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Contents

Publisher's Note

RMC will not be published next week. The next issue will be dated June 1, 2026.

Managing Editor
Nina Youngstrom
nina.youngstrom@hcca-info.org

Copy Editor
Jack Hittinger
jack.hittinger@hcca-info.org

Site Visits Surge for Home Health, Hospice Providers; CMS Implements Enrollment Moratoria

Even before CMS on May 13 shut the door to new home health and hospice providers nationally for six months, established providers were feeling the enrollment heat.[1] The number of site visits has surged in the past eight to 12 weeks, with CMS's new site-visit contractors doing more than snapping a picture of the outside to confirm the home health agency (HHA) or hospice is operational. At initial Medicare enrollment, revalidation, practice location changes and sometimes randomly, the site-visit contractors are sniffing around inside.

"It's been fast, it's been furious," said Gretchin Heckenlively, a partner with Eide Bailly. "They're trying to weed out the fraudulent and nonoperational providers."

The site visits and HHA/hospice moratoria are another display of the Trump administration's program integrity and fraud enforcement posture that some experts worry will compromise beneficiary access to care and increase administrative burden.

'Awareness Goes a Long Way Here'

With the increasing prospects of a site visit, HHAs and hospices must ensure their staff gives contractors information consistent with what they have reported on the Medicare enrollment form, she said.

"Awareness goes a long way here," Heckenlively noted. "Don't let them operate in the dark and give inaccurate information to site-visit contractors." It could adversely affect the enrollment of the HHA or hospice.

For example, if a managing employee has left, staff should know so they don't report the person to the site-visit contractor as still in charge, said attorney Judy Waltz, with Foley & Lardner.

CMS Will Turn Away New Branches

And now here comes the enrollment moratoria for new HHAs[2] and hospices.[3] Medicare is turning away HHAs and hospices as well as new branches or practice locations. But the moratoria don't apply to changes in practice locations, and existing HHAs and hospices shouldn't run into it when they move a location or change ownership, except for a change in majority ownership in the past 36 months, because that creates an initial enrollment, Heckenlively noted.

However, changes in HHA and hospice main practice locations require a close look, she said. "Relocations outside a primary approved site or geographical area could be processed as a voluntary termination if CMS determines a change in main location no longer serves the same community or services to existing patients are interrupted."

IG Threatens Federal Medicaid Funds

HHS flexed other enforcement muscles May 13. In a letter to all state attorneys general (AGs), HHS Inspector General (IG) Thomas March Bell warned they could lose federal Medicaid funding if they can't prove their Medicaid fraud enforcement is up to snuff.

The IG's letter focuses on the effectiveness of their Medicaid Fraud Control Units (MFCUs). Bell said the Office of Inspector General (OIG) will be reviewing every state's MFCU, which is required to "effectively fulfill its statutory functions and responsibilities."

If the MFCU drops the ball, Bell said it may face consequences, including a corrective action plan; loss of MFCU funding from the federal government; or "denial of recertification, which could lead to the loss of all Federal grant funds" to Medicaid in that state. MFCUs are

recertified annually by OIG, which funds a portion of operational costs through grants, Waltz said.

"Noncompliance with your MFCU obligations can take your State's *entire Medicaid program* out of compliance," Bell wrote. "This means your failure to do your job as head of the MFCU has put all of your State's Medicaid funds in jeopardy."

OIG Already Reviews MFCUs

It's a shrewd move to light the fire under states without directly taking benefits away from Medicaid beneficiaries, Waltz said. The problem is, if OIG strips funding from the MFCU, how will the state effectively fight fraud? If the MFCU is denied recertification, responsibility could fall back on the federal government to go after Medicaid fraud in that state, Waltz said.

And there's something strange about OIG going on the offensive because it routinely reviews MFCUs' activities. "MFCUs have pretty impressive successes," Waltz noted. "OIG has never made a conclusion I know of that the MFCU will be refused the recertification. I'm sure these MFCUs are thinking, 'What the heck? I sat down with them two years ago and showed them everything we were doing.'"

If OIG is talking about cutting off federal funds for Medicaid generally, "it would be a disaster," she said. Losing federal financial participation "would result in loss of benefits for a large number of people."

Waltz also worries that compliant hospices will be a casualty of the wave of Medicare payment suspensions. CMS has reportedly suspended 800 hospices in California alone. Some small hospices don't have the financial wherewithal to survive even a short payment suspension. "I get that CMS is trying to stamp out fraud, but I worry about beneficiary access to care," she said.

Moratoria Took Effect Immediately

In the May 13 notices announcing the enrollment moratoria on HHAs and hospices, CMS said they took effect that day. They follow on the heels of CMS's moratorium on new enrollment of durable medical equipment suppliers. In the notices, CMS said the Affordable Care Act authorizes it to impose temporary moratoria with an option to renew "if the Secretary determines that a moratorium is necessary to prevent or combat fraud, waste, or abuse."

But moratoria have their limitations. "Maybe that reduces the number of fake providers coming into the industry, but it doesn't do anything about the fake providers already in the industry," said attorney Bob Markette, with Hall Render. "We have done moratoria before and it doesn't seem to have helped anything." Perhaps something like saying "no" to the sixth hospice that enrolls at the same address, or having a larger capital requirement for Medicare enrollment, would move the needle, Markette noted. "This is a difficult problem to solve."

Prepare for Enrollment Site Visits

Meanwhile, HHAs and hospices already in the Medicare fold should prepare for enrollment site visits, Heckenlively said.

"We have seen a big uptick in the number of site visits being done when submitting a change of information even if there's no practice location change," she noted. "And they've been more comprehensive than in the past." Usually, the site visit confirms the HHA or hospice is at the location reported on the Provider Enrollment Chain and Ownership System (PECOS) and is operational. Sometimes staffers don't even realize the site-visit contractors were there. "Now we are seeing them come in, asking for the NPI [National Provider Identifier] and taking pictures not only of the door but also the front desk and supply room," Heckenlively said.

In addition to site visits for initial enrollment and revalidations, contractors are dropping in when more than 12 months have elapsed since the last visit, Heckenlively said. And contractors may make special enrollment site visits at any time. During special site visits, the contractors may ask for a list of managing employees and owners, organizational charts and other supporting documentation.

To prepare for site visits, Heckenlively suggests HHAs and hospices arm staff with the information

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they need to satisfy the contractors. For starters, make sure staff is clear on whether it is, in fact, a CMS site-visit contractor eyeing enrollment versus a surveyor assessing compliance with the Medicare conditions of participation. Otherwise, HHA or hospice staff may identity employees "who are important for survey purposes but who aren't reportable to CMS as a managing employee for enrollment purposes" (e.g., a volunteer coordinator). Staff also should know the NPI and be able to name the administrator and medical director.

'Compliance Challenges for the Good Guys'

The moratoria and other "crushing fraud" initiatives will have a ripple effect on compliant providers, Markette said. "Every time there's a major fraud or compliance issue, it always leads to compliance challenges for the good guys." They will wind up jumping through more regulatory hoops to prove their good faith, he said.

For example, in response to a rash of home health fraud around 2010, CMS started requiring physicians to have a face-to-face encounter with patients before certifying their home health eligibility, Markette said. The face-to-face rule and others like it are "designed to solve one problem but create barriers for legitimate folks," he said.

And they may not have a material effect on the prevalence of fraud, said Markette, who is also legal counsel to the Indiana Association for Home and Hospice Care.

If they did, HHAs and hospices wouldn't be facing a moratorium and other program integrity measures. "I suspect there will be regulatory changes," with the government "trying to find ways to add layers of proof and prevent or identify early fraudulent claims."

Contact Heckenlively at gheckenlively@eidebailly.com, Waltz at jwaltz@foley.com and Markette at rmarkette@hallrender.com. ✧

Endnotes

1 Centers for Medicare & Medicaid Services, "Home Health and Hospice Nationwide Moratorium Q&As," May 11, 2026, https://go.cms.gov/3RHFAPG.

2 Centers for Medicare & Medicaid Services, "Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Home Health Agencies (HHAs)," May 15, 2026, https://bit.ly/439DY3O.

3 Centers for Medicare & Medicaid Services, "Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratorium on Enrollment of Hospices," May 15, 2026, https://bit.ly/4tLm9Di.

Queries Aren't 'Stand-Alone Grounds' For Recoupment, New Guidance Says

It was a red flag when a Medicare Advantage (MA) plan downgraded a DRG over a query that the payer didn't approve of. Although there's no such thing as compliant or noncompliant queries—no laws or regulations govern their use—they may be used as a vehicle to deny hospital claims, an attorney said.

The query was "the sole reason the payer downgraded the DRG for this claim," said attorney Richelle Marting, director of managed care contracting at NKC Health in Missouri. "They declined to recognize the condition that was stated in the physician's response to the query."

Hospitals may want to keep their eye on the part that queries play in claim reviews, as noted in the proposed 2026 update to query guidance from the American Health Information Management Association (AHIMA) and the Association of Clinical Documentation Integrity Specialists (ACDIS) released April 20.[1] The way physicians respond to clinical validation queries "represent that provider's clinical judgment at the time of documentation and do not constitute independent admissions, stand-alone grounds for post-payment recovery, or evidence of fraudulent billing absent other supporting findings," according to the guidance, known as a practice brief. The AHIMA/ACDIS's clarification on the use of their guidelines by payers "is a direct response to how these guidelines have been used inappropriately in the real world," Marting noted.

More Denials Where Queries Factored In

The hospital query that led to the downcoding asked the physician to "review indicators and render your clinical opinion. Is the patient being treated/monitored for: acute on chronic hypoxic respiratory failure; other condition (please specify); or unable to determine (please provide rationale)." The payer determined that the query didn't follow the 2022 AHIMA/ACDIS query guidance, noting it states in part, "All clinically supported options should be included as well as additional options that permit the provider to craft their own alternate response. Options may include other, unknown, unable to determine, not clinically significant, integral to, or other similar wording." In the eyes of the payer, the query was "inappropriate as supportive documentation for the related code" and "didn't "provide all clinically reasonable choices regardless of impact on reimbursement or quality reporting."

Marting is seeing more denials like this based on the way queries are structured. "It doesn't matter if the resulting diagnosis recorded by the physician was right or wrong," she noted. "The payers throw out the

documentation in a query based on the format it was presented to the physician."

The purpose of a query is to clarify information about diagnoses and procedures and help providers create thorough and complete documentation in the medical record. Coders and clinical documentation specialists (CDSs) typically submit queries to physicians to get a fix on the patient's diagnosis for coding and documentation integrity purposes.

As the guidance puts it, "a compliant query adheres to established professional guidelines to ensure accurate, complete, and unbiased documentation clarification. A compliant query is nonleading, includes relevant clinical indicators, excludes references to reimbursement or quality outcomes, and allows the provider to exercise independent clinical judgment."

Name of Guidance Is 'a Little Bit of a Misnomer'

Although the guidance has best practices, queries aren't under the thumb of any laws or regulations. "There's no such thing as a compliant query or a noncompliant query," Marting said. That's why the title of the 2026 AHIMA/ACDIS draft guidance—*Guidelines for Achieving a Compliant Query Practice*—"is a little bit of a misnomer, and it has created a lot of confusion in the industry and unintended consequences," she said. "No doubt they are best practices to follow in the way queries are drafted, but the word 'compliant' has opened the door for third-party payers to refuse to accept documentation from a query if it doesn't align with these guidance documents."

Even so, it has become conventional wisdom that hospitals shouldn't use "leading" queries. Even CMS weighed in on leading queries, which could walk a physician into a higher-paying diagnosis (i.e., upcoding), in a 2014 Medicare transmittal.

"The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the patient, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the patient's medical record. Refer the case for a physician review if medical judgment is needed when changing the narrative diagnosis that the codes were based upon," CMS said. "Your reviewer must use his or her professional judgment and discretion in considering the information contained on a hospital's physician query form along with the rest of the medical record. If the physician query form is leading in nature or if it introduces new information, the nonphysician reviewer must refer the case to the physician reviewer."

The transmittal doesn't forbid leading queries, but it introduced the precedent of asking a physician reviewer to double-check a diagnosis that stemmed from a query.

Instead of the binary of compliant and noncompliant queries, Marting thinks of them as facilitating "what we are trying to maintain compliance with": an accurate, complete medical record that satisfies laws, regulations and accreditation standards.

Less of a Checklist, More of a Framework

The guidance at a high level has a different tone from the 2022 version, which reads like a checklist, Marting said. The 2026 draft "introduces the concept of substantial compliance with a framework. What they are trying to get at is professionals should substantially follow the principles, concepts and underlying goals set out in these guidance documents."

Queries don't tell physicians what to do, Marting noted. For example, they shouldn't contain statements like, "Dr. X, write down a diagnosis of sepsis." But the coder or CDS may say, "The patient had a mean arterial pressure below 70, a PF ratio of 250 and was treated with antibiotics. Which of these are correct: sepsis unspecified organism, unable to determine or other condition?"

That kind of query is necessary when a physician documents the clinical indicators of sepsis but never mentions the word. Rather than asking whether the patient had sepsis, which may not be a best practice, put clinical indicators on the query, Marting suggested.

New sections in the guidance also tackle areas like the definition of noncompliant multiple queries, the role of prior encounters in query initiation and the compliance framework for queries generated by technology.

For example, even when they use technology, hospitals are responsible for ensuring their queries are compliant. Required elements should appear in queries even when they're automated and may have different names (e.g., nudges). And technology-generated queries call for the same oversight. "Query professionals and compliance leaders must be involved in the evaluation, configuration, and ongoing monitoring of any technology that generates queries or influences the query process," the guidance states.

'Two Fundamentally Different Concepts'

In fact, clinical indicators are "the foundation of compliant queries" but the guidance makes it sound like all of them come from physician documentation, said Cheryl Ericson, senior director of clinical policy and education at the Brundage Group. Some clinical indicators are "objective findings," such as elevated white blood count. If providers lack objective findings, "we shouldn't always be asking physicians to add documentation to support a diagnosis that seems weakly supported," Ericson said at a Talk Ten Tuesdays podcast. "For diagnoses defined by objective diagnostic

findings, when that criteria is absent, additional provider documentation won't add clinical validity."

There's also a risk that asking the physician for more clinical indicators or their decision-making process when the documentation isn't adequate "can be weaponized by payers," even though original Medicare allows medical necessity to be inferred from documentation and defers to physician judgment. "Requiring additional documentation shifts clinical validation from assessing whether a condition exists to judging whether there's enough documentation," Ericson said. "They are two fundamentally different concepts."

Ericson suggests that coders and CDSs focus less on whether a condition exists and more on whether it was reasonable for the provider to evaluate, monitor or treat the condition. "Reframing clinical validation in this way strengthens the role of clinical reasoning as a defensible counter to payer-specific criteria and better aligns with quality care," she noted.

Contact Marting at rmarting@richellemarting.com and Ericson at cericson@brundagegroup.com. ✧

Endnotes

1 Association of Clinical Documentation Integrity Specialists and American Health Information Management Association, "ACDIS/AHIMA Guidelines for Achieving a Compliant Query Practice—2026 Update," April 20, 2026, https://bit.ly/42wH7uk.

Surgeon Settles FCA Case Set In Motion by 'Data-Miner' Whistleblower

In a whistleblower case fueled by a so-called data miner, California surgeon Feliciano Serrano and his practice, Serrano Kidney & Vascular Access Center, have agreed to pay $6.73 million to settle false claims allegations they billed for medically unnecessary vascular intervention procedures, the U.S. Department of Justice (DOJ) said May 6.[1]

The whistleblower, Lincoln Analytics, alleged that publicly available data showed Serrano, a nephrologist, was the highest-paid Medicare provider with a nephrology specialty for five consecutive years ending in 2020, according to its False Claims Act (FCA) complaint.[2] During that same period, Serrano also had the highest rate of Medicare payments per beneficiary. The complaint called Serrano an "extreme outlier."

The data was reinforced by interviews, including with a former licensed practical nurse (LPN) for Serrano's practice, the complaint alleged.

Around the same time the settlement came down, DOJ unveiled an initiative to meet with whistleblowers before they file cases based mostly or solely on data analytics/AI. As part of its Fraud Oversight through Careful Use of Statistics (FOCUS) initiative for whistleblower cases driven by publicly available government data—what DOJ is calling "data miners"—DOJ invited them to meet to talk over how their "data signals reliably correlate to fraud." It's not a pre-filing requirement, but DOJ will look more favorably on data miners who show they know their stuff—legally and otherwise. More than 45% of whistleblower complaints filed since FY 2024 come from data miners, DOJ noted.

'Straying From' the Purpose of Qui Tams?

FOCUS is cultivating a closer relationship between DOJ and data miners, which is unfortunate for defendants, said former federal prosecutor Melissa Jampol, with Epstein Becker Green. "We should all pause and think about whether it's appropriate to have companies formed for the sole purpose of filing qui tam complaints" (i.e., whistleblower lawsuits under the FCA), she said. "It seems to be straying far from what the drafters of the qui tam provisions intended in the post-Civil War era. I have spoken to people at DOJ who have a lot of concerns about it." One concern is that data miners "undermine the intent of the law, which is to enable inside folks with personal knowledge of fraud to be able to bring it forward."

The use of publicly available government data also may "vitiate" the public disclosure bar to whistleblower lawsuits, Jampol said. In other words, the fact the government already has the data may bar whistleblowers from litigating qui tams.

Data outliers alone may not be incriminating. They could just point to more complicated procedures performed at a tertiary care hospital, for example. "The rush to judgment and expense that goes along with being under the microscope for an analytics-driven type of investigation often has extremely serious impact for someone under investigation," Jampol noted.

As long as data miners are out there, however, organizations have another reason to double down on the use of data analytics in their compliance programs, she said. That way, they can identify and fix their errors before an enforcer comes knocking.

Some Patients Had Multiple Procedures

The whistleblower, Lincoln Analytics, alleged it had "personal knowledge of the facts alleged" based on data analysis and interviews with people.

According to the complaint, Serrano performs vascular procedures, such as angiographies, angioplasties, endovascular revascularization and stent placements. Most of the patients who undergo the procedures have kidney problems or receive dialysis and require vascular function. Medicare is billed for vascular access procedures with CPT codes

36901, 36902, 36903, 37225, 37229 and 37238. Stent procedures are billed with CPT codes 36901, 36902, and 36903, with the latter representing the most complicated and high-paying procedures. Medicare pays $5,090 for 36903 (insertion of needle and/or tube into hemodialysis circuit and insertion of stent in dialysis segment with review by radiologist).

Serrano and his practice allegedly submitted false claims to Medicare for medically unnecessary vascular procedures. The complaint cites a review of Medicare data to support its allegations.

For example, Serrano billed $5.9 million for 36901, 36902 and 36903—30 times the average—in 2017 through 2019, the complaint alleged. He billed multiple procedures per patient compared to the typical single procedure billed by other providers.

For example, the defendants billed Medicare for eight stent procedures (code 36903) performed on one patient during a 10-month period.

Serrano and his practice collected about $17.55 million for the vascular procedures, far more than other providers who specialize in nephrology, the complaint alleged.

LPN Alleged 'Working There Was Really Bad'

The complaint alleged the data was backed by interviews. Before filing the first complaint, representatives from Lincoln Analytics interviewed people associated with Serrano and his practice. That included two interviews with an LPN who worked for them in 2020. In a 2023 phone interview, the LPN allegedly told the whistleblower that "Working there was really bad. I'm happy to help because a lot of people are being ripped off and I don't think what they're doing is even legal," the complaint alleged. The LPN, who didn't participate in the stent procedures but helped patients with recovery, allegedly said: "Many patients received stent procedures because Defendant Dr. Serrano was providing false information about how the stent procedures would benefit them."

In the settlement, DOJ alleged that from Jan. 1, 2016, to Dec. 31, 2024, Serrano performed medically unnecessary procedures on 18 patients ostensibly because of stenosis in their dialysis segments.[3] The interventions allegedly were scheduled without the appearance of symptoms or complications. Certain patients were given a dialysis access intervention during or shortly after an office visit for unrelated symptoms (e.g., cough, anxiety or cat scratch) even though they had no dialysis-access complaints.

Serrano and his practice didn't admit liability in the settlement.

Contact Jampol at mjampol@ebglaw.com. ✧

Endnotes

1 U.S. Department of Justice, Office of Public Affairs, "Vascular Practice and Physician Agree to Pay More Than $6.73M to Settle False Claims Act Allegations of Unnecessary Vascular Interventional Procedures," news release, May 6, 2026, https://bit.ly/42E5LJx.

2 First Amended Complaint, United States and California ex rel. Lincoln Analytics, Inc. v. Dr. Feliciano Serrano, et al., Civil Action No. 2:23-cv-04178 (C.D. Cal.), September 29, 2025.

3 Settlement Agreement, United States and California ex rel. Lincoln Analytics Inc. v. Dr. Feliciano Serrano, et al., May 6, 2026, https://bit.ly/3Po9ibJ.

Want Your Own Hospital Docudrama? Bulletproof Privacy Protections Are Needed

Real-life documentaries with actual providers, patients and hospital drama—such as two series featuring Northwell Health that aired on Netflix over the past six years—require months of legwork to ensure they comply with the HIPAA Privacy Rule, the top attorney at Northwell Health said.

The same protections apply when news crews plan to film anything at a healthcare institution, said attorney Stacey Goldston, vice president of the Office of Legal Affairs at Northwell Health.

"Filming is a lot of work from a legal perspective," Goldston said at the National HIPAA Summit, sponsored by Global Health Care LLC, April 8.[1] "You need a very, very detailed process to do it right."

Northwell was featured in Lenox Hill and in Emergency NYC, two Netflix documentary series. Lenox Hill premiered in 2020 and followed four physicians at Lenox Hill Hospital in New York City, while Emergency NYC premiered in 2023 and chronicled patient stories from various Northwell departments, including the emergency department, pediatric trauma and organ transplant.

Four Settlements Involve Filming

The HHS Office for Civil Rights (OCR) began to focus on the issue of filming in treatment areas in 2012 when a woman saw an episode of NY Med on ABC and realized that she was watching her husband's death, said attorney Adam Greene, with Davis Wright Tremaine.

Even though her husband's face was blurred in the footage, the woman recognized his voice, Greene said. The woman subsequently filed complaints with the hospital, the New York State Department of Health, ABC, a hospital accrediting group and HHS, he said. The hospital in question, New York Presbyterian Hospital, had allowed film crew into its facilities without obtaining consent from patients being treated there, Greene explained. In April 2016, OCR announced a $2.2 million settlement with New York Presbyterian, he said.

OCR determined during its investigation that the hospital had impermissibly disclosed the protected

health information (PHI) of two identified patients to the film crew and other staff members, Greene said. In conjunction with the settlement, OCR also released FAQs on HIPAA and access to the media, including film crews, he said.[2]

In 2018, OCR settled three additional cases related to filming where patients' PHI potentially could be accessed. OCR reiterated its filming guidelines at the beginning of the COVID-19 epidemic in May 2020, Greene said.

Blurring faces in footage or taking other steps to protect patients' identities and information doesn't solve the problem because having a film crew view PHI without permission violates HIPAA, Greene said. However, there's a workaround: healthcare providers can allow filming or other media in treatment areas if every patient there signs a HIPAA authorization, he said.

Northwell Created Filming Guidelines

To comply with HIPAA, Northwell created "an incredibly robust and stringent set of guidelines that has been developed over the years and are continually improved," Goldston said. The Northwell legal department partners with other departments in the organization that are responsible for filming to ensure the guidelines are followed, Goldston said. For filming, a HIPAA representative is assigned to every project to ensure compliance with all privacy laws and with Northwell's process, she said.

Those HIPAA representatives ensure that all areas in which filming is taking place are secure from a patient privacy perspective, and that there's no documentation in the area that might be viewed, she said. The HIPAA representative accompanies the film crew everywhere, except for bathroom breaks.

Northwell also limits the size of the film crew to the minimum necessary for the project, and requires training of the entire production crew on the legal requirements for the project and Northwell's requirements, Goldston said.

"We've always taken the approach that when people understand the why, when everything makes more sense to them, cooperation increases, and overall it makes for a much better partnership," she said.

Northwell team members who are participating in the project also undergo training.

News Media Treated Differently

Northwell believes the news media has a right to access information pertinent to the community, "so we provide this access, subject to applicable laws, in order for the media to be able to report on that which is newsworthy," she said.

Filming for a Netflix series plays a different role, Goldston said. For example, the Lenox Hill series helped to "humanize providers, and that has really been a tremendously meaningful thing for our providers in the whole healthcare system," she said. "Lenox Hill also highlighted very important cultural moments that were impacting the lives of not only our patients, but our team members, during the COVID pandemic. So, we consider all of our filming efforts as distinguished from media to be purpose-driven in that they're a very powerful and effective way to effectuate positive change in healthcare."

In the case of the Netflix series and other non-news projects, Northwell requires approval from the applicable department or service line, as well as approval from the organization's entertainment marketing team, which oversees all large-scale filming projects.

Northwell carefully evaluates the production company involved, looking at its track record, whether its vision aligns with core Northwell values and "whether or not we feel that they would be a good and trusted partner," she said.

If a project gets a green light, Northwell requires written agreements from the production company, Goldston said. "We only use our own forms, and we are constantly working on those forms to make them better over time," she said, adding, "our agreements

CMS Transmittals and *Federal Register* Regulations, May 8-14, 2026

Transmittals

Pub. 100-04, Medicare Claims Processing

- July 2026 Quarterly Update to the Clinical Laboratory Fee Schedule (CLFS) and Clinical Laboratory Improvement Amendments (CLIA): Healthcare Common Procedure Coding System (HCPCS) Codes, Waived Tests, and Reasonable Charge Payments, Trans. 13,763 (May 7, 2026)

Pub. 100-08, Medicare Program Integrity

- Offering and Reporting of Targeted Probe and Educate (TPE) One-On-One Education Clarification, Trans. 13,775 (May 14, 2026)

Pub. 100-02, Medicare Benefit Policy

- Update to Pub. 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 110.8 Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Benefit Category Determinations

Pub. 100-07, State Operations Provider Certification

- Revisions to the State Operations Manual (SOM) Appendix Y Organ Procurement Organizations, Trans. 241 (May 8, 2026)

Federal Register

Interim final rule; request for comments

- Extension of Compliance Dates for Nondiscrimination on the Basis of Disability; Accessibility of Web Content and Mobile Applications of Recipients of Departmental Financial Assistance, 91 Fed. Reg. 25,496 (May 11, 2026)

Notice

- Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—January through March 2026, 91 Fed. Reg. 27,339 (May 14, 2026)

emphasize a patient-first approach and privacy commitments throughout."

Northwell also customizes its filming guidelines for each major project in consultation with the clinical team and provides that customized document to the production staff, she said. For example, if filming takes place in a lab, the production staff can't use certain lights, and that information would be included in the filming guidelines, she said.

Once the agreement has been executed, training begins for the production staff and the Northwell employees involved in the project, Goldston said. It can take months to get an agreement signed and the training in place.

Patient Consent Is Standardized

The providers themselves are responsible for determining which patients are appropriate to film and for obtaining consent from those patients, Goldston said.

To make consent forms user-friendly, the Northwell legal department streamlined the process, using three forms in total: two different HIPAA authorizations and irrevocable consent, she said. Patients sign one of the two HIPAA authorizations, and nonpatients, including Northwell employees, sign the irrevocable consent, she said.

Production companies have their own release forms, and Northwell generally asks those companies to provide patients with a three-day grace period in which they can revoke their permission, Goldston said. All these forms need to be presented to patients in their preferred language, she added.

Filming in an emergency department (ED) poses significant challenges beyond filming in non-emergent settings, but it's not impossible, Goldston said. In Northwell's case, "I don't know of a time we've ever allowed them to film in the ED, unless it was staged," she said.

HIPAA-compliant filming requires an appropriate physical setup with separation between rooms and buy-in from the staff, Goldston said.

Hospitals can't film anybody who doesn't have capacity to consent. "Healthcare proxies cannot sign consent forms to be consented for filming," she noted. Also, patients who are in need of urgent and emergent care can't be approached for filming, "so that essentially leaves your non-emergent or no longer emergent emergency room patients as patients that are potentially eligible to be filmed."

Northwell relies on the responsible provider to select eligible patients to obtain their authorization and consent, Goldston said. They can only be filmed if they're in a location that's completely separated. The film crew is quarantined in that area and must be escorted through an area where they won't pass any other patients, she said.

"So you essentially have to isolate your film crew in the ED and they have to wait for these cases to come up," Goldston said. "It's really, really time-consuming and really, really difficult. And you need the buy-in from the staff to be able to identify these cases and work with your HIPAA representative to be able to get them done. If you don't have all that, it's close to impossible." ✧

Endnotes

1 Adam Greene and Stacey Goldston, "Navigating Filming at Health Care Facilities," Virtual 43rd National HIPAA Summit, April 8, 2026, https://bit.ly/4c9uSbi.

2 U.S. Department of Health and Human Services, Health Information Privacy, "Can health care providers invite or arrange for members of the media, including film crews, to enter treatment areas of their facilities without prior written authorization?" FAQ, last reviewed January 9, 2023, https://bit.ly/4tM71WF.

NEWS BRIEFS

◆ **The HHS Office of Inspector General (OIG) has updated its Work Plan.**[1] Among other things, OIG will audit selected inpatient and outpatient billing requirements and Medicare payments for Spravato, as well as do a national compliance audit of home health claims billed with an institutional admission source. On the evaluation side of the house, OIG will look at Medicare Advantage organizations' use of prior authorization for post-acute care, Medicaid payments to terminated providers, and CMS's tracking and refunds of deductible and coinsurance amounts for adjusted and cancelled Medicare Part A and B claims.

◆ **The revamped version of the Program for Evaluating Payment Patterns Electronic Report (PEPPER) will be available to critical access hospitals (CAHs) in mid-May**, the Medicare administrative contractor Novitas Solutions said in an email. CAHs are the second provider type, after short-term acute care hospitals, to have access to the new PEPPERs.

Endnotes

1 U.S. Department of Health and Human Services, Office of Inspector General, "Browse Work Plan Projects," accessed May 15, 2026, https://bit.ly/4dqomNY.