September 15, 2025 | Volume 39, Issue 35

Part B News
partbnews.com
COLLECT EVERY DOLLAR YOUR PRACTICE DESERVES

In this issue

Practice management

Beware of signs of lawsuit-prone patients, and keep documentation professional

Train everyone in your practice to take a preventive approach to litigious patients, meaning patients who threaten to file complaints or sue for any reason or no reason at all. Everyone in the practice, from the scheduler to the surgeon, needs to recognize the signs and know how to communicate their concerns about a patient so they don't make a bad situation worse. The approach also works for patients who are merely difficult and reasonable patients who are considering a lawsuit.

"Contentious and potentially litigious patients pose significant operational dangers to health care practitioners, which should prompt clinicians to develop proactive policies and procedures to minimize liability risks," says Richard F. Cahill, J.D., vice president and associate general counsel for The Doctors Company, a division of TDC Group.

Share common red flags with staff

You should not assume a patient who is grumpy or questions a provider's diagnosis is a troublemaker or planning to sue. Your patients usually aren't feeling their best when they come to the practice and might be short-tempered. And sometimes the practice is at fault, observes Angela T. Burnette, counsel, Alston & Bird. Patients will become impatient and even angry if they spend half an hour in the waiting room followed by a longer wait in an exam room, she says.

However, experts did provide several common warning signs that a patient is more likely to escalate from being unpleasant during visits to a lawsuit. Some signs are hard to

decisionhealth® an hcpro brand

miss, such as a patient who hints they will sue or openly threatens to sic a lawyer on the practice. When this happens, the threats "should be escalated to the practice manager or owner," says Ericka L. Adler, partner and leader of the health care practice, Roetzel & Andress, Chicago.

However, some warning signs are less obvious, and they may require observation over time and a strategic response from one or more member of the group. Patients who are sick might not have the best manners, but a patient who is always hostile or aggressive toward staff is a red flag.

Perfectionism is another common warning sign. These patients will have unrealistic expectations, be very demanding and impossible to satisfy. As a result, they are more likely to sue because a treatment or its outcome can't meet their standards.

Here are seven more common signs that a patient is more likely to seek a legal solution to a disagreement with your practice.

1. "Noncompliant patients who often cancel appointments and do not follow care instructions," as well as patients who never listen, Burnette says.
2. Patients who had a negative health care experience in the past, says Craig Conley, shareholder and chair of Baker Donelson's health care litigation group.
3. Patients who want to modify basic practice documents or demand the practice change its documents, Adler says.
4. Patients who have an "excessive focus on documentation," and want everything in writing, Conley says.
5. "Patients who are sexually suggestive during appointments or physical exams," Burnette says. If this happens, the provider should "immediately have a same-sex chaperone come into the room," she says.
6. Patients who will only accept treatment from a physician, not other qualified health care professionals or clinical staff, Adler says.
7. Patients who have sued or filed a complaint about other providers.

Everyone should be on the lookout

Don't expect your providers to witness all of these signs. Different members of your team might catch different issues, depending on the patient and how they interact with the patient.

"Before the patient sees the provider, members of the provider's staff can be the eyes and ears for potential flags and alert the provider as appropriate," Burnette says. "A scheduler might observe a patient complain about scheduling, wait times and costs that a treating provider may not observe or be aware of," Conley says.

decisionhealth®

SUBSCRIBER INFORMATION

Have questions on a story? Call or email us.

***PART B NEWS* TEAM**

Maria Tsigas
Product Director
maria.tsigas@hcpro.com

Marci Geipe
Senior Manager, Product and Content
marci.geipe@hcpro.com

Richard Scott
Content Manager
richard.scott@hcpro.com

Roy Edroso
Editor
roy.edroso@hcpro.com

Julia Kyles, CPC
Editor
julia.kyles@hcpro.com

Medical Practice & Hospital community!

www.facebook.com/DecisionHealthPAC
www.twitter.com/DH_MedPractice
www.linkedin.com/groups/12003710

SUBSCRIPTIONS
Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email: customerservice@hcpro.com

DECISIONHEALTH PLEDGE OF INDEPENDENCE:
At DecisionHealth, the only person we work for is you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. Every reasonable effort has been made to ensure the accuracy of the information contained herein. However, the ultimate responsibility for correct billing and compliance lies with the provider of services. DecisionHealth, its employees, agents and staff make no representation, warranty or guarantee that use of the content herein ensures payment or will prevent disputes with Medicare or other third-party payers, and will not bear responsibility or liability for the results or consequences resulting from the use of the content found herein.

CONNECT WITH US
Visit us online at: www.partbnews.com.

CEUS
Part B News offers prior approval of the American Academy of Professional Coders (AAPC) for 0.5 CEUs for every other issue. Granting of this approval in no way constitutes endorsement by the Academy of the program, content or the program sponsor. You can earn your CEUs by passing a five-question quiz delivered through the *Part B News* CEU website (https://ceus.coursewebs.com).

ADVERTISING
To inquire about advertising in *Part B News*, call 1-855-CALL-DH1.

Part B News® is a registered trademark of DecisionHealth, a division of HCPro LLC. *Part B News* is published 48 times/year by DecisionHealth, 201 West Lake Street, #226, Chicago, IL 60606.
ISSN 0893-8121. pbncustomer@decisionhealth.com Price: $699/year.

decisionhealth® an hcpro brand

A scheduler would also know if a patient repeatedly cancels appointments, Burnette says. The treating provider is more likely to be aware the patient has unrealistic expectations or is excessively focused on documentation, Conley says.

Staff involved in collecting payments might be the first to hear that a patient is refusing to pay because they're planning to sue, Burnette says. The practice's marketing team might catch negative comments on social media, she adds.

Keep it professional when you document red flags

Staff should document concerns about patient behavior, but remind them that they should not vent when they do so. A chart note that states, "That creep Mr. Smith called me a woke quack and hung up when I called him with his test results," might make the treating provider feel better, but it could make matters worse if Mr. Smith's chart winds up as evidence in a malpractice case. The same goes for company-wide emails. "Look out, that jerk Ms. Jones has an appointment tomorrow, LOL," won't be funny if Ms. Jones' attorney reads it to a jury.

"The staff should document interactions with patients where they observe conduct or behavior that is an issue [and/or] concern," Adler says. "It will not likely be that they are necessarily 'litigious,' although certainly threats should be escalated to the practice manager or owner," she advises.

"Providers should be particularly mindful that federal and state privacy laws, notably the Health Insurance Portability and Accountability Act (HIPAA) and the 21st Century Cures Act, afford individuals extensive access to their medical records," Cahill warns. But remind staff to be careful when they email or text each other about a patient. "Even internal administrative files or electronic communications such as emails and texts may be subject to disclosure," he says. "Derogatory or offensive personal comments should be expressly avoided."

Concerns about patient behavior "should be documented in a factual manner rather than judgmental," Conley advises. "They should be communicated to the proper person within the group and not broadcasted, and it should be communicated in a discrete, professional manner," he says.

"Clinically relevant information (such as a Munchausen by proxy concern) should be noted in a separate risk management or peer review section of the chart," Burnette advises. That section of the chart is usually not in the "designated record set" that HIPAA allows patients to receive, she says.

"If a lawyer has requested a patient's medical records from the provider, that request could also be noted in the risk management or peer review section of the chart," Burnette says. If the patient is still being treated at the practice, this will warn providers to take extra time with the patient and their documentation, Burnette adds. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com) ■

Capitol Hill

Get ready for 4% cut: Budget shutdown not likely to stop Medicare sequester

There's an opportunity for Congress to take advantage of the shutdown threat to head off the extra 2% sequestration cut providers face in 2026, but experts advise against getting your hopes up.

As has happened several times since the 1980s, congressional appropriations to fund the government over the upcoming fiscal year, which begins October 1, have fallen far enough behind deadline that there's a risk that many functions will go unfunded and be shut down until Congress wrangles, and the president signs, new appropriation bills or a continuing resolution (CR) that will temporarily extend current spending until new appropriations can be made.

This impasse is traditionally seen as an opportunity for the party out of power, as well as for factions that have not been able to get their budget issues addressed during regular order, to apply pressure on the majority.

The shutdown would not apply to all government functions. For example, while much of the civilian workforce of the Defense Department would be put on furlough, armed services would remain at full force. A shutdown "just means there's no discretionary funding available, but programs like Medicare and Social Security are mandatory spending programs, and are not impacted," says Martie Ross, office managing principal for the PYA consultancy in Kansas City and director of

the PYA Center for Rural Health Advancement. "That money has already been appropriated."

What about the cut?

But the prospect of new budget-related negotiations does raise a question relevant to Medicare providers: Can Congress do something about the looming 2% increase in the sequestration of Medicare physician payments?

In many of the past 12 years, the payments have been automatically trimmed by 2% because federal budgets have gone deep enough into the red to trigger the Budget Control Act of 2011, which requires the sequestration. There's also a separate sequestration element in the Pay-As-You-Go, or PAYGO Act, which would allow Medicare reimbursement in years when the deficit goes high enough to be sequestered by as much as 4%. The law also stipulates that 4% is as much as Medicare can be cut, so the total 2026 sequester would amount to 4% rather than 6% (*PBN 7/21/25*).

The One Big Beautiful Budget Act (OBBBA) passed in the summer increased the deficit sufficiently that the PAYGO sequester will kick in. So have previous budget bills. But the PAYGO sequester has never gone into effect. Invariably, whenever a bill has increased the deficit enough to require the PAYGO sequester, Congress has managed to kick the can down the road with supplemental legislation. In 2021, for example, the American Rescue Plan Act blew a PAYGO-triggering hole in the deficit but Congress later passed the Protecting Medicare and American Farmers from Sequester Cuts Act to waive it.

Bills to waive PAYGO require 60 votes to pass in the Senate. Congress might use reconciliation, a more limited kind of spending legislation, to waive PAYGO with just a simple Senate majority. But the increasingly bitter partisan division in Congress adds a new degree of difficulty to getting that done, observes Claire Ernst, director, government relations and public policy for Hooper, Lundy & Bookman, Washington, D.C.

"The nature of reconciliation is politically contentious," Ernst says. "So it's hard to come to an agreement on something that needs to be passed by the normal majority."

Ross notes that "there has been some noise" on Capitol Hill about using reconciliation, but "the folks who are proposing that want to cut Medicaid even further by, for example, eliminating the expansion of Medicaid from the Affordable Care Act," as was proposed by Senator Rick Scott (R-Fla.) during the run-up to the OBBBA. That reduces chances of passage.

Waiver harder than ever

As Congress deliberates, no word has leaked on the possibility of a waiver in any continuing resolution under consideration. "It is still truly the smoky back-room type of work going on" in Congress, Ross says. "Right now, congressional leaders are focused on a stopgap funding measure to prevent a government shutdown at the end of the month. At this point, there's no consensus around how long such stopgap funding would remain in place, and whether it would include changes to FY 2025 funding levels."

House Minority Leader Hakeem Jeffries (D-N.Y.) has said that "health care is a clear red line … We will not support a partisan Republican spending bill that rips health care away from the American people." But he is thought to have been talking about Medicaid and ACA cuts such as what Scott had proposed. And a Democratic statement on the Medicare sequester has not been forthcoming.

Part B News will monitor the situation and report any new developments on the sequestration front, but as of now, look for the deficit to eat twice as much reimbursement as it currently does in 2026. – *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

Coding

Capture CPT, diagnosis coding for accurate pelvic floor therapy billing

When therapy is recommended for a patient, your mind may turn to physical, occupational and speech therapy. However, there is a new type gaining momentum: pelvic floor therapy. This therapy helps individuals to relax and coordinate their pelvic muscles, and understanding the coding terminology and guidelines specific to pelvic rehabilitation is essential for accurate documentation and billing.

According to Michel Devos, a physical therapist at Hartford HealthCare, "Pelvic muscles tighten up

(continued on p. 6)

Benchmark of the week

RPM, RTM utilization zooms, and so do RTM denial rates

In a series of reports, the OIG warns of possible serious misuse of remote physiological monitoring (RPM) codes, for which Medicare utilization has skyrocketed (*see related story, p. 7*). OIG clarifies that they're not talking about remote therapeutic monitoring (RTM) codes, possibly because, from rising denial rates, it appears as if the MACs are doing a good job of spotting bad claims themselves.

OIG has issued a report on its investigation of RPM use, which found suspicious patterns of "billing for a high proportion of enrollees who have no prior history with the medical practice" and "billing for multiple monitoring devices a month for an enrollee" at some practices. RPM centers around physiologic data, such as blood pressure and heart rate; RTM is about compliance and progress with therapy services.

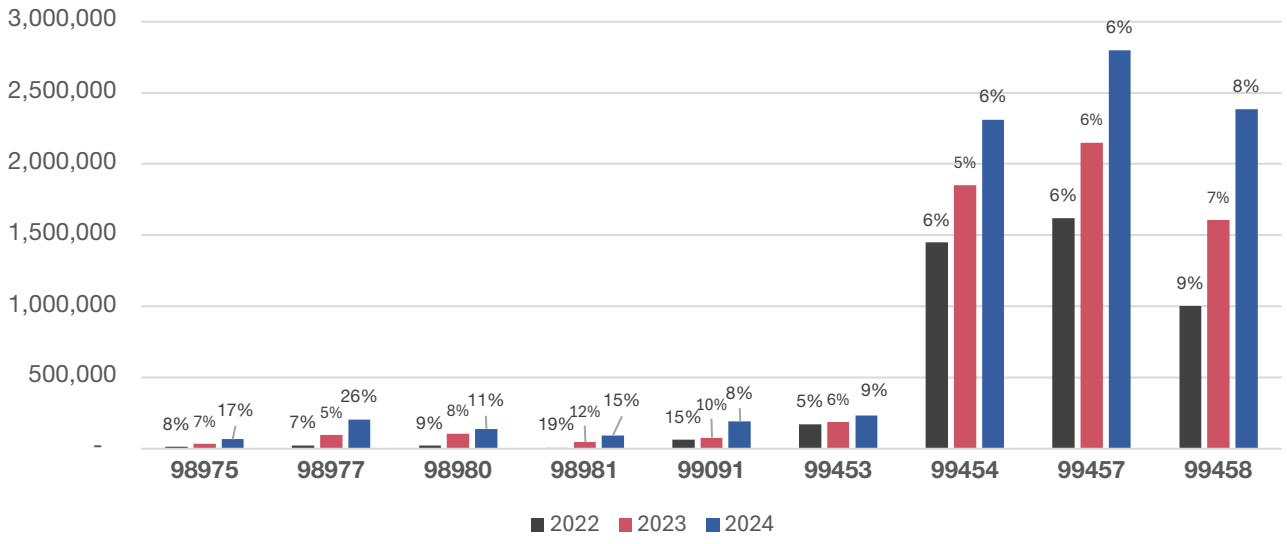
As you can see in the chart below that covers 2022-2024 Medicare claims data, the long-term upward trend in RPM and RTM services is holding fairly steady (*PBN 2/6/23*). In 2023, there was a 41% rise in use of these codes from the year prior; from 2023 to 2024, the lift was 37% (*PBN 10/21/24*). Providers reported the codes almost 2.4 million times in 2024, as opposed to a little over 1 million times in 2022.

But the change that really stands out is in denial rates for the RTM codes, with increases ranging from 3% for **98980** (first 20 minutes) and **98981** (additional 20 minutes) to 10% for **98975** (initial set-up and patient education on use of equipment) and a remarkable 21% for **98977** (Device[s] supply for data access or data transmissions to support monitoring of musculoskeletal system, each 30 days).

Denials for the RPM codes have been steady, and even decreased a few points in 2024 for **99091** (Collection and interpretation of physiologic data, each 30 days).

The most-used code-specialty combo for RPM is internal medicine and **99457** (first 20 minutes), with 741,141 claims; for RTM, it's internal medicine and 98977, with 78,774 claims. — *Roy Edroso* (*roy.edroso@decisionhealth.com*)

RPM and RTM codes, utilization and denial rates, 2022-2024



Source: Part B News *analysis of 2022-2024 Medicare claims data*

(continued from p. 4)

because maybe our hip or abdominal muscles are weak, and they tighten to stabilize the rest of the body. When you relax those muscles, everything starts to change."

Pelvic floor dysfunction is a condition where the muscles, ligaments and connective tissues that support the pelvic organs become weak, tight or impaired in some way. This leads to problems with pelvic floor function. Pelvic muscle rehabilitation is a non-invasive and conservative approach to managing pelvic floor dysfunction.

Strengthen coding accuracy

Some common ICD-10-CM diagnostic codes that pelvic floor therapy may be a treatment for are:

- **R10.30** (Lower abdominal pain, unspecified).
- **N39.46** (Mixed incontinence).
- **M54.50** (Lower back pain, unspecified).
- **R10.2** (Pelvic and perineal pain).
- **N94.1-** (Dyspareunia). Note: This code for painful sex can be used for females as it is a general classification for pain. Some insurance companies might not pay for it. Also, keep in mind that the code needs to be expanded for a more specific detail.

Pelvic floor therapy differs from other types of physical therapy that treat various body areas or illnesses. It targets mostly the muscles and underlying tissues in the pelvic area. In fact, physical therapists who provide it are required to complete additional training after completing their physical therapy degree. Studies have shown this therapy to be not only clinically effective but cost-effective as well.

Reeducating these important muscles can result in improved overall bladder function, as well as release from painful abdominal, C-section, hysterotomy and incontinence issues. It helps both males and females in relieving these painful body areas.

There are several benefits that pelvic floor physical therapy has to offer for individuals who are dealing with a form of pelvic floor dysfunction. Specialized treatment concentrates on enhancing the pelvic muscles, resulting in considerable health benefits. The main benefits are:

- Improvement of muscle strength and coordination, which enhances bladder and bowel control and lowers urine and fecal incontinence. Improved bladder and bowel control also betters muscle control and relaxation, resulting in a more fulfilling sexual encounter.
- Reduction of pain and discomfort with manual therapy and stretching.
- Support for postpartum recovery by restoring pelvic function.
- Early detection of suspected disorders, which can help reduce the likelihood of chronic illnesses.
- Posture and core stability improvement, which helps reduce back pain.
- Increased self-esteem, resulting in more active engagement in daily activities.

Through pelvic floor physical therapy, patients also become educated on anatomy and pelvic health, which encourages active participation in their rehabilitation process.

Capture CPT coding

Biofeedback training can be used in pelvic floor therapy and is billed with the appropriate CPT codes. Multiple CPT codes are used that fit the patients' care needs along with the standard therapy codes. Here is a detailed breakdown of the CPT codes:

- **90912** is used for billing the initial 15 minutes of one-on-one biofeedback training for perineal muscles, anorectal, or urethral sphincter. It includes EMG and/or manometry. Treatment must be by a licensed medical professional who specializes in pelvic floor rehabilitation and biofeedback therapy.
- **90913** is used to bill each additional 15-minute increment of biofeedback training, in conjunction with code 90912.
- **97161-97163** are used because, like all the other therapies, an evaluation is necessary. These evaluation codes range from low to moderate to high complexity.

When it comes to pelvic floor therapy, there is not just one CPT code that fits every scenario. Instead, therapists often combine multiple codes to accurately reflect the different components of a session. Here is a rundown of the most frequently used codes:

- **97110** (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to devel-

op strength and endurance, range of motion and flexibility) is used when patients perform muscle-strengthening activities focused on pelvic floor and core stabilization. Whether you are doing targeted Kegel exercises or integrated movements that activate the entire lower body, this code is likely in play.

- **97112** (Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities) is essential when retraining muscle movements and coordination. Pelvic floor therapy often taps into neuromuscular reeducation to improve muscle control and reduce dysfunction.
- **97140** (Manual therapy techniques, 1 or more regions, each 15 minutes) is for hands-on manipulation of soft tissue or joint mobilizations around the pelvic regions. Physical touch is vital for alleviating chronic pain and tension, which needs to be properly accounted for.
- **97530** (Therapeutic activities, direct [one-on-one] patient contact [use of dynamic activities to improve functional performance], each 15 minutes) is used to report one-on-one patient contact that enhances mobility, strength, coordination and activities of daily living (ADL). It differs from code 97110, which focuses on improving strength, range of motion and flexibility. Code 97530 is more specific in targeting functional performance improvements.
- **97535** (Self-care/home management training, direct one-on-one contact, each 15 minutes) is similar in some ways to 97530; it continues to help with ADLs and instructions in use of assistive technology devices/adaptive equipment.

Modifier **GP** (Services delivered under an outpatient physical therapy plan of care) would need to be used on all the codes.

It is important to note that the specific selection of codes depends on a thorough evaluation of the patient's condition as well as the treatment performed. In some instances, therapists might use more than one code in a single session to capture the full range of interventions needed.

What is the magic behind these codes? Essentially, they are the keys that unlock proper reimbursement, ensure documentation accuracy, and ultimately guarantee that your path to improved pelvic health is backed by both clinical precision and financial clarity.

Keep in mind that not all insurance companies recognize pelvic floor therapy as a form of physical therapy. That is the reason why some pelvic therapists choose to opt out of enrolling with health insurance companies. The good thing about this is that they are not limited to treating just one body area but can treat several. Like all therapists, their goal is to promote pain-free wellness by finding the triggers that promote pain. — *Beth Morgan, CPC, MCS-P* (pbnfeedback@decisionhealth.com) ■

Editor's note: *Beth Morgan CPC, MCS-P, is owner and president of Medical Bill Consultants LLC.*

Billing

After spike in payments, OIG seeks closer watch on remote monitoring

Payments for remote physiologic monitoring (RPM) services have skyrocketed under Medicare, surpassing $535 million in 2024. That's up from just $15 million five years earlier. As services spike, the HHS Office of Inspector General (OIG) is sending out a warning: we're keeping an eye on you.

In a data snapshot released in August, the OIG found that more than 1 million Medicare enrollees received some form of RPM services in 2024. More than 10,300 distinct medical practices billed traditional fee-for-service Medicare or Medicare Advantage for at least one RPM offering. That's according to the OIG, which examined claims from CY 2024, looking specifically at CPT codes **99091**, **99453**, **99454**, **99457** and **99458**.

In an effort to spot fraudulent claims, the OIG identified several measures to track utilization, including "billing for a high proportion of enrollees who have no prior history with the medical practice" and "billing for multiple monitoring devices a month for an enrollee." The former is important because medical groups must have an established relationship with a patient prior to offering an RPM service, while the latter measure might indicate double billing.

Of the more than 10,000 medical practices that reported at least some RPM services, the OIG found that about 4,600 practices "routinely billed" Medicare

for the services. On average, these frequent RPM utilizers provided services to 70 enrollees per year and added five new enrollees per month.

However, some medical practices stood out. More than 30 practices that the OIG reviewed saw at least a 150% growth rate in a single month, and one medical practice added more than 3,400 enrollees in a given month. These outliers are now officially on the OIG's radar, and other groups who are expanding RPM services should take note of the utilization patterns that the OIG is monitoring.

"While significant increases in billing may represent legitimate growth in a practice's uptake of remote patient monitoring, these types of spikes in billing have been a marker of fraud in other Medicare services," the OIG said in the report. "As such, they signal a need for further scrutiny."

The requirement of having an established relationship with a patient prior to launching an RPM arrangement appears to be a primary focus for the OIG.

The agency's review found that "45 medical practices ... did not have a prior medical relationship with more than 80 percent of the patients for whom they billed remote patient monitoring in 2024. In one example, a medical practice lacked a prior relationship with more than 30,000 enrollees. Further review of these medical practices is warranted."

The OIG expects RPM services to fluorish in the coming years, saying they have "the potential to greatly expand in the future." Practices expanding their offerings should monitor the OIG's warning shot. — *Richard Scott* (*richard.scott@decisionhealth.com*) ■

RESOURCE

- Billing for Remote Patient Monitoring in Medicare: *https://oig.hhs.gov/documents/evaluation/10901/OEI-02-23-00261.pdf*

Compliance

OIG: CMS should enforce post-op reporting data during global period

On August 27, the OIG published a report regarding global surgery data. CMS bundles all services associated with a surgical procedure under its global surgery policy, and it collects information on the number of post-operative visits for a typical patient to help set the valuation for these procedures.

This report examines global surgeries without any reported post-operative visits that were not covered by the congressionally mandated audit and assesses whether there were any post-operative visits included in the medical record and whether the global surgery valuation fee was accurate.

The OIG found that fewer post-operative visits are provided than the amount considered in the valuation. For 98 sampled global surgeries, the OIG found that CMS valued those fees considering a total of 133.5 post-operative visits, but practitioners only provided a total of 13 post-operative visits. The OIG estimates that for global surgeries included in the sampling frame, Medicare paid $7.8 million more and Medicare patients paid $4.8 million more than would have been paid if global surgery fees reflected actual utilization. CMS, however, does not use actual data when setting these rates and instead relies in part on practitioner surveys.

The OIG also found a large difference in the number of post-operative visits supported by patients' medical records and the number of post-operative visits reported to CMS. For nine global surgeries, there were a total of 24 unreported post-operative visits. The OIG attributed this difference to practitioners and office staff not properly billing CPT code **99024** for the post-operative visit.

The OIG recommends CMS confirm it is receiving Medicare postoperative visit data from practitioners that it expected would be reporting post-operative visits and notify any practitioners if no post-operative visits are reported, as the OIG said this report indicates that improvements to global surgery valuation are necessary. CMS concurred with the recommendation. — *HCPro staff* (*pbnfeedback@decisionhealth.com*) ■

RESOURCE

- OIG report: *https://oig.hhs.gov/documents/audit/10899/A-05-20-00027.pdf*

Have a question? Ask PBN

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email *askpbn@decisionhealth.com* with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.