Report on
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Contents

Health System Settles Case Over E/M Levels, Modifier 25; Diagnoses Are Key to Downcoding

Evaluation and management (E/M) levels of service and modifier 25—two compliance perennials—are at the heart of an academic health system's settlement with the HHS Office of Inspector General (OIG). It comes on the heels of potential E/M downcoding by Cigna Healthcare and apparently other commercial payers, highlighting the continued risk in this area. Cigna said it will downcode professional services based on claims information, including diagnosis codes, without reviewing medical records, which ups the ante for physicians to be as precise as possible when reporting diagnoses, experts said.

According to OIG, The University of Texas Health Science Center at Houston (UTHSC) agreed to pay $390,853 for allegedly violating the Civil Monetary Penalties Law.[1] OIG alleged that UTHSC submitted claims for levels four or five E/M services when a lower level of service was performed by a physician. UTHSC also allegedly billed for E/M services provided by a physician "when he only performed a procedure during the visit and, in fact, no separately identifiable, medically necessary E/M services were provided," OIG said. That points to potential noncompliance with modifier 25 requirements. UTHSC didn't respond to *RMC*'s requests for comment on the settlement, which stemmed from UTHSC's self-disclosure to OIG.

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Minefields Lurk in ED Call, Other Administrative Compensation; Avoid Journal Club Payments

When physicians attend a so-called journal club, where they have wine and cheese with other physicians and jaw about journal articles and other developments, they're doing something valuable—but it probably doesn't count as a service that hospitals would pay for under an administrative services agreement.

"I believe there's a certain level of responsibility any professional has to stay current, and journal club is that," said Joe Aguilar, managing partner at HMS Valuation Partners. "You are using that to the betterment of your own performance as a physician. It's not an administrative role you should get paid for." There are plenty of other reasons to hire physicians for administrative services, but it's hard to defend hospital payments for journal clubs. "That's one I would take off the list," he noted, although nothing is black and white.

Considering the extraordinarily large volume of their agreements with physicians—for emergency call, medical directorships and other administrative services—hospitals are at risk of allegations they're paying for too many or too much with the ulterior motive of inducing or rewarding referrals. According to a 2024 Gallagher survey of 213 health care organizations, 5,473 physicians were either medical directors or had graduate medical education positions, Aguilar said at HCCA's Physician Practice Compliance Conference Oct. 28. And dollars can rise fast between the median percentile of compensation and the 75th percentile. For example, 2024 data from the Medical Group Management Association shows the 50th percentile for a trauma surgery medical

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directorship was $59,000, the 75th percentile was $139,670 and the 90th percentile was $285,000.

Paying physicians for certain administrative services "is a necessary cost you have to incur," Aguilar said. But hospitals walk a tightrope because they have to keep physicians happy without running afoul of the twin hallmarks of the Stark Law and Anti-Kickback Statute: fair market value and commercial reasonableness. Some hospitals allegedly have dropped the ball in this area, settling cases that allege payments for on-call coverage and administrative services were excessive. For example, Ascension St. John Medical Center in Oklahoma agreed to pay $556,717 to settle allegations that it paid remuneration to a group of referring physicians "in the form of above-fair market payments for on-call services for general surgery and trauma surgery," according to its settlement with OIG, which was obtained through the Freedom of Information Act.

"You can see a theme here," Aguilar said. Are services necessary? Are physicians providing genuine administrative services? If so, are they documented? "As OIG has gotten wind of this, medical directors are one of the forms of compensation that will be closely looked at over the next five years," he noted.

Availability Is Main Driver of Call Payments

Complexity is an understatement when it comes to hospital payments to physicians for being on call to the emergency department (ED). Although call coverage is necessary for compliance with the Emergency Medical Treatment and Labor Act, hospitals should tread carefully with the level of coverage and payments for it. Several variables affect how much hospitals can pay without running afoul of fraud and abuse laws, with availability the dominant feature, Aguilar said. Physicians are paid for being available and, if necessary, seeing the patient at the hospital, although physicians are still free to bill the patient's payer for services provided, Aguilar said. But a physician can only be available to the ED one time per shift.

Another feature is payer mix, with the patient's insurance affecting reimbursement. "Call pay often gets looked at as an opportunity cost," he said. Gastroenterologists (GIs), for example, may think to themselves, "why would I take a GI call from the hospital when I could stay in the endoscopy suite and see more patients and get paid more?" An answer came from an OIG advisory opinion, which said the value of call should be tied to the services provided, not necessarily the opportunity cost, Aguilar explained. But it's not an absolute. If the call lasts for eight hours because the patient takes a turn for the worse—and the physician isn't fully reimbursed by the payer—value can be attributed to the call because the physician has to be on-site the entire time. In other words, hospitals may increase payment for call coverage when physicians have "restricted coverage"—they're unable to perform other services during call that they could charge to payers.

He also noted that call rates are affected by whether the physician is a W-2 employee or 1099 independent contractor. Because 1099 physicians don't receive benefits, the hospital may be able to pay a higher rate.

"It comes up many times where the physicians would say, 'I hear these other cardiologists at an independent group get paid more for call than we do. It doesn't seem fair,'" said Jaime Bailey, director of market institutes at Novant Health. "You need to remind them that employed physicians get a different rate." A prime reason: They're shielded from collections.

The Challenge of Concurrent Call Rates

It may seem more like an art than a science when it comes to calculating concurrent call rates. Suppose a health system requires cardiology ED coverage at two of its hospitals and one physician could provide both. Hospital A's call rate is $1,000 per shift and Hospital B's call rate is $750. Would the appropriate rate be $1,750? Not necessarily, Aguilar said, because covering both hospitals yields efficiencies. "The physician can't be available twice," he noted. "You only pay for the availability once." Should it be $1,375—the sum of the highest rate from one hospital plus half from the other? The answer is, it depends. The number should reflect the value of availability once in

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addition to the value associated with the call burden, case mix and payer mix, he explained. "That will avoid the potential for double dipping."

In a similar vein, suppose Dr. Jones takes interventional cardiology call coverage at two local hospitals. One hospital pays the doctor $1,200 for every 24-hour shift and the other forks over $1,700—both amounts at the upper end of fair market value. What accounts for the disparity? It's possible one of the hospitals is a county hospital and the other a suburban hospital, with the county hospital a level one trauma center, which results in more complex patients presenting at its ED, Aguilar said. "Another aspect is the sheer volume of cases," he noted. The on-call physician may need to show up for 10 emergent cases per shift at the county hospital, while a phone conversation suffices for most patients at the suburban hospital. Also, a patient at the county hospital who requires an appendectomy, for example, may not have insurance, while the suburban hospital has more patients with commercial insurance. "It will be the same appendectomy, but your reimbursement can be very different," Aguilar noted.

Call-coverage agreements aren't one and done. Bailey suggests revisiting them every couple of years. The circumstances may change and, if that's the case, the payments should as well. "The burdens go up and down," she noted.

Right, Wrong Reasons for Agreements

Oversight of other administrative agreements, including medical directorships and graduate medical education positions, requires asking an existential question: why do they exist? Aguilar said hospitals may give reasons like "we need to pay the physician a certain number and medical directorships are a way to get there," or "we need to reward physicians for referrals they're generating," but they won't fly in terms of the fraud and abuse laws. "You'd be surprised what you find both in verbal conversations and written emails," he said. A telltale question is whether the hospital would suffer operationally if it removed a particular medical director.

Before writing checks, hospitals should have a legit answer to "why" they pay physicians for medical directorships and other administrative agreements. Reasons include clinical leadership (e.g., driving compliance with regulations, ensuring protocols are evidence-based); operational support (e.g., implementing quality improvement initiatives); strategic development (e.g., overseeing a new service line); and graduate medical education (e.g., running the residency service).

Hospitals also should consider whether the time commitments are reasonable. "Are you asking one physician to do 60 hours a month? It may need to be a two-person role," Aguilar said. For example, a single hospital with 30 medical directors may be asking for trouble, but a nine-hospital system perhaps needs that many.

Compensation for certain administrative agreements should drop over time. For example, the hospital may bring in a specialist to oversee development of a pediatric cardiovascular surgery program. "Early on, you would argue they need more hours to prop up the program, but two to three years into it, you may not need as much administrative help," Aguilar said. The payment for the specialist's administrative services may require adjustment to ensure its continued commercial reasonableness.

Suppose Dr. Jones has a medical directorship for cardiology services at a local hospital. It calls for a physician in the specialty of noninvasive cardiology. Jones is highly productive, and his clinical hourly rate is $400, while the directorship rate is $300. The physician thinks his administrative pay should be $400 per hour because of his specialty and productivity, but that's not relevant for the administrative hourly rate. Aguilar explained that survey data is different for clinical versus administrative services. Even when physicians have great people skills and are highly organized and well versed in evidence-based practices—justifying a 90th percentile for administrative services—the hourly pay may be less than the clinical pay.

On a related note, the administrative rate should be the same whether the person who fills it is a family physician or neurosurgeon, Aguilar said. The pay is based primarily on the administrative services required, not the specialty.

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Telehealth Flexibilities Are Back Through January; It's 'Hard to Plan'

Telehealth flexibilities will come flooding back any minute because they were included in the stopgap funding bill approved by Congress Nov. 12.[1] The consensus is they're retroactive, although this isn't crystal clear. Before providers throw a party, however, they should keep in mind that the telehealth flexibilities and other Medicare extenders in the continuing resolution only last through Jan. 30, 2026. Then lawmakers, in a version of Groundhog Day, again must negotiate 2026 appropriations and telehealth flexibilities or risk another federal government shutdown.

Meanwhile, providers are awaiting CMS guidance, expected as early as Nov. 14, on submitting certain claims for services delivered by telehealth during the six weeks they were in limbo.

"The good news is the shutdown is over," said attorney T.J. Ferrante, with Foley & Lardner LLP. But 2 1/2 months more for the extenders isn't a lot of time.

"Continuing resolutions these days are the train that everything gets hitched to," said Claire Ernst, director of government relations and public policy at Hooper, Lundy & Bookman. "Most likely all these extenders will get caught up in full-funding situations come January."

The ephemeral nature of telehealth extensions is wearing thin, Ferrante added. "We are coming up on almost six years" since they took effect with the COVID-19 public health emergency (PHE), and providers need a permanent fix. "There's a lot of data and clinical evidence it should be extended permanently, and it's bipartisan," but Congress keeps kicking the can down the road, he noted. That makes it "hard to plan" for providers and telehealth platforms.

The continuing resolution again removed geographic and originating site requirements, which means telehealth services may be delivered everywhere in the country and to patients in their homes. Audio-only telehealth is OK, although CMS added a caveat through regulations (i.e., Medicare covers audio-only encounters only when beneficiaries won't or can't consent to the use of video technology).

Congress also won't require an in-person visit within six months of a behavioral/mental health telehealth visit. Medicare coverage of behavioral/mental health telehealth services are permanently authorized by Congress across the country and in patients' homes, but the in-person visit requirement only kicks in if (and when) flexibilities expire.

Another flexibility that will continue is allowing federally qualified health centers and rural health clinics to serve as Medicare distant site providers. They will be paid the national average payment rates for comparable services under the Medicare Physician Fee Schedule (MPFS).

Three more: physical therapists, occupational therapists and speech language pathologists have a greenlight to deliver services via telehealth, and face-to-face encounters before hospice recertification can continue to be performed virtually. And Acute Hospital Care at Home is back.

Other types of Medicare extenders will last through Jan. 30 because of the continuing resolution. A biggie is the geographic practice cost index (GPCI), which provides a reimbursement lift for services reimbursed under the MPFS in rural and other areas. The GPCI adjusts Medicare payment rates to account for cost variations in different states or regions. The brief expiration of the GPCI, which applies only to the work portion of relative value units, had translated into lower payments under the MPFS in about 50 places. Now that the GPCI is back, it's

Tip Sheets on Physician Call Coverage, Other Administrative Agreements

Here are summaries of certain aspects of on-call coverage and administrative agreements, such as medical directorships, with physicians (see story, p. 1).[1] They were prepared by Joe Aguilar, managing partner at HMS Valuation Partners. Contact him at joe.aguilar@hmsvalue.com.

Anatomy of a Directorship Agreement

Scope of Duties are Defined	Time Commitment & Documentation	Compensation	Agreement Terms
Be Specific and Clear	Hours requirement per month	Choose appropriate specialty resource for the position	Define specific term lengths with renewal provision (1-3 years)
Identify measurable responsibilities (i.e. time, outcomes-based)	Require physician to log timesheets	Compensation should have FMV/CR support either internally or externally	Consider performance reviews and/or audits
Align duties to organizational goals	Timesheets should have meaningful detail to support the scope of duties	Avoid lump sum payment terms in the agreement	Provide mechanism for with and without cause termination

unclear how Medicare administrative contractors (MACs) will reprocess six weeks of claims, Ernst said. "If the GPCI provision is retroactive, they could reprocess [claims] at the higher amount. I don't know what that translates to in terms of money but any money on the table is money you want."

Next: More Guidance from CMS

What providers need now is CMS instructions on how to proceed with telehealth claims for services provided between Oct. 1 and mid-November. "Where the real rubber meets the road will be how CMS instructs the MACs to handle certain issues," Ernst said. Until now, CMS told MACs to hold telehealth claims with dates of service on or after Oct. 1, unless they're covered by statute (i.e., mental health/behavioral telehealth if CMS is absolutely certain the claims are for behavioral/mental health) or otherwise meet the requirements described at Section 1834(m) of the Social Security Act as indicated in a list of HCPCS codes. But in a Nov. 7 MLN Connects, CMS said it couldn't identify all payable claims and would

Compensation Considerations

Factors To Review When Considering Compensation	
Compensation Terms	• Base Salary • Production-Based • Value-Based • Stackable Compensation (ER call, administrative, GME, etc.)
Provider-Specific Characteristics	• Unique Clinical Skills • Additional Certifications • Services Offered
Position-Specific Requirements	• Hours Worked • Patient Volume • Other Work Requirements
Geographic-Specific Factors	• Cost Of Living • Patient Demographics • Payor Sources
Employer Considerations	• Practice Economics • Organizational Mission • Specific Business Purpose

CR Threshold Analysis

Commercial Reasonableness Threshold Analysis	
CR Threshold Test	**Guiding Questions**
Business Purpose	• Does the transaction serve a legitimate business purpose? • Does the transaction align with the organization's mission, satisfies a regulatory obligation, or meets licensure criteria? • Is the arrangement appropriate given national, state, and local economic conditions and future outlook?
Service Specific Needs / Demand for Specialty	• Is there a need and/or demand for the services under the arrangement? • Do the services require a particular set of skills and/or experience? • Do the services correspond to data provided in a community needs assessment report or a community health needs • assessment?
Subject Agreement / Compensation Terms	• What is the subject agreement compensation terms? Is it structured as a base guarantee or is it based on a set of • performance metrics? • Does the compensation in the arrangement correspond to the manner in which other providers with the same • qualifications are paid under similar conditions?
Alternative Options / Duplicative Services	• Do the services in the agreement require a physician? Do they require a physician with a particular specialty? • Are the services being performed superfluous? • Are there any reasonable lower cost alternatives to the subject agreement transaction? • Are the services duplicative?
Financial / Production Review	• Where does compensation benchmark? • Where does production (wRVU/Collections) benchmark? • How do they relate to each other and how do they relate to the facts and circumstances surrounding the transaction?

Endnotes

1 Nina Youngstrom, "Minefields Lurk in ED Call, Other Administrative Compensation; Avoid Journal Club Fees," *Report on Medicare Compliance* 34, no. 41 (November 17, 2025).

return the subset of telehealth claims to providers that were submitted on or before Nov. 10, 2025.[2] "Practitioners may resubmit returned claims that meet the statutory requirements," CMS noted.

That MLN Connects seems to be moot. CMS may not have to distinguish between covered and noncovered telehealth claims, Ernst noted. "I expect to see some sort of correspondence to MACs" about how to handle claims dating back to Oct. 1 and for claims affected by the resumption of the GPCI. And "hopefully telehealth will be extended past Jan. 30, and this issue won't continue to flare up in this way," she said.

Extension of Virtual Prescribing Is at OMB

Separate from telehealth flexibilities extended by Congress, all signs point to another one-year extension of telehealth prescribing of controlled substances when the current one expires Dec. 31. "It's the fourth temporary extension," Ferrante noted. The Office of Management and Budget received it from the Drug Enforcement Administration (DEA) Nov. 12, "so we will expect it to come out shortly, theoretically," he said.[3]

If it's the same as previous extensions, the extension would let physicians prescribe Schedule II-V controlled substances virtually next year without an in-person visit. Without another extension, physicians and advanced practice providers won't be able to prescribe controlled substances via telemedicine after Dec. 31, 2025, unless the patient shows up once in person for a medical evaluation.

A more permanent solution is still in the ether. DEA proposed two regulations in 2023 on virtual prescribing of controlled substances but appears to have abandoned them after an outcry from the industry. They appeared to inhibit telehealth prescribing of controlled substances.

The prospect of a future without an in-person visit took root early in the COVID-19 PHE, when the DEA granted a temporary exception to the 2008 Ryan Haight Act, which requires providers to have one in-person visit with a patient before prescribing controlled substances by telehealth (e.g., drugs for severe pain, anxiety and attention deficit hyperactivity disorder and buprenorphine to treat opioid addiction). Because of the PHE waiver, many patients established relationships with virtual-only physicians and telehealth companies to get their controlled substances. The Ryan Haight Act also requires the DEA to develop a provider registration process, which would pave the way for permanent use of telehealth for controlled substance prescriptions without an in-person visit, but it hasn't materialized.

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Endnotes

1 Senate Appropriations Committee, "Division E—Extension of Agricultural Programs," October 2026, https://bit.ly/49iWsTP.
2 Centers for Medicare & Medicaid Services, "MLN Connects Newsletter for November 7, 2025," November 7, 2025, https://bit.ly/3WT8iwH.
3 Executive Office of the President, Office of Management and Budget, "Pending EO 12866 Regulatory Review," November 10, 2025, https://bit.ly/49ezDAL.

Health System Settles Case Over E/M Levels

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Upcoding of E/M levels of service for office/outpatient visits is a target of auditors and payers. Physicians and advanced practice providers (APPs) have the option to select E/M codes based on either time or medical decision making. Time varies by code, with physicians or APPs required to spend at least 40 minutes with a patient to bill 99214, for example. To code based on medical decision making, physicians and APPs consider the complexity of diagnoses to be addressed; the amount and/or complexity of data to be analyzed; and the risk of complications or morbidity from testing or treating, with a 99214 requiring a medically appropriate history and/or examination and moderate level of medical decision making.

There's virtually no wiggle room with time, said attorney Judy Waltz, with Foley & Lardner LLP. Although decisions about levels of service are a bit more fluid with medical decision making—"there's some room for differences of opinion" on whether the services provided are a level three versus four or level four versus five—the level of service based on time is black and white.

"If you do coding based on medical decision making, you can make that argument about differences of opinion, but on time you're dead in the water," Waltz explained. "Some providers have time-tracking devices, particularly for telehealth calls, and if the time spent did not align with the time claimed, there really isn't any way around a conclusion of upcoding."

She noted that higher-level CPT codes "might be slightly easier to defend if you are just one level off." When the provider has no pattern or practice of coding variance, "there's room for a difference of opinion between one level or the other, usually best addressed as an educational opportunity," Waltz noted. "But two levels is typically too far off to support an argument about a limited difference of opinion." ICD-10 specificity also raises the stakes for providers. "Medical decision making will take into account the diagnoses," Waltz noted. "Under ICD-10, you can't just call it a cold. You have to dig in a lot deeper in terms of documentation. And the increased level of specificity may contribute to the

complexity level, either higher or lower, of the medical decision making."

It's noteworthy that OIG said UTHSC billed for a higher level of service than performed rather than a higher level of service than documented, said attorney David Glaser, with Fredrikson & Byron. Often errors in Medicare relate to the failure to have supporting documentation instead of the services themselves. "I thought the word performed rather than documented was interesting and important," he said. "It's a reminder that the impulse to refund Medicare because of missing documentation is incorrect unless we're talking about a situation with an explicit documentation requirement. For example, there must be documentation from someone about the teaching physician's participation in a service, or shared visits require a signature from the billing professional. The presence of a documentation requirement there, in the absence of any other explicit requirement, explains why it's the level of service performed, not the level of service documented, that matters."

Modifier 25: Everything Old Is New Again

With regard to modifier 25, compliance never seems to improve, said Jean Acevedo, president of Acevedo Consulting. OIG said in a 2005 report that there was a 35% error rate, and Acevedo doubts it's lower 20 years later.[2] Modifier 25 generates separate payment for a significant, separately identifiable E/M service provided on the same day as another service or procedure.

And now modifier 25 is more vulnerable to audit in the wake of September CMS guidance. In an MLN Booklet on E/M services, CMS said for the first time that the use of modifier 25 is required on claims for new patients—not just established patients—who have minor procedures if there's grounds for the additional payment.[3]

According to the MLN Booklet, "If you perform a minor surgical procedure on a new patient, the same rules for reporting E/M services apply." But as usual, modifier 25 shouldn't be used routinely. "The fact that the patient is new to the provider or supplier isn't sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure," CMS noted.

Acevedo said that's a change in policy. It means that physicians and APPs will only get paid for the procedure when they report an E/M new visit code and minor procedure, such as joint and eye injections, with the modifier—assuming CMS adds adjudication edits to reflect the change.

CMS said it's echoing language in the National Correct Coding Initiative (NCCI) policy manual, which Acevedo said doesn't appear to be new.[4] But there it is, and as a practical matter, new patient office visits that haven't been billed with modifier 25 are vulnerable to recovery audit contractor desk audits, she said. Physicians may expect their office staff to sort this out, but the staff depends on the physician to know what's billable and not give them a code to report that shouldn't be billed at all.

Glaser said Medicare administrative contractors often deny legitimate claims with modifier 25. For example, when a Medicare patient visits the dermatologist for a suspicious mole and has a biopsy, modifier 25 would be appropriate, he said. But sometimes MACs say the skin exam was related to billing for the mole, "failing to understand it's related in the diagnostic sense of the word but it was a separately identifiable service."

New Cigna Policy: Downcoding on Claims Alone

In the commercial-payer world, physicians are facing E/M downcoding that's based on claims alone, without reviews of medical records. Cigna Healthcare, for example, has a new policy that calls for using diagnosis codes to review professional claims billed with CPT E/M codes 99204-99205, 99214-99215, and 99244-99245.[5]

It's alarming because the American Medical Association's requirements for selecting E/M levels of service "are clearly only to be determined by the amount of time spent or the complexity of medical decision making as documented in the medical records, not by the diagnosis codes," Acevedo noted.

According to FAQs on the Cigna policy, which took effect Oct. 1, "Cigna Healthcare will review claims only from providers identified as having a pattern of coding at a higher E/M level."[6] Only a small number of in-network providers will be affected. Cigna said it's using "claim-based criteria as an initial screening mechanism to detect potential discrepancies, examining relevant claim data, associated diagnoses, and any additional services rendered during the same encounter. We do not rely exclusively on algorithms to make final determinations." The policy is similar to its competitors' policies, Cigna stated.

The FAQs note that "Cigna Healthcare took a conservative approach and reviewed claims over a 12-month period, with a focus on providers who consistently billed diagnosis codes and higher-level E/M codes not typically associated with complex cases

CMS Transmittals and *Federal Register* Regulations, Nov. 7-13

Please note: There are no relevant transmittals and regulations because of the federal government shutdown, which ended November 13, 2025, when Congress passed a continuing resolution that was signed by President Donald Trump.

requiring additional decision-making time." Examples include earache or sore throat, which Cigna said generally doesn't warrant high-level decision-making codes.

Downcoding based on claims information alone is disturbing, Acevedo said. "How can Cigna downcode the doctor based on the 1500 claim form? To downcode a physician based on information only on the claim without looking at the medical record is not only counterintuitive but seems to me to be wrong." As Acevedo reviewed the new policy, she realized Cigna is emphasizing ICD-10 diagnosis codes. "It's unusual to use diagnosis codes to make level-of-service determinations," she noted. Suppose a physician bills a level four CPT code—which requires a moderate level of decision making across at least two of the three components—with a diagnosis code of E11.9 (Type 2 diabetes mellitus without complications). That could be downcoded because it's not actually a level four, Acevedo said. "One stable chronic illness would be a level three E/M," but because the patient often has other diagnoses, it's the failure to include all relevant ICD-10 codes on the claim that could result in downcoding. Also, there's a series of ICD-10 codes that indicate prescription drug management (e.g., Z79.4, long-term current use of insulin) "that can help support complexity when reported with the diabetes code," she noted.

Acevedo urges physicians to report as complete and specific a diagnostic picture as possible. It's particularly important when physicians work in a risk environment (i.e., under capitated contracts with Medicare Advantage plans) and with payers and auditors using artificial intelligence to review claims. "It can make a huge difference in proper reimbursement," she noted. But this is easier said than done. "Doctors are not diagnosis code people. They're more CPT code people."

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Endnotes

1 U.S. Department of Health and Human Services Office of Inspector General, "The University of Texas Health Science Center at Houston Agreed to Pay $390,000 for Allegedly Violating the Civil Monetary Penalties Law by Submitting Upcoded Evaluation and Management Claims," fraud self-disclosure, October 16, 2025, https://bit.ly/47VDL6w.

2 U.S. Department of Health and Human Services, Office of Inspector General, Daniel R. Levinson, *Use of Modifier 25*, November 2005, OEI-07-03-00470, https://bit.ly/3XxyGfz.

3 Centers for Medicare & Medicaid Services, "Evaluation and Management Services," MLN Booklet, MLN006764, September 2025, https://go.cms.gov/46tgo38.

4 Centers for Medicare & Medicaid Services, "General Correct Coding Policies For Medicare National Correct Coding Initiative Policy Manual," revised February 28, 2025, https://bit.ly/4h2KMGK.

5 Cigna, "Evaluation and Management Coding and Accuracy," July 2025, https://bit.ly/4p91zuw.

6 Cigna, "Professional claims for evaluation and management services," September 9, 2025, https://bit.ly/4nVKenR.

NEWS BRIEFS

◆ **Granite Md Opco D/B/A Patapsco Healthcare agreed to pay $200,000 to settle allegations of violating the Maryland False Health Claims Act, the state's attorney general (AG) said Nov. 4.**[1] Patapsco, a nursing facility, allegedly provided substandard care to residents that was discovered during an investigation by the AG's Medicaid Fraud and Vulnerable Victims Unit. "The investigation uncovered (1) serious wound care inadequacies leading to hospitalizations; (2) the failure to provide residents with adequate nutrition and hydration; (3) regulatory violations compromising patient care; (4) numerous preventable falls; and (5) the failure to prevent residents from overdosing on opiate medications," the AG alleged. The settlement includes $100,000 that will pay for a quality improvement plan that involves AG oversight of the facility for four years.

◆ **In a special edition of MLN Connects sent in a Nov. 14 email, CMS reiterated that the deadline for provider participation in 2026 is Dec. 31.**[2] "As you plan for next year, CMS reminds you of the advantages of participating in Medicare," including payment of the full Medicare Physician Fee Schedule allowed amount and "Medicare forwards claim information to Medigap (Medicare supplement coverage) insurance (if any)." If providers already participate in Medicare, CMS advises them to confirm that their data is accurate in the National Plan and Provider Enumeration System (NPPES) taxonomy.

◆ **Massachusetts physician Ali Tural and his company, Tural Pediatrics, Inc., agreed to pay $175,000 to settle false claims allegations,** the Massachusetts Attorney General's Office said Nov. 4.[3] Tural and his company allegedly submitted claims for services he supposedly provided to MassHealth members but they were actually provided by midlevel practitioners.

Endnotes

1 Attorney General of Maryland, Anthony G. Brown, "Attorney General's Medicaid Fraud and Vulnerable Victims Unit Secures a $200,000 Settlement and Corporate Oversight of Patapsco Healthcare," news release, November 4, 2025, https://bit.ly/3JAOlaZ.

2 NPPES Registration, homepage, last accessed November 14, 2025, https://bit.ly/3Ly0bTR.

3 Massachusetts office of the Attorney General, "AG's Office Secures $175,000 from Fall River Pediatrician for Submitting False Claims to MassHealth," news release, November 4, 2025, https://bit.ly/3JPgUl2.