

Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

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News Briefs

## Risk Mounts From Impossible Days; Documentation May Not Tell the Whole Story, Interviews Are Key

Impossible days have climbed the list of risk areas in the wake of 2021 changes to Medicare evaluation and management (E/M) coding guidelines. With more visibility into the hours that physicians spend on patient care, auditors have a better shot at finding what could be physician billing for impossible days.

Data mining alone won't prove impossible days. A review of documentation is also necessary, although auditors shouldn't take it at face value because the documentation may be misleading, experts say. These twists and turns create a challenging environment for oversight of potentially impossible days.

"We really started seeing Medicare focusing on this when it became trackable and that was when Medicare E/M changed in 2021," said Jodi Nayoski, senior compliance auditor at Scripps Health, a health system in San Diego, California.

### Total Time Is What Counts

New guidelines and code descriptors for outpatient and office visits (99202-99215) from the American Medical Association and CMS allow physicians to base their level of service on time alone and specified how many minutes are required for each code. Total time is now the magic phrase, and includes the minutes spent in both face-to-face time with the patient and non face-to-face time, such as reviewing diagnostic test results, as long as it all happened on the same day.

Documentation includes time statements and a description of the activities performed. The E/M guidelines were later extended to hospital visits.

"Physicians were like, 'Thank you so much. I can talk in my car about a patient

to another physician or log in at 4 a.m. and review medical records and count that,'" Nayoski said at the HCCA Compliance Institute April 30.

### 'Documentation Alone Isn't Enough'

As a result, more physicians and advanced practice providers (APPs) are documenting based on time versus medical decision making. "The fact you have chosen to bill them on time is what's ringing alarm bells," Nayoski explained. Although physicians may bill 40 patients a day at 99214 the same way they did pre-2021, auditors now can easily count up the minutes—e.g., 40 patients times 30 minutes is 20 hours—and raise questions about an impossible day. Whether that's the case depends on what's in the documentation.

"We don't want to make assumptions on the data alone," said Angie Paine, director of revenue cycle services at Pinnacle Healthcare Consulting.

Medicare uses the impossible-day concept to flag claims with an unusually high volume of patient encounters, diagnostic tests or procedures in one day, which could suggest overbilling, fraud or documentation errors. The description of an impossible day is when providers exceed "what's realistically achievable in a single work day" in the context of time constraints and quality of care, she said. Auditors will identify providers who bill impossible days through data mining and documentation, Paine noted.

"The billion-dollar question is, what actually makes a day impossible? The only answer is 24-plus hours," Nayoski said. The other options are improbable, highly unlikely or suspicious. "We have to

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dig to try and figure out what the number is. It's different for every provider," she said. "You can have superstar providers who are working 18 hours a day consistently and some who started on paper charts and say, 'I can't be doing this anymore.'"

Complicating matters, documentation doesn't necessarily mean the physician is home free. "The documentation alone isn't enough anymore," she noted. "We could have a doctor who documents 40 minutes on every inpatient but that adds up to 25 hours," Nayoski said. "We are at a point where you can't say if it's documented, it's all good."

There are too many ways for documentation to go awry, including templates and copy/forward. "There's a risk with documentation generated very quickly with AI," Nayoski said. She saw this personally when viewing her portal after seeing a physician. "You spent 40 minutes with me? No, you did not," Nayoski recalled. "Patients are becoming much more savvy than they have been in the past because we're giving them the information. We see a lot of patient complaints come through because they can say, 'That didn't happen.'"

### Several Settlements for Impossible Days

Impossible days have cropped up in several settlements. For example, IPC Hospitalists of Michigan Inc., Inpatient Consultants of Michigan P.C., IPC Healthcare f/k/a IPC The Hospitalist Company and Team Health Holdings Inc. agreed to pay \$4.384 million to settle false

claims allegations that they upcoded inpatient hospital services, "allowing their doctors to bill for more services than they could possibly provide in one day, and billing for services not rendered," the U.S. Attorney's Office for the Eastern District of Michigan said.<sup>1</sup> The settlement was set in motion by two whistleblower lawsuits.

Also, in 2024, New Jersey physician Arun Sehgal and his practice, Preventive & Diagnostic Medical Center P.A., agreed to pay almost \$700,000 to settle false claims allegations they upcoded physician services, billed for impossible days and billed for services the physician never provided, the U.S. Attorney's Office for the District of New Jersey said.<sup>2</sup> For example, the time associated with CPT codes billed by the defendants for services provided by Sehgal on March 2, 2018, exceeded 43 hours.

And the risk isn't just about original Medicare, Paine said. "It's Medicare and Medicaid and commercial plans."

### Auditing for Potential Impossible Days

There are various ways to identify potentially impossible days. In her daily audit plan, Nayoski audits five charts for the 10 providers who code the most level-five visits. If three of them, for example, have the same time statement for every patient, "they get put on my list to dig in for an impossible day."

She recommends using dashboards to identify possible impossible days (see box, p. 4).<sup>3</sup> But dashboards are only as good as the data they're based on. A common error involves incident-to and split/shared billing. If the service provider isn't entered correctly or it's not transmitted on the claim directly, the payer sees "a ton of services on a single day by a single provider and it's not adding up," Nayoski said.

Dashboards require the use of IT and "a good data scientist. We have one of the finest at Scripps," she said. For example, the data scientist creates dashboards so Nayoski can see which provider has the highest number of relative value units (RVUs) on any given day. "We take this dashboard and then dig into the top provider and sort it by RVUs and E/Ms," she said. If a physician has a higher level of RVUs but is billing only level three E/Ms, Nayoski isn't worried. But if a physician has a high level of RVUs, and level threes and fours plus a few new patient visits, "you might want to look into it."

It's better to review a "big range" of RVUs based on the type of specialist, "so we don't get a provider who just had a wacky day."

### 'One of the Most Fascinating Experiences'

Time studies are another auditing strategy, Paine said. They start with a documentation review "because

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we want to see if what's being said is tracking in the notes," she explained. If a time statement is contradictory or causes an impossible day, "you may have a problem."

With time studies, Paine follows providers from room to room and location to location and documents what they're doing. If access to the patient's room is a no-go, another option is to sit in the physician's "bullpen and watch them go in and out and see what activity they're doing."

Sometimes an auditor may find a physician is working crazy hours, but they're not impossible days. In a previous job, Nayoski did a time study of three critical care intensivists facing allegations that they performed too many services in a day. "For seven days, we followed them around," she said. Everything was tracked, including conversations with nurses and time spent in patient rooms.

"It was one of the most fascinating experiences because here are three individuals fighting for their lives, saying 'I can bill a level three subsequent visit in a quick two or three minutes.' They were so efficient and worked a ton of hours—18 to 19 hours a day." It showed that very long hours aren't necessarily a sign of errors or wrongdoing.

Unlike time studies, Nayoski takes time stamps in medical records with a grain of salt. They're often added during the last half hour of the day. The same goes for physician signatures. "It's not reliable because they can sign all their notes at the end of the day."

Schedules also are breadcrumbs to an impossible day, with a caveat. "Looking at schedules is something I do as part of my investigations," Nayoski said. For example, if a physician has scheduled 80 patients for a two-hour period of time, "It's a good data point." But a schedule may not always be a reliable narrator. A physician may have 15-minute time slots, which should mean four patients an hour, "but we see 10 on the schedule," she said. Does it necessarily mean the physician hasn't seen all 10 patients? "Maybe he extended his day or maybe the nurse practitioner saw some of them and they were doing incident to."

Templated statements are another red flag. A physician may repeatedly report spending 40 minutes with patients, using the same phrases. "We're at the point where we have to justify those words. We used to be able to get away with saying, 'I spent greater than 50% of the time counseling and coordinating care'" but that's not the case anymore.

### **'The Interview Is Really Key'**

Interviews with a physician or APP suspected of an impossible day also are critical. In one situation, Nayoski interviewed a physician who billed for more

than 24 hours of services in one day. In his defense, the physician said he spent the time in a combination of seeing patients and looking at their medical records.

But the electronic medical record (EMR) system told a different story. Nayoski explained to the physician that she could tell from the EMR logins that he hadn't viewed the medical records before the patient encounter. The physician then said he printed them out the night before and took them home to review them. Again, it was apparent from the EMR that wasn't true. "I see nothing printed on this patient," she told the physician. "Also, you're printing out medical records and taking them home? Now we have a privacy problem."

### **Reviewing Time Through Other Lenses**

Other options for checking the veracity of the services are parking swipes and terminal logins. How long were the physicians at the location and logged into terminals? "What I found was I had some providers who easily fell out of range by time," Nayoski explained. Some are very talented physicians who may be able to bill 24 hours a day, but "I don't want those claims out there."

If that happens, Scripps Health rebills the services with medical decision making mixed in. Behind the scenes, she takes one-third of the CPT time (e.g., 10 of 30 minutes) and allocates it to the visit. "Then I can also add in some time for visits that the physician had where they billed based on medical decision making."

Auditing for impossible days when the provider only bills based on medical decision making requires far more diligence, she noted. "How did they do 80 99214s in a four-hour appointment window? That can take more time."

### **'Creating a Culture of Impossible Days?'**

Organizations also should look at whether they have a system set-up issue, Paine said. "Some providers don't realize the time statement was being added to their notes," she explained. "A lot of our EMR systems put updates in that change things and we don't know it until we do an audit of the system." Examples include incident-to and split/shared billing, Paine said. "Let's deep dive into the system and make sure that's not the root cause of an impossible day."

As part of the remedy to impossible days, compliance professionals should consider the culture of the organization, Nayoski said. Are physicians pressed to reach a level of productivity to get a bonus? "You could be creating a culture of impossible days."

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**Endnotes**

- 1 U.S. Department of Justice, U.S. Attorney’s Office for the Eastern District of Michigan, “Hospitalist Companies Agree To Pay Nearly \$4.4 Million To Settle False Claims Act Allegations,” news release, October 17, 2023, <https://bit.ly/4dvUwJq>.
- 2 U.S. Department of Justice, U.S. Attorney’s Office for the District of New Jersey, “Doctor to Pay Nearly \$700,000 to Resolve False Claims Act Allegations,” news release, February 22, 2024, <https://bit.ly/4wUcbll>.
- 3 Nina Youngstrom, “Sample Dashboard to Identify Potentially Impossible Days,” *Report on Medicare Compliance* 35, no. 20 (June 1, 2026).

**HHS Will Review Single Audits With AI Tool; ‘It’s Going to Be a Beast’**

In a variation on the Trump administration’s crushing fraud theme, HHS said May 21 it will take another pass at audits of healthcare organizations that spend at least \$1 million of federal money. The new Audit Enforcement and Risk Oversight (AERO) initiative will use AI agents to review five years of funding that has already faced a so-called single audit and evaluate whether organizations have followed through on audit findings.<sup>1</sup>

**Sample Dashboard to Identify Potentially Impossible Days**

Here’s an example of a dashboard (with fictional data) that helps Scripps Health in California detect potential billing for impossible days, said Jodi Nayoski, senior compliance auditor (see story, p. 1).<sup>1</sup> Impossible days have climbed the list of risk areas in the wake of 2021 changes to Medicare evaluation and management (E/M) coding guidelines. With more visibility into the hours that physicians spend on patient care, auditors have a better shot at finding what could be billing for impossible days. For example, the dashboard shows which provider has the highest number of relative value units (RVUs) and the number of services billed at each E/M level on any given day. “We take this dashboard and then dig into the top provider and sort it by RVUs and E/Ms,” she said. Contact Nayoski at [nayoski.jodi@scrippshealth.org](mailto:nayoski.jodi@scrippshealth.org).

Service Date		Medical Group	Medicare Specialty Name	EM Code Group								
Service Date		All	All	All								
6/4/2025	6/30/2025											
Service Date	Medicare Specialty	EM Code wRVUs	Units	99202	99203	99204	99205	99211	99212	99213	99214	99215
1/9/2025	Hematology	93.5	55	1	1				2	33	18	
7/30/2025	Orthopedic Surgery	91.8	54		6	1				36	11	
6/27/2025	Hematology-Oncology	90.1	53		7				6	12	28	
7/30/2025	Medical Oncology	90.1	53		4	2			7	20	20	
2/19/2025	Orthopedic Surgery	88.4	52			1				23	28	
7/15/2025	Family Practice	88.4	52			4				27	21	
10/2/2025	Hematology	88.4	52			3			1	24	24	
7/25/2025	Neurology	88.4	52	1	4	1			1	19	25	
9/17/2025	Hematology-Oncology	88.4	52							25	27	
11/19/2025	Orthopedic Surgery	88.4	52			3			1	21	26	
12/19/2025	Neurology	86.7	51	2	6	1				17	25	
12/31/2025	Orthopedic Surgery	86.7	51		8	4			7	12	20	
5/29/2025	Medical Oncology	85	50		4	3			3	13	27	
10/1/2025	Neurology	85	50	1	4	1			2	13	29	
11/10/2025	Family Practice	83.3	49	2	4	3			1	11	27	
7/31/2025	Ophthalmology	83.3	49			5				20	24	
8/19/2025	Ophthalmology	83.3	49			4				19	26	
10/30/2025	Dermatology	83.3	49		10	6		1		15	17	
11/6/2025	Ophthalmology	83.3	49							17	32	
6/4/2025	Ophthalmology	83.3	49			2				20	27	
10/1/2025	Ophthalmology	83.3	49			1				19	29	
2/25/2025	Ophthalmology	83.3	49			3				22	24	
7/23/2025	Dermatology	83.3	49		6	1			2	14	25	
8/20/2025	Ophthalmology	83.3	49							19	30	

**Endnotes**

- 1 Nina Youngstrom, “Risk Mounts From Impossible Days; Documentation May Not Tell the Whole Story, Interviews Are Key,” *Report on Medicare Compliance* 35, no. 20 (June 1, 2026).

AERO raises questions about both the duplicative nature of the audits and their use of unknown AI methodology, said attorney Stephen Bittinger, with Polsinelli. “The whole process is pretty unprecedented,” he contends.

HHS said it will deploy AERO to “hold states and grantees accountable for persistent audit noncompliance.” Hospitals and other organizations that have received money from Medicaid, National Institutes of Health grants and the Health Resources and Services Administration, as well as pandemic relief funds, disproportionate share payments and graduate medical education, are “directly affected,” Bittinger said. AERO focuses on the Single Audit Act, which requires recipients of federal financial assistance that spend more than \$1 million in federal funds per year to conduct audits and report their results to HHS.

### **HHS: Some Audits Are Two Years Overdue**

The audits, which have financial and compliance components, are usually performed by independent auditors on the recipient’s behalf. Virtually all health systems are required to do single audits annually, which makes them AERO targets, Bittinger said.

“The wild thing is this is just a *carte blanche* statement that ‘we will re-review with an AI agent everything [audited] in the past five years,’” he asserted.

According to HHS, the Office of the Assistant Secretary for Financial Resources is analyzing single audit information in all 50 states, stretching back as far as five years.

Hundreds of grantees haven’t given HHS their audits, and some are two years overdue. Previous enforcement in this area hasn’t prompted meaningful compliance, which puts federal dollars at risk of fraud, waste and abuse, HHS contends. “Initial findings reveal states and grantees have consistently failed to remedy serious internal control issues, with some persisting for three, four, or even five or more years.”

HHS also is reviewing whether audits are performed with enough rigor to identify vulnerabilities.

### **‘It’s Going to Be a Beast’**

Bittinger is alarmed by several aspects of AERO. For one thing, the funding will be reviewed by a contractor using an AI agent that healthcare organizations have no visibility into. For another thing, it’s a second review of the same funding. “You already had a first bite at the apple,” Bittinger noted. “You concluded a resolution on some kind of review or completed the process and got the funds, and now we have an AI agent that’s apparently independently re-reviewing everything.”

AERO will strain academic medical centers and other health systems, Bittinger said. “It’s going to be a beast because you will have to come armed with an AI and algorithmic specialist. You have to learn how to fight fire with fire.”

With the AI tool an unknown commodity, Bittinger suggests hospitals file Freedom of Information Act (FOIA) requests before they respond to AERO audits. The FOIA requests should seek information on the AI methodology, validation studies and federal approval records, he said. The information that hospitals glean from FOIA requests could expose weaknesses in possible enforcement actions.

AERO also shows “a complete and utter disregard for due process,” Bittinger said. Under the Administrative Procedure Act, the government is required to disclose its rationale. “That’s due process 101,” he said. “If you’re going to take my money, you need to tell me why and show me the evidence” supporting the takebacks. To him, AERO “screams arbitrary and capricious.”

### **Risk of Payment Withholds, Suspensions**

If HHS determines that recipients of federal funds don’t address findings identified in audits, it may take action against them. That could include:

- ◆ “Temporarily withholding payments until the recipient or subrecipient takes corrective action;
- ◆ “Disallowing costs for all or part of the activity associated with the noncompliance of the recipient or subrecipient;
- ◆ “Suspending or terminating the award in part or its entirety;
- ◆ “Initiating suspension or debarment proceedings as authorized in 2 CFR part 180 and the Federal agency’s regulations, or for pass-through entities, recommending suspension or debarment proceedings be initiated by the Federal agency;
- ◆ “Withholding future federal funds (new awards or continuation funding) for the project or program; and/or
- ◆ “Pursuing other legally available remedies.”

HHS said it has notified all state governors that states with continued noncompliance will hear more from HHS in coming weeks.

### **DOJ Ups the Whistleblower Ante, Again**

In another fraud-related development, the U.S. Department of Justice (DOJ) said May 27 it will prioritize False Claims Act (FCA) lawsuits filed by whistleblowers who allege benefits fraud. A memo from Brett Shumate, assistant attorney general of the DOJ Civil Division,

said to the extent possible, DOJ will finish reviews of whistleblower lawsuits alleging fraud in federally funded benefits administered by states (e.g., Medicaid, food, housing) within 60 days.<sup>2</sup>

After its review, DOJ said it will make one of the following decisions: allow the whistleblower to continue its FCA lawsuit, subject to government control; conclude the allegations merit more government investigation; or dismiss the complaint.

When deciding if the relator should go ahead with its case, DOJ will consider, among other things, whether the allegations amount to an FCA violation, are supported by information (e.g., data analytics or insider intelligence) and relate to misconduct that isn't "novel or complex."

"When electing to allow a relator to quickly proceed to litigate a new benefits fraud matter, Department attorneys should communicate that it is the Department's expectation that the whistleblower and his counsel will be prepared to shoulder the obligations of the litigation," the memo states.

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## Endnotes

- 1 U.S. Department of Health and Human Services, "HHS Cracks Down on Years of Unchecked Audit Findings," news release, May 21, 2026, <https://bit.ly/4vaO3JO>.
- 2 U.S. Department of Justice, Civil Division, "Accelerating Review and Enhancing Enforcement in Benefits Fraud Matters," memorandum, May 27, 2026, <https://bit.ly/3RzQpDC>.

## OIG OKs Free Cancer Reports; Opinion Is Seen More as 'Policy Analysis'

Legal judgments seem to take a back seat to policy considerations in a new HHS Office of Inspector General (OIG) advisory opinion, an attorney said.<sup>1</sup> OIG greenlit an arrangement in which a lab adds a free report on a patient's risk of other cancers to results of a colon cancer screening test covered by Medicare.

"This is much more of a policy analysis," said attorney Jeff Fitzgerald, with Polsinelli. "It gives some helpful insight into how OIG looks at some of these issues, which is different than strict legal standards of what's a kickback or in a safe harbor."

But a physician sees OIG's approval as a slippery slope to more cancer screening that may be risky, expensive and unnecessary. "It's opening a Pandora's box that may be harmful to patients, providers and our healthcare system," said Ronald Hirsch, M.D., vice president of R1 RCM.

In the advisory opinion, which was posted May 20, OIG weighed in on a precision oncology company's arrangement. The company, which is the requestor, offers a proprietary blood-based biomarker test for colorectal cancer (CRC) screening. The test, which has been approved by the Food and Drug Administration (FDA), is typically ordered by a primary care physician and covered by Medicare every three years.

The company also developed an algorithmic analysis that flags risks for other cancers at the same time. The algorithm is run on the same blood sample used for the CRC test. "The Algorithm is part of an investigational assay under development for submission to the FDA as an in vitro diagnostic medical device" (MCD test), OIG explains. The MCD test generates information on detecting bladder, breast, colorectal, esophageal, gastric, liver, lung, ovarian, pancreatic and prostate cancers.

### Company Doesn't 'Actively Market' MCD Test

The MCD test got an FDA breakthrough device designation last year, but FDA approval is necessary for coverage by Medicare and other payers as a stand-alone test. For now, the requestor is offering the MCD test as "optional, medically relevant additional information in connection with orders for the CRC Screening Test."

There aren't any screening tests recommended by the U.S. Preventive Services Task Force for six of the cancers detected by the MCD test.

The arrangement calls for the requestor to give consenting patients a free supplemental report on the MCD test results in addition to the primary results from the CRC screening test. To get the supplemental report, the patient must have an order from a physician who isn't affiliated with the requestor and the physician must opt in to get the results.

The requestor said it doesn't "actively market" the supplemental report as a benefit to providers, although it's available to physicians. When the requestor initially launched the arrangement, it sent emails to ordering providers that the supplemental report was available and explaining how to opt in.

Otherwise, the requestor is low-key. For example, it doesn't do direct-to-consumer advertising or promotional activities for the supplemental report and tells ordering physicians not to post about it on social media.

### OIG: Risk of Fraud and Abuse Is Low

In its opinion, OIG said the arrangement could violate the Anti-Kickback Statute (AKS) and civil monetary penalty law prohibiting beneficiary inducements and isn't immunized by any safe harbor. But the risk of fraud

and abuse is “sufficiently low,” OIG said, so it gave the arrangement a pass for several reasons.

For one thing, the arrangement probably won’t cause inappropriate utilization, partly because the supplemental report is only available to patients who are eligible for the Medicare-covered CRC screening test and have a valid order for it, OIG said. The MCD test isn’t separately reimbursable. “While it is possible that a positive result

of either the CRC Screening Test or the MCD Test could generate a follow-up appointment with the ordering provider (or referrals to other providers), any such appointments or referrals would be based on the clinical information included in the test results and would not be inappropriately caused by the Arrangement,” OIG contends.

Second, OIG doesn’t think the arrangement will “skew clinical decision-making.” Various factors affect the decision

## **CMS Transmittals and Federal Register Regulations, May 15-28, 2026**

### **Transmittals**

#### **Pub. 100-04, Medicare Claims Processing**

- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Updates for Shared System Edits for Category II Codes, Care Coordination Services and Revisions to the Internet Only Manual (IOM) Publications (Pub.) 100-04, Chapter 9, Trans. 14,452 (May 28, 2026)
- NCD 20.40- Renal Denervation (RDN) for Uncontrolled Hypertension, Trans. 13,802 (May 28, 2026)
- NCD 20.38 - Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (TTEER), Trans. 13,801 (May 28, 2026)
- NCD 20.37 - Transcatheter Tricuspid Valve Replacement (TTVR), Trans. 13,800 (May 28, 2026)
- Updates to Publication 100-04, Chapter 4, Section 250.3.3.1 and 250.18 of the Internet Only Manual (IOM) for Critical Access Hospital (CAH) Line Level Rendering Providers, Trans. 13,799 (May 28, 2026)
- Quarterly Update to the End Stage Renal Disease Prospective Payment System (ESRD PPS), Trans. 13,770 (May 28, 2026)
- October 2026 Healthcare Common Procedure Coding System (HCPCS) Quarterly Update Reminder, Trans. 13,784 (May 27, 2026)
- New Physician Specialty Code for Physician Nutrition Specialist (F7), Trans. 13,765 (May 27, 2026)
- Combined Common Edits/Enhancements Modules (CCEM) Code Set Update, Trans. 13,790 (May 27, 2026)
- Claims Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), Medicare Remit Easy Print (MREP), and PC Print Update, Trans. 13,791 (May 27, 2026)
- File Conversions Related to the Spanish Translation of the Healthcare Common Procedure Coding System (HCPCS) Descriptions, Trans. 13,723 (May 27, 2026)
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2026 Update, Trans. 13,777 (May 27, 2026)
- Annual Updates to the Prior Authorization/Pre-Claim Review Federal Holiday Schedule Tables for Generating Reports, Trans. 13,786 (May 20, 2026)

#### **Pub. 100-08, Medicare Program Integrity**

- Updates of Chapters 4 and 8 in Publication (Pub.) 100-08, Including Updates to the Existing Payment Suspension Process Guidance, Trans. 13,762 (May 27, 2026)

#### **Pub. 100-20, One-Time Notification**

- Send ‘Reason for Denial’ Value in Prior Authorization Data to the Integrated Data Repository (IDR), Trans. 13,798 (May 28, 2026)
- Fiscal Intermediary Shared System (FISS) - Modify the Expert Claims Processing System (EPCS) to Process More Than 10 Medical Policy Reason Codes, Trans. 13,730 (May 27, 2026)
- Billing of Distant Site Telehealth Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), Trans. 13,776 (May 27, 2026)
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)- October 2026, Trans. 13,792 (May 26, 2026)

#### **Pub. 100-05, Medicare Secondary Payer**

- Creating Additional Medicare Secondary Payer (MSP) Error Codes to Better Identify Incoming MSP Claims that Conflict with MSP Records Found on the Common Working File (CWF), Trans. 13,783 (May 27, 2026)
- Update the International Classification of Diseases, Tenth Revision (ICD-10) 2027 Tables in the Common Working File (CWF) for Purposes of Processing Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Records and Claims, Trans. 13,782 (May 20, 2026)

#### **Pub. 100-03, Medicare National Coverage Determinations**

- Cardiac Contractility Modulation (CCM) for Heart Failure (HF), Trans. 13,806 (May 28, 2026)
- NCD 20.40- Renal Denervation (RDN) for Uncontrolled Hypertension, Trans. 13,802 (May 28, 2026)
- NCD 20.38 - Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (TTEER), Trans. 13,801 (May 28, 2026)
- NCD 20.37 - Transcatheter Tricuspid Valve Replacement (TTVR), Trans. 13,800 (May 28, 2026)

#### **Pub. 100-19, Demonstrations**

- Transforming Episode Accountability Model (TEAM) Telehealth Waiver – Implementation, Trans. 13,778 (May 19, 2026)

### **Federal Register**

#### **Final Rules**

- Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program, 91 Fed. Reg. 29,526 (May 20, 2026)
- Authority of Drug Enforcement Administration Supervisory Diversion Investigators, Field Intelligence Managers, and Intelligence Group Supervisors To Sign and Issue Administrative Subpoenas, 91 Fed. Reg. 29,897 (May 21, 2026)

#### **Notices**

- Medicare, Medicaid, and Children’s Health Insurance Programs: Announcement of Nationwide Temporary Moratorium on Enrollment of Hospices, 91 Fed. Reg. 27,946 (May 15, 2026)
- Medicare, Medicaid, and Children’s Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Home Health Agencies (HHAs), 91 Fed. Reg. 27,954 (May 15, 2026)

#### **Proposed Rule**

- Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments, 91 Fed. Reg. 30,400 (May 22, 2026)

#### **Proposed Rule, Correction**

- Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes; Correction, 91 Fed. Reg. 30,269 (May 22, 2026)

to order a CRC test, including the patient's willingness to take it, and the requestor said it isn't paying physicians for ordering the CRC or MCD test. The requestor also discloses limitations on cancer detection by the MCD test.

Third, OIG doubted the arrangement will "inappropriately result in steering or unfair competition." Although the supplemental report is only available to patients who have the requestor's CRC test, the requestor's lab is the only one that performs it. "Therefore, any time an enrollee selects the CRC Screening Test, the enrollee also selects Requestor's laboratory, even in the absence of the Arrangement," OIG said. Also, the requestor doesn't market the supplemental report as a benefit to providers or advertise it directly to consumers.

### Attorney: Opinion Provides a Checklist

The advisory opinion was welcome as a window into OIG's thinking independent of "strict legal standards," Fitzgerald said. "It read as a crisp, check-the-box exercise. It goes through this checklist" of whether the arrangement would potentially cause inappropriate utilization, skewed clinical decision making and unfair competition.

Although the arrangement raises questions about whether there's remuneration from the free supplemental report, OIG "skipped that thinking," Fitzgerald noted.

OIG also didn't draw a line between an AKS analysis and a beneficiary inducement analysis, Fitzgerald said. "They kind of squished the two together and apply a

three-part test. Their analysis here is, 'We don't see a bad policy outcome and therefore we are going to approve that.'"

### Physician: Risk of Adverse Patient Outcomes

Hirsch sees a downside to OIG's opinion. Inducements may not be as much of a concern as "the downstream effects of having patients receive a test that has no proven validity" and isn't FDA approved. "Two things can happen: every test is negative or someone has a positive test and needs further testing. There's very little chance everyone will come out clean on all these tests," he said.

Patients who get positive results from the MCD tests may then have additional testing that's risky and expensive, such as biopsies of internal organs.

"We have a structure for getting new tests and procedures reviewed and approved and to allow these results to be released to patients without any of that" is "dangerous," Hirsch said.

Patients also may be on the hook for them, he noted. Most screening tests aren't covered, putting physicians in the uncomfortable position of trying to code for a potential diagnosis indicated by the MCD test.

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### Endnotes

- 1 Office of Inspector General, U.S. Department of Health and Human Services, "OIG Advisory Opinion No. 26-11 (Favorable)," May 15, 2026, <https://bit.ly/4v6S2am>.

## NEWS BRIEFS

◆ **CMS and other federal agencies have finalized a rule on the federal independent dispute resolution (IDR) process under the No Surprises Act (NSA).**<sup>1</sup> The NSA protects people who have group and individual health plans from getting surprise medical bills for most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. Providers and payers are required to negotiate payments for out-of-network services, leaving the patient out of the equation. The NSA created the IDR process to resolve payment disputes between providers and payers, but it has been the source of great friction and the subject of multiple lawsuits. CMS said the new rule will improve the IDR process.<sup>2</sup> Among other things, CMS and the other departments (e.g., the Department of Labor) now require payers to use claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs)

when they provide a paper or electronic remittance advice to an entity that doesn't contract with the payer.

◆ **HHS said May 18 it has reorganized its Office for Civil Rights (OCR).**<sup>3</sup> "The reorganization returns OCR to a program-based structure that aligns OCR's three critical substantive areas with three distinct subject-matter divisions: the Conscience and Religious Freedom Division, the Civil Rights Division, and the Health Information Privacy, Data, and Cybersecurity Division."

### Endnotes

- 1 Centers for Medicare & Medicaid Services, "Federal Independent Dispute Resolution Operations," CMS-9897-F, 88 Fed. Reg. 88494 (December 21, 2023), <https://bit.ly/3RBjj6k>.
- 2 Centers for Medicare & Medicaid Services, "Federal Independent Dispute Resolution Operations Final Rule," fact sheet, May 28, 2026, <https://go.cms.gov/4dOTfvU>.
- 3 U.S. Department of Health and Human Services, "HHS Announces Restructuring of its Office for Civil Rights," news release, May 18, 2026, <https://bit.ly/4vhxKeq>.