

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment. Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular member. The member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members. CMS's Coverage Database can be found on the CMS website. References included were accurate at the time of policy approval and publication.

OVERVIEW

Telehealth is broadly defined by the Health Resources and Services Administration (2022) as the use of electronic information and telecommunication technology to facilitate long-distance clinical health care, patient and professional health-related education, health administration, and public health. Technologies used in telehealth include the internet, video conferencing, store-and-forward imaging, streaming media, and landline or wireless communications. Telehealth services may be delivered synchronously through real-time interactions between patients and providers, or asynchronously through store-and-forward communication, in which clinical information is transmitted for later review (¹Telehealth.HHS.gov). Telehealth also includes remote patient monitoring, which uses digital devices to collect and transmit patient health information to clinicians (²Telehealth.HHS.gov).

Remote physiologic monitoring (RPM) is a subset of telehealth sometimes referred to as telemonitoring. RPM is the collection and transmission of physiologic data (e.g., blood pressure, weight, pulse oximetry, blood glucose) from the patient's home to the medical record where a provider can review the patient's data and adjust the treatment plan when necessary. Devices in scope are clinician prescribed, FDA approved devices that are designed for medical purposes only. Overall, the clinical utility of RPM depends on the condition being monitored, the physiologic parameters collected, and the presence of structured care-management protocols that guide clinician response to transmitted data.

RELATED POLICIES

MCP-412: Prescription Digital Therapeutics
MCP-428: Mobile Cardiac Outpatient Telemetry
MCP-393: Wireless Pulmonary Artery Pressure Monitoring for Heart Failure
MCP-341: Smart Watch Photoplethysmography (PPG) for Detection of Atrial Fibrillation

COVERAGE POLICY

Please refer to the member's Plan benefit and any applicable Federal/State telehealth program requirements, including limits, definitions, eligibility, service authorization conditions, and data requirements.

Initial Requests for Remote Physiologic Monitoring (RPM)

RPM may be **considered medically necessary** in accordance with the member's plan benefit and all applicable regulatory requirements, and when ALL the following criteria are met:

1. RPM is prescribed by a qualified healthcare practitioner who is a network provider participating in telehealth AND licensed to practice in the state where the member is located
2. Member has a diagnosis of ONE of the following chronic conditions as defined by applicable Federal/State

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Centers guidelines and member's Plan benefit (e.g., asthma, chronic obstructive pulmonary disease, diabetes, heart failure, hypertension)

3. The prescriber has determined ONE of the following pertaining to the member's condition:
 - a. High-risk for decompensation or complication that may lead to hospitalization, or another acute intervention and the provision of an RPM may reduce this risk (e.g., member with recent hospitalization(s) or recurrent admissions for a chronic condition)
 - b. Requires monitoring for a current or new treatment plan
4. RPM services prescribed monitor parameters appropriate for the member's condition and consistent with the provider's scope of practice
5. Prescribed remote monitoring device must meet ALL the following:
 - a. Meet the *FDA definition of a "medical device" defined as: an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is: recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them and ONE of the following:
 - i. Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals
 - ii. Intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes

Note: Personal devices (e.g., Apple Watch, Fitbit) are NOT approved for RPM.
 - b. Provide monitoring consistent with the symptoms or diagnosis and treatment of the member's condition, illness, or injury
6. A plan of care, signed and dated by the prescriber, includes ALL the following:
 - a. Specific physiologic clinical patient data to be monitored and measured (e.g., weight, blood pressure, pulse, respirations, blood glucose, pulse oximetry)
 - b. Date and duration of monitoring requested
 - c. The frequency a qualified practitioner will be performing a reading of the transmitted health information
 - d. Intervention process by which the monitoring provider will address potential health concerns or abnormal data measurements to prevent avoidable hospital utilization
 - e. If medication adherence management services are ordered in addition to physiologic monitoring:
 - i. Medication regimen/plan
 - ii. Medication adherence monitoring method to be used for timing, dosing, and frequency of medication/plan
 - iii. Records to support a documented history of poor adherence to ordered medication regimen
7. Prescriber attestation that the member meets ALL the following conditions:
 - a. Member has consented to RPM services in writing or verbally
 - b. Cognitively intact and capable of operating the RPM device or has a willing and capable caregiver to assist in the completion of electronic data transmission
 - c. Has connectivity sufficient for the device to transmit data (broadband or cellular)
8. Duration of Initial Service Authorization: Initial duration should not exceed 90 days. This may rarely be extended on a case-by-case basis for complex members with chronic conditions at very high risk of exacerbation and documented compliance with RPM

Continuation Requests for RPM

RPM is authorized as a time-limited intervention when the member is at risk of decompensation or is being monitored for a current or new treatment plan. It is not approved as indefinite surveillance once the member is stable (i.e., returns to baseline or establishes a new baseline).

For continuation of service requests: Authorization may be extended in increments up to 90 days provided ALL

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documentation noted above is submitted. This includes a written order for RPM and duration, updated plan of care, rationale/supporting evidence that the member's clinical condition requires ongoing monitoring.

Exclusion or Discontinuation of RPM Service

1. Molina Clinical Reviewer or Medical Director determines that ANY of the above criteria are not met
2. Prescriber has not submitted ALL documentation/records requested
3. Member is hospitalized or receiving duplicative services while under an RPM plan of care
4. Member's condition has returned to baseline, or has reached a new established baseline and ongoing physiologic monitoring is no longer required to manage the condition or treatment plan
5. Continuation of service beyond 90 days without a submission of a new records meeting all continued eligibility criteria stated in policy and approval of authorization

DOCUMENTATION REQUIREMENTS: Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

Evidence is condition and program specific. In heart failure, non-invasive RPM programs have been associated with reductions in first heart failure hospitalization and all-cause mortality compared with usual care. Programs that include education and self-management components appear to demonstrate greater reductions in heart failure hospitalizations than monitoring alone (De Lathauwer et al. 2025). For hypertension, home blood pressure monitoring combined with protocolized, team-based follow-up is an established tool and strategy to improve control. Cuffless devices, including smartwatches, should not be used for clinical blood pressure measurement until they are shown to be accurate and reliable (Jones et al. 2025). Effects of RPM on hospitalizations and cost outside heart failure and protocolized home blood pressure programs are mixed. In asthma, telemedicine interventions more often report better adherence and quality of life than reductions in healthcare cost (Almasi et al. 2022). In COPD, remote home monitoring has not been shown to consistently reduce healthcare utilization (Nagase et al. 2022).

Smedslund et al. (2025) conducted a systematic review and meta-analysis of 40 randomized trials published 2017-2024 that compared remote patient monitoring with usual care in adults with non-communicable disease. Cardiovascular disease was the largest subgroup (16 trials). Other conditions included mixed chronic disease. Certainty of evidence was graded moderate to very low. Remote patient monitoring may slightly reduce the proportion of patients hospitalized versus usual care (RR 0.86, 95% CI 0.77 - 0.95, low certainty). The mean number of hospitalizations is similar or slightly lower (mean difference -0.13, 95% CI -0.29 to 0.03; low certainty). Length of stay may be slightly shorter (mean difference -0.84, 95% CI -1.61 to -0.06 days; low certainty). The proportion of patients with outpatient visits was probably similar between groups, (RR 0.94, 95% CI 0.87 to 1.02; moderate certainty). Emergency visit results were imprecise (low to very low certainty). The authors concluded that RPM possibly leads to a small reduction in hospitalizations and length of stay and possibly more outpatient visits. Results should be interpreted with caution because certainty was generally low and interventions were heterogeneous. The review is not limited to FDA home physiologic devices as defined by this policy and should not be read as disease specific coverage evidence for asthma, COPD, diabetes, heart failure, or hypertension.

Asthma

Systematic Reviews and Meta-Analyses

Almasi et al. (2022) conducted a systematic search of clinical trials that investigated the effectiveness of telemedicine in the management of asthmatic patients from 2005 to 2018. A total of 33 articles were included by researchers for review with 23 studies employing telemedicine for the promotion of patient compliance to treatment. Study inclusion criteria consisted of randomized trials in English; intervention tools for the diagnosis and management of asthma; any age group; and results of interventions that correlated to asthma management, symptom control, quality of life, costs, and adherence to prescribed treatment programs. Researchers separated telemedicine functions into five categories: consultation, communication, education, monitoring, and reminder. Remote patient monitoring functions identified were online asthma control, respiratory functions, data entry regarding asthma symptoms including physical data,

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medication dosage and monitoring, and disease progression. Reminders and alarms were the most frequent function employed using telemedicine interventions followed by communication with healthcare providers. Most studies did find that treatment adherence and quality of life improved when patients received telemedicine interventions, but the cost of care did not decrease. Patients did report that telemedicine interventions improved education on asthma, anatomy of the lungs, common asthma symptoms, medication compliance, device use (inhalers, peak flow meters, spacers, and telemedicine tools), following treatment programs, and the causes for asthma exacerbation. When multiple diverse types of telemedicine interventions are implemented overall, asthma management does improve when compared to a single intervention. Currently the cost of care is not reduced with the use of telemedicine and RPM.

Chronic Obstructive Pulmonary Disease (COPD)

Systematic Reviews and Meta-Analyses

Nagase et al. (2022) conducted a systematic review of the scholarly literature released in the last 10 years. The evaluation comprised 17 RCTs and two comparative observational studies. The key finding of this systematic review is that there is a substantial amount of evidence relating to the efficacy/effectiveness of remote home monitoring, however it is of poor quality. Although remote home monitoring is safe, it does not appear to improve health related quality of life, lung function, or self-efficacy, or to reduce sadness, anxiety, or healthcare resource consumption (independent of the kind of remote home monitoring). Regular feedback from clinicians may help to decrease COPD-related hospitalizations. Though remote home monitoring adherence remains unknown, both patients and providers expressed high levels of satisfaction with the intervention.

Lu et al. (2021) conducted a systematic review and meta-analysis that included 3,001 patients from 17 trials with both telemonitoring intervention and a control group. This study was based on a search of PubMed, Embase, and the Cochrane Library for RCTs published between 1990 and May 2020. The authors noted that although an increasing number of studies have reported that telemonitoring in patients with COPD can be useful and effective for hospitalizations and quality of life, its actual utility in detecting and controlling acute exacerbations of COPD is less well-established. The purpose of the meta-analysis was to identify the best available evidence regarding the efficacy of telemonitoring targeting early and optimized management of acute exacerbation COPD in patients with a history of previous acute exacerbations versus a control group without telemonitoring intervention. Primary endpoints included emergency room visits and exacerbation-related readmissions. According to the evidence presented in this meta-analysis, telemonitoring reduced ER visits and acute exacerbation-related readmissions, as well as acute exacerbation-related hospital days and mortality in patients with acute COPD exacerbation, particularly when the telemonitoring intervention was carried out for more than 12 months. The rapid development and reform of telemonitoring in practice may necessitate further recurrent control studies to determine the efficacy and advantage of certain types of telemonitoring. Consequently, telemonitoring constitutes a novel approach for the management of the condition.

Diabetes Mellitus

Non-Randomized Studies, Retrospective Reviews, and Other Evidence

Park et al. (2023) conducted a retrospective cohort study investigating patient adherence to daily diabetes management protocols using RPM over a 180-day period from 2016 to 2018. The study included Texas Medicaid patients who were enrolled in RPM and transmitted blood glucose data following a 30-day training period. Initially, 2099 patients referred by their physicians were enrolled. Patients were assigned to either an adherent or nonadherent cohort based on their frequency of data transmission. The adherent cohort included 460 patients who transmitted blood glucose data at least once daily for a minimum of 120 out of 150 study days. The nonadherent cohort consisted of 382 patients who consented to transmit data at least twice monthly. Both groups received adherence reminder calls if data were not transmitted. Both cohorts demonstrated improvements in blood glucose control; however, adherence calls significantly increased transmission rates—by 50.7% in the adherent cohort and 29.5% in the nonadherent cohort. Nearly half of the adherent cohort maintained approximately 90% adherence throughout the study with the support of reminder calls. Challenges were noted, as 20.9% of the total population failed to transmit daily glucose levels despite reminders, with the adherent cohort representing 8.1% of this subgroup. The study did not collect data on patient medications, physical activity, carbohydrate intake, diabetes type (type 1 or type 2), or HbA1c levels. Despite these limitations, RPM demonstrated potential benefits, and adherence calls were associated with improved patient compliance and blood glucose control. The authors emphasized the need for further research to identify all factors contributing to optimal diabetes management.

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Lee et al. (2018) conducted a systematic review and meta-analysis of RCTs to establish the efficacy of telehealth interventions on the glycemic management of adults with type 2 diabetes. Two reviewers identified and reviewed eligible studies published between 1990 and 2016. Of 3,279 references retrieved, 4 systematic reviews reporting 29 unique studies were included. Pooled evidence indicated that telemedicine interventions resulted in a minor but substantial improvement in HbA1c levels when compared to standard care. Telephone-delivered interventions had the greatest benefit, followed by internet blood glucose monitoring system interventions, and finally, interventions including automatic transmission of self-monitoring of blood glucose via a mobile phone or a telehealth unit.

Heart Failure (HF)

Systematic Reviews and Meta-Analyses

De Lathauwer et al. (2025) conducted a systematic review and meta-analysis of randomized trials published January 2012 through June 2023 that compared non-invasive remote patient monitoring for heart failure with usual care. Forty-one trials (16,312 patients; mean follow-up 9.88 $\pm$ 6.37 months) were included. Programs differed in devices, transmission schedules, and whether they added education, self-management tools, or video contact. Pooled results favored RPM for all-cause mortality (OR 0.81, 95% CI 0.69 – 0.95) and first heart failure hospitalization. Additional analyses found that a self-management module ($p < 0.001$) and an education module ($p = 0.028$) were associated with fewer heart-failure hospitalizations. Video calls during the RPM program were associated with fewer heart failure hospitalizations ($p = 0.047$) and fewer all-cause hospitalizations ($p < 0.001$). The authors concluded that non-invasive RPM can reduce heart failure hospitalization and mortality compared with usual care. And that program design (education, self-management, and video contact) influences effect size. Limitations include heterogeneous interventions and follow-up generally under one year.

Kitious et al. (2021) conducted a systematic review and meta-analysis to compare mobile health interventions with usual care for patients with heart failure. This systematic review focused on noninvasive mobile health interventions. 16 RCTs ($n=4389$) with the following criteria were included: patients 18 years of age and older with noninvasive intervention(s), living at home and providing for their own care. Interventions with and without remote transfer of physiologic data were included. Patients receiving usual care were included as a comparison group. Primary outcomes were all-cause mortality, cardiovascular mortality, heart failure related hospitalizations and all-cause hospitalizations. Remote monitoring with clinical feedback compared to usual care was found to have high-quality evidence of reduced risk of all-cause mortality ($p = 0.02$), cardiovascular mortality ($p = 0.009$), and heart failure hospitalizations ($p = 0.0001$). For all-cause hospitalizations, there was no significant difference between remote monitoring and usual interventions ($p = 0.99$). The authors concluded that remote patient monitoring with clinical feedback had a statistically significant effect on the care of heart failure patients.

Non-Randomized Studies, Retrospective Reviews, and Other Evidence

Bhatia et al. (2020) reviewed RPM for heart failure (HF) and identified inconsistencies that lacked evidenced-based data for clinical management. Research reviewed existing options for RPM and found that a framework was needed that included the following components: patient data collection, data transmission including analysis and presentation, and team care review with clinical action. Current modalities of RPM comprise both noninvasive and invasive devices. Noninvasive devices such as blood pressure cuffs, scales, and other wearable devices present minimal patient risk and are less expensive than invasive devices. The clinical benefit is mixed for noninvasive devices and requires more research that establishes effectiveness in specific patient populations. Implantable invasive devices present a greater risk to the patient at a significantly higher cost. That said, for specific patient populations there is potential to optimize better HF care. Research is needed for all types of RPM that clearly establishes specific patient care needs and treatment options that enhances monitoring for clinical HF decompensation. Moving forward, specific patient selection criteria is necessary for HF RPM and will need to identify when incorporating this type of intervention will provide the greatest patient benefit.

National and Specialty Organizations

The 2025 **American Heart Association (AHA)/ American College of Cardiology (ACC)** multisociety *Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults* (Jones et al. 2025) states that home blood pressure monitoring, combined with frequent interaction with a multidisciplinary team using standardized measurement and treatment protocols, is an important integrated tool to improve rates of blood pressure control. The guideline also notes that reliance on cuffless devices, including smartwatches, for accurate blood pressure measurement should be avoided until those devices demonstrate greater precision and reliability.

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The **Agency for Healthcare Research and Quality (AHRQ)** (Hood et al. 2023) reviewed the evolution of remote patient monitoring (RPM) as a specific type of telehealth that rapidly advanced during the Covid-19 pandemic. Prior to the pandemic RPM was utilized primarily for patients with chronic health conditions that required frequent monitoring through digital medical devices such as weight scales, blood pressure monitors, pulse oximeters, and blood glucose meters. Disease management for patients with specific medical conditions such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes reduced emergency visits, hospital readmissions, and hospital length of stay with the use of RPM.

The 2022 **American Heart Association (AHA)/American College of Cardiology (ACC)/Heart Failure Society of America (HFSA) Guideline for the Management of Heart Failure** (Heidenreich et al. 2022) addresses wearables and remote monitoring. The usefulness of wireless pulmonary artery pressure monitoring using an implanted sensor to reduce future heart failure hospitalizations is uncertain (Class 2b). The guideline also notes that prior trials do not support routine use of noninvasive telemetering or remote monitoring of parameters such as activity, thoracic impedance, or heart rate obtained through implanted electrical devices to improve outcomes. Further study is needed before those approaches can be recommended for routine care.

CODING & BILLING INFORMATION

Diagnostic, consultative and treatment services should be reported with the appropriate Category I or Category III CPT code and the HCPCS modifier -GT (via interactive audio and video telecommunication systems) or CPT modifier-95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system).

CPT (Current Procedural Terminology)

Code	Description
98975	Remote therapeutic monitoring (e.g., therapy adherence, therapy response, digital therapeutic intervention); initial set-up and patient education on use of equipment
98984	Remote therapeutic monitoring (e.g., therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 2-15 days in a 30-day period
98976	Remote therapeutic monitoring (e.g., therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 16-30 days in a 30-day period
98977	Remote therapeutic monitoring (e.g., therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 16-30 days in a 30-day period
98978	Remote therapeutic monitoring (e.g., therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 16-30 days in a 30-day period
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 20 minutes
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)
98985	Remote therapeutic monitoring (e.g., therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 2-15 days in a 30-day period
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate); initial set-up and patient education on use of equipment
99445	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, 2-15 days in a 30-day period
99454	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory

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	flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, 16-30 days in a 30-day period
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 20 minutes
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)
99470	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days

HCPSC (Healthcare Common Procedure Coding System)

Code	Description
G0322	The collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (i.e., remote patient monitoring)

CODING DISCLAIMER: Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

10/14/2026	Policy reviewed. No changes to coverage criteria. Title updated to "Remote Physiologic Monitoring".
10/08/2025	Policy reviewed. No changes to coverage criteria. Updated Summary of Medical Evidence and References.
10/09/2024	Policy reviewed, no changes to criteria. Updated Summary of Medical Evidence and References. IRO Peer Review on September 5, 2024 by a practicing physician board-certified in Internal Medicine; Hospital Medicine.
10/12/2023	Policy reviewed, no changes to criteria. Updated Summary of Medical Evidence and References.
10/12/2022	New policy. Titled "Remote Patient Monitoring"

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