patient can use the device or has a caregiver who can reliably assist.
- The office has verified benefits, coverage rules, cost sharing, authorization requirements, and billing frequency.
- The same data, time, or work will not be counted toward another billed service.

Practical ChiroPlus workflow

1. Identify: Select a patient whose prescribed home care requires monitoring because adherence, response, or functional progress will influence clinical decisions.

2. Verify: Confirm payer coverage, provider eligibility, patient benefit details, authorization, and financial responsibility. Medicare fee-schedule publication alone is not verification of coverage for a DC.

3. Enroll and educate: Assign the appropriate ChiroPlus plan, explain app use, confirm access, teach the patient how to submit qualifying data, and document setup and education. (98975)

4. Monitor: Review the dashboard at an established cadence. Track qualifying data days separately from clinical management minutes. (98977, 98985)

5. Interact: Complete at least one synchronous, real-time interaction with the patient or caregiver during any month in which a treatment-management code will be reported. Document date, participants, mode, clinical content, and outcome. (98979, 98980, 98981)

6. Respond clinically: Use the data to assess adherence or response and, when appropriate, modify, reinforce, or progress the care plan. Record the clinical reasoning.

7. Close the period: At the end of the rolling 30-day device period and calendar-month management period, reconcile data days, qualifying time, communication, and code compatibility before creating the claim.

8. Audit before submission: Confirm medical necessity, provider identity, date ranges, exact minutes, no duplicate time, correct code pairing, modifiers, and payer-specific requirements.

Documentation standards

Documentation element	What the record should show
Order and treatment plan	Condition monitored, reason RTM is needed, intended goals, prescribed home program, monitoring period, and responsible clinician.
Consent	Patient or caregiver consent, date obtained, and any required discussion of cost sharing.
Device setup	Device or software used, setup date, education provided, patient competency, and any support needed.
Data days	A defensible count of days with qualifying device data in each rolling 30-day period; do not substitute logins or app openings unless they meet the device and code requirements.
Clinical review	What data was reviewed, the clinician's interpretation, and how the information affected management.
Time log	Date, activity, qualified professional, start/stop or exact minutes, and monthly total. Exclude general administration, scheduling, or technical-support time.
Interactive communication	At least one real-time patient or caregiver interaction for 98979/98980/98981, with the clinical substance and outcome.
Claim support	Code selected, relevant date range, rendering and billing provider, modifiers when required, and payer verification notes.

What may count toward management time

- Reviewing and interpreting RTM data as part of treatment management.
- Updating the treatment plan in response to monitored information.
- Clinically meaningful communication with the patient or caregiver related to the monitored treatment.
- Documenting the RTM assessment, decision, and plan when integral to the service.

What should not be counted automatically

- General scheduling, billing, marketing, or benefit-verification work.
- Purely technical troubleshooting that does not constitute clinical treatment management.
- Time already counted toward another reported service.
- Passive availability, automated alerts without clinical work, or undocumented review.
- Work performed by personnel who do not meet the code or payer requirements.

Recommended monthly billing review

- Confirm the device-data period and the calendar-month management period are calculated correctly.
- Choose one musculoskeletal device code: 98985 or 98977, never both for the same 30-day period.
- Choose either 98979 or the 98980 pathway. Do not report 98979 with 98980 or 98981.
- Use 98981 only after 98980 and only for each complete additional 20 minutes.
- Verify real-time interactive communication before reporting a management code.
- Confirm the treating/billing professional's eligibility and any required modifier.
- Review same-day and same-month services for overlapping time, bundling, or payer edits.

Common implementation mistakes

Mistake	Better practice
Treating RTM as automatic recurring revenue	Make medical necessity and documented clinical management the reason for the service; reimbursement is secondary.
Billing 98977 after only a few data days	Use 98985 for 2–15 qualifying days in 2026; reserve 98977 for 16–30 days.
Billing both short- and long-duration device codes	Select only the code matching the actual day count for the period.
Using 98979 and 98980 together	Choose the 10–19 minute pathway or the 20-minute pathway, not both.
Counting every staff touch as clinical time	Log only qualifying treatment-management work performed by eligible personnel.
Documenting "patient contacted"	Record that the interaction was real time and capture its clinical substance and outcome.
Assuming a CMS rate means a DC is covered	Verify Original Medicare statutory limits and each commercial or Medicare Advantage payer's provider policy.

Sample RTM treatment management note

Patient and condition: [Name or ID] — [musculoskeletal diagnosis or functional problem]

Monitoring period: [Start date] through [End date]; [number] qualifying device-data days.

Data reviewed: [Adherence, response, pain/function report, completed exercises, barriers, trends].

Clinical interpretation: [What the data mean and why intervention is or is not needed].

Real-time interaction: [Date, time, patient/caregiver, telephone/video/live audio method, clinical discussion, patient response].

Plan: [Continue, reinforce, regress, progress, modify, schedule reassessment, or refer].

Time: [Date/activity/minutes by eligible professional]; total qualifying monthly time: [XX] minutes.

Code review: Device days support [98985/98977/none]. Management time supports [98979/98980 + units of 98981/none]. Coverage and provider eligibility verified: [yes/no; source/date].

Office policy statement

ChiroPlus supports assignment, communication, adherence tracking, and documentation workflows. The clinic remains responsible for determining medical necessity, choosing the correct code, confirming that its device configuration and personnel satisfy current requirements, verifying payer coverage, obtaining consent, applying modifiers, and submitting an accurate claim. No software feature or fee-schedule amount guarantees reimbursement.

Authoritative references

- **CMS MLN Matters MM14250 Therapy Code List 2026 Annual Update:** https://www.cms.gov/files/document/mm14250-therapy-code-list-2026-annual-update.pdf
- **CMS CY 2026 Physician Fee Schedule Final Rule:** https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f
- **CMS PFS National Payment Amount File PFREV26D October 2026:** https://www.cms.gov/medicare/payment/fee-schedules/physician/national-payment-amount-file/pfrev26d
- **CMS Physician Fee Schedule Look Up Tool:** https://www.cms.gov/medicare/physician-fee-schedule/search
- **CMS Therapy Services:** https://www.cms.gov/medicare/coding-billing/therapy-services

Version note: Prepared September 2026 using the 2026 code structure and the CMS October 2026 fee-schedule release. Recheck CPT, CMS, MAC, state scope, and payer policies before each annual update or workflow change.