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

Contents

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Hospital Settles EMTALA CMP Case Over 14 Patients; FCA Allegations Delayed Settlement

In a case that was delayed for years because of a whistleblower's false claims allegations rooted in the Emergency Medical Treatment and Labor Act (EMTALA), Merit Health Central Hospital in Jackson, Mississippi, agreed to a July 1 civil monetary penalty (CMP) EMTALA settlement with the HHS Office of Inspector General (OIG).[1]

The hospital, which will pay $350,000, allegedly violated EMTALA between Jan. 15, 2013, and April 14, 2015, with respect to 14 patients who went to the emergency room for gunshot wounds, head trauma, psychiatric crises or other conditions.

The strangest part has to do with the dates of the allegations, said attorney Kelsey Jernigan, with K&L Gates. They don't square with the fact that CMS moves fast when its surveys uncover deficiencies, Jernigan said. If they put patients in "immediate jeopardy," Medicare requires hospitals to get in compliance in 23 days.

"The whole structure is very timely because the failure to comply with EMTALA has material patient safety risk," Jernigan noted. "The 23-day timeline leads to being disenrolled from Medicare if the hospital doesn't take immediate action to correct deficiencies. A 2013 patient is clearly outside of that window."

The hospital didn't admit liability in the settlement.

Court Upheld Dismissal of FCA Lawsuit

OIG's EMTALA enforcement action was stayed as the False Claims Act (FCA) lawsuit against Merit Health, formerly known as Central Mississippi Medical Center, worked its way through the legal system. The FCA lawsuit was filed by a whistleblower, physician Blake Vanderlan, who tried to connect EMTALA violations to improper payments, according to the U.S. Court of Appeals for the Fifth Circuit.[2] It was dismissed by the U.S. Department of Justice (DOJ) and then OIG settled the EMTALA action July 1.

Meanwhile, OIG and the hospital had settlement discussions about possible CMPs; no settlement was reached, "and administrative enforcement proceedings were stayed pending this litigation," the court decision states.

Vanderlan's last hurrah was last year, when the Fifth Circuit upheld DOJ's right to throw out the case. The court noted, however, that Vanderlan exposed the EMTALA violations, setting the CMP settlement in motion.

Even though the allegations date back more than a decade, hospitals face the same kinds of EMTALA compliance challenges. An increase in patients with behavioral health problems and violence against emergency department (ED) employees has upped the ante for compliance, Jernigan said. Sometimes compliance is an uphill battle, especially when patients want to leave before having a medical screening exam (MSE), she noted.

Gunshot Wounds Were a Theme

EMTALA requires hospitals with an ED to provide an MSE and stabilizing treatment to all comers if they have an emergency medical condition (EMC), within the capacity and capability of the hospital (see box, p. 3).[3] In the absence of that capacity and capability, hospitals are permitted to transfer patients, and receiving hospitals can't turn them away.

According to the settlement, OIG alleged Merit Health Central Hospital didn't provide an adequate MSE and/or stabilizing treatment to 14 people who showed up at its ED.

In nine cases, the patients were transferred to the University of Mississippi Medical Center "without providing, within the staff and facilities available to it (including on-call surgeons or specialists), further medical examination and treatment required to stabilize the individual's condition or to minimize the risks for transfer."

The hospital transferred six of the patients based on its application of Central MS Trauma Region Trauma Activation Criteria and Destination Guidelines for the transfer of people who had penetrating trauma.

The settlement, which was obtained through the Freedom of Information Act, said the episodes involved the following patients: J.C. (gunshot wound to knee and abdomen); J.J. (gunshot wound to neck); C.G. (gunshot wound to penis, leg and pubic ramus); R.W. (gunshot wound to hip, thigh and pelvis); D.W. (gunshot wound to foot); G.T. (head and facial lacerations, chest injuries, pain with breathing, shortness of breath, pain with movement and loss of consciousness due to a motor vehicle accident); J.H. (neuro and head trauma); H.L. (stab wounds to neck and torso); and A.P. (injuries to shoulder and elbow from falling from the roof).

In separate allegations, four other people presented to the ED with a psychiatric EMC. OIG alleged the hospital neglected to nail down whether the patients had an EMC and to provide, "within the staff and facilities available to Respondent (including on-call psychiatrists), further medical examination and treatment required to stabilize the individual's condition." The four people were sent by taxi to a homeless day shelter.

Finally, there was a patient who showed up at the ED for treatment in connection with his end-stage renal disease and had an EMC requiring dialysis. OIG alleged the hospital didn't furnish "this available stabilizing treatment."

Do Psychiatric Patients Require More?

The allegations hit on three EMTALA staples: MSEs, stabilizing treatment and transfers. For example, OIG challenged the MSE for a psychiatric patient, Jernigan said.

"The government thinks MSEs for psychiatric patients require more specialized qualified medical professionals rather than an ED physician and midlevel provider in the ED," she noted. If the hospital has a psychiatrist on staff, the government questions why the psychiatrist doesn't perform the MSE, although she noted that's not required by EMTALA regulations.

EDs may find themselves between a rock and a hard place. For example, some patients leave before they have an MSE, with hospitals failing to inform them they have that right and the risks of leaving against medical advice (LAMA).

"Hospitals really struggle with what this means, especially in the last few years when aggression in the ED toward healthcare workers has increased and there are more high-acuity patients," Jernigan said. "Hospitals are walking the line between intervening when the patient who didn't receive the MSE wants to leave" and responding to the government's pressure to stop them or at least ask them to sign an LAMA form.

Best Practice: Unique LAMA Form for EDs

Jernigan said it's a best practice to use an LAMA form that's unique to the ED setting. That way, the patient acknowledges they're going before being seen. Although that's standard operating procedure at a lot of hospitals, they may not be able to snag a signature. "You can't stop everyone who leaves the ED," Jernigan noted. It's just too busy with people taking snack breaks and family members milling around. She made that argument to OIG during discussions on a case, but it wasn't persuasive because hospitals are expected to keep track of their patients.

OIG is the last stop on the EMTALA enforcement train. The vast majority of alleged EMTALA deficiencies are resolved when CMS accepts the hospital's corrective action plan, Jernigan said. Sometimes, however, hospitals may push back on the surveyor's findings and appeal to the quality improvement organization.

"They have a physician reviewer who reviews all the materials and they make a recommendation to OIG as

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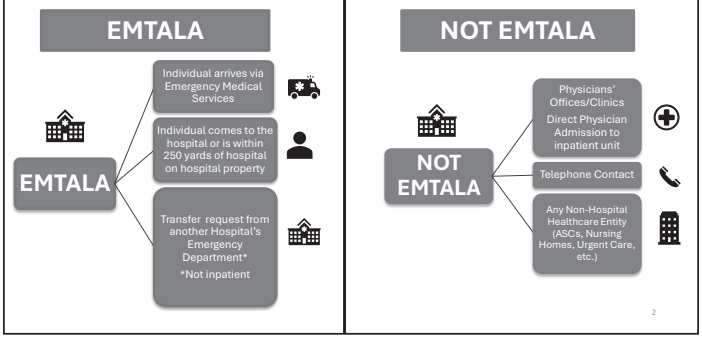
Quick Guide to EMTALA Compliance and Enforcement

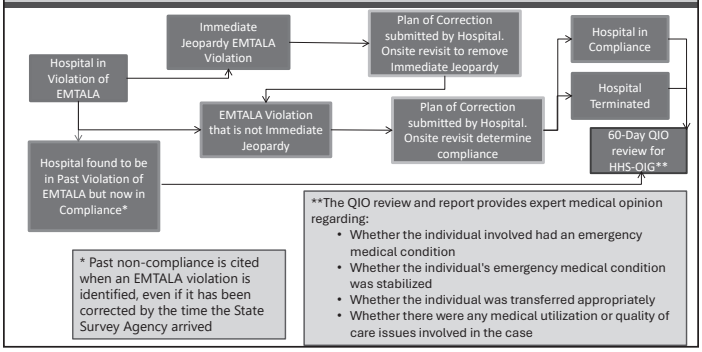
Here are the requirements of the Emergency Medical Treatment and Labor Act (EMTALA) in a nutshell and the consequences for running afoul of them, as was alleged in a hospital's recent settlement with the HHS Office of Inspector General (see story, p. 1).[1] The summary appears on CMS's website.[2]

Emergency Medical Treatment and Labor Act (EMTALA)
Process Overview

EMTALA Pathways



EMTALA Violation



EMTALA Ends When

- The individual is:
  - Screened by a physician or qualified medical personnel and does not have an emergency medical condition, or
  - Stabilized to resolve the emergency medical condition, even if ongoing care is needed for an underlying medical condition, or
  - Admitted to the hospital as an inpatient in good faith (not in observation status), or
  - Transferred safely to another hospital that assumes EMTALA obligation.
- Or any time the individual refuses care.

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Enforcement

By statute, the only sanction CMS can impose for an EMTALA violation is termination from the Medicare program.

The HHS Office of the Inspector General has the authority to impose civil monetary penalties (fines) against hospitals and/or physicians for violations of EMTALA.

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Endnotes

1 Nina Youngstrom, "Hospital Settles EMTALA Case Over 14 Patients; FCA Allegations Delayed Settlement," *Report on Medicare Compliance* 35, no. 26 (July 20, 2026), 1.

2 Centers for Medicare & Medicaid Services, "Emergency Medical Treatment and Labor Act (EMTALA): Process Overview," accessed July 16, 2026, https://bit.ly/4wbpmOk.

to whether OIG should pursue CMPs," she explained. "You never hear what their recommendations are, but if you don't hear from the OIG, you presume they didn't pursue it."

Contact Jernigan at kelsey.jernigan@klgates.com. ✧

Endnotes

1 U.S. Department of Health and Human Services, Office of Inspector General, "Merit Health Central Hospital Agreed to Pay $350,000 for Allegedly Violating Patient Dumping Statute by Failing to Provide Adequate Medical Screening Examinations and Stabilizing Treatment," July 1, 2026, https://bit.ly/4pqE7dJ.

2 Vanderlan v. Jackson HMA, L.L.C., No. 24-60215 (5th Cir. Apr. 18, 2025), https://bit.ly/4wQMPV2.

3 Nina Youngstrom, "Quick Guide to EMTALA Compliance and Enforcement," Report on Medicare Compliance 35, no. 26 (July 20, 2026).

Some Hospitals Find WISeR Unpredictable, With Alleged Lack of 'Consistency'

It was a piece of cake for Olympic Medical Center in Washington state to get prior authorization for the insertion of a penile pump under CMS's Wasteful and Inappropriate Service Reduction (WISeR) model. The hospital submitted paperwork, including medical records, to the AI vendor assigned to its state, and received an "affirmation" for the procedure, which diagnoses and treats impotence.

"It was super easy and we got approved," said Stephanie Gunn, provider revenue supervisor at Olympic Medical Center.

But the hospital's other experience with WISeR—the prior authorization model for certain procedures in original Medicare underway in six states—hasn't gone well, Gunn said. Other hospitals sometimes also feel they're forced down the rabbit hole with the AI vendors hired by CMS to determine whether prior authorization requests meet local coverage determinations (LCDs) and national coverage determinations (NCDs).

The states are Arizona, New Jersey, Ohio, Oklahoma, Texas and Washington, and the targeted procedures include skin substitutes, knee arthroscopy for osteoarthritis, hypoglossal nerve stimulation for obstructive sleep apnea and cervical fusion. When hospitals or physicians ask for prior authorization, the vendor either says yes (a "provisional affirmation") or no (a "nonaffirmation").

Olympic Medical Center's other prior authorization request was for sacral nerve stimulation for urinary incontinence with CPT code 64590 (insertion or replacement of a peripheral, sacral, or gastric neurostimulator pulse generator or receiver). The hospital uploaded the documentation to the portal for Virtix Health, the AI vendor.

The vendor's response: prior authorization isn't necessary. "NCD 230.18 (Sacral Nerve Stimulation for Urinary Incontinence) and the WISeR Model Provider and Supplier Guide (v. 3.0, updated December 23, 2025) address temporary test stimulation as well as permanent implantation," the vendor wrote to the hospital. "The NCD and the Guide do not address device replacement. Because the device replacement is outside the scope of the NCD and of WISeR program, prior authorization is not necessary in this specific instance. Therefore, this prior authorization request will be dismissed."

Gunn submitted it again, thinking the vendor was missing something. But Virtix stuck to its guns, replying that 64590 is "an invalid CPT code for the WISeR program," according to communications shared with *RMC*. She found this unhelpful, especially since the urology department had confirmed the accuracy of the code.

More Back and Forth

The hospital also sent an email to the CMS WISeR support team, explaining that "we have found that we are unable to request authorization for CPT 64590 as it is considered an associated CPT. If a patient meets the criteria under NCD 230.18, we would submit CPT code 64590 on our claim. Why is the WISeR program only allowing us to request authorization under 64581, which would be included in CPT 64590? In our opinion, we should be able to obtain authorization for 64590? Can you help us understand your logic in section 6.2.7?"

In response, the CMS WISeR support team told the hospital that the procedure doesn't require prior authorization or prepayment review, which is an option for providers if they decide to skip prior authorization. CMS explained that prior authorization or prepayment review applies to the primary CPT codes in Appendix A of the WISeR Operational Guide.[1] Associated codes, which are in Appendix C, aren't meant to be billed as stand-alone services and therefore don't call for prior authorization or prepayment review.

The hospital went ahead with the surgery anyway. Gunn said she favors prior authorization in this context over prepayment review, especially because the mechanics are a breeze. She puts the prior authorization request and medical records in the portal and voila! It spits out a response. "It was great" for one of the requests.

Sometimes Vendor Gets It Wrong

The director of clinical revenue integrity at another hospital in a different state said it has had its share of WISeR problems, with some of the vendor's determinations flat-out wrong. She's worried care will be delayed and money lost with no rhyme or reason. Some of the challenges stem from prior authorization requests involving independent physicians, according to the revenue integrity director, who prefers not to be identified.

"My issues are lack of consistency and accountability," she said.

The hospital hasn't committed to prior authorization exclusively, keeping prepayment review in the mix. But prior authorization hasn't always been pretty.

For example, the hospital submitted a prior authorization request for a procedure with fluoroscopy that complied with coverage requirements, the revenue integrity director said. Zyter, the AI vendor for her state, denied the request because it couldn't tell whether the physician intended to use contrast during the procedure.

That led to some eye rolling because "fluoroscopy by definition includes contrast," the revenue integrity director said. The vendor wasn't "able to recognize fluoroscopy and contrast are the same thing." The hospital had to resubmit the prior authorization request several times with the word "contrast."

The vendor also denied a prior authorization request for a procedure on the premise there were frequency limits with medically unlikely edits. Again, it misunderstood, the revenue integrity director said. The physician had documented a plan to perform the procedure on two sites on different days, "but WISeR said 'there are two treatments, so we are denying it outright.'"

"Our experience with WISeR is very unpredictable," she said.

Hospital Doubted Vendor's Affirmation

The revenue integrity director also contends the vendor has trouble interpreting some LCD requirements.

That came to light in connection with the hospital's routine internal reviews of procedures with a high denial rate, which are performed by a nurse to ensure the hospital has the documentation required for prior authorization.

In one case, the nurse determined a stimulator implant didn't comply with the LCD because the patient had a home sleep study, not a polysomnography (a sleep study at a facility). As a result, the hospital didn't ask the vendor for prior authorization.

After the hospital broke the news to the independent physician who ordered the procedure, the physician said they would request an affirmation anyway. WISeR allows either the hospital or physician to do the prior authorization legwork, but they share a unique tracking number, which is required for payment.

As it turned out, Zyter gave the go-ahead even though it was incorrect, the revenue integrity director said. She double-checked with CMS, which confirmed the procedure isn't covered with only a home sleep study.

The vendor's green light "puts us in a precarious position with the physician and the patient," the revenue integrity director said. "When you're working with providers who aren't part of your organization, and they say it's approved and we know it doesn't meet medical necessity, it's a difficult conversation to have."

The overarching concern is the lack of trust in AI vendors "to adequately interpret the documentation," she said. "We are putting decisions about patient care in the hands of a tool that's not necessarily accurate."

Although a majority of the hospital's prior authorization requests have been affirmed, they often require resubmissions and clarifications, the revenue integrity director said.

"It's tedious," she noted. It would be comforting if she felt the vendor "understood our information."

Contact Gunn at sgunn@olympicmedical.org. ✧

Endnotes

1 Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation, *Wasteful and Inappropriate Service Reduction (WISeR) Model: Provider and Supplier Operational Guide*, last updated April 24, 2026, https://go.cms.gov/3WQF7dk.

Incident-To Audits Resurface With a Twist; Treatment Plan Rules

Advanced practice providers (APPs) at Florida Cancer Specialists & Research Institute often ask Chief Compliance Officer Tonja Wise for an example of how incident-to billing rules apply in every conceivable situation.

"I can never give you that," Wise tells them. But she does educate APPs on broad strokes, such as when changes to treatment plans affect incident-to billing and when a physician's idea of direct supervision doesn't cut it. The stakes are high for hashing out Medicare requirements now that incident-to billing is under the microscope both directly and indirectly when auditors review evaluation and management (E/M) levels of service, Wise said.

It attracts audit attention because Medicare pays more when an APP performs services incident to the physician and they're billed with the physician's National Provider Identifier (NPI).

The way incident-to billing rules apply is fact-specific. For example, the particulars of a medication-dose adjustment determine the yay or nay on incident-to billing. "It depends on the original treatment plan," Wise said. "If it's management of a new symptom that's clearly from the meds, that may be fine."

But the answer might be different in other circumstances. A patient on chemotherapy who comes in with a severe rash that appears unrelated to the chemo may need additional treatment, and "if you start going down that path without reconsulting the physician, you should bill under the APP" unless the rash was anticipated in the treatment plan.

With all the twists and turns, it's important "to be really intentional when it should be incident to and when it can't be," Wise explained. Because answering the questions is challenging, she's holding lunch and learns in July for APPs.

'Continues to Be a Hot-Button Area'

Incident-to billing has always been a target, but it's "garnering more interest," Wise said. The HHS Office of Inspector General (OIG) is doing probe audits, asking some practices for incident-to data, she said. "They would like to see the documentation and understand the process between the supervising physician and the rendering physician, who was actually in the office providing the service," Wise said. Although the number of claims is small because it's a probe audit, "they're asking about a variety of services."

Incident-to billing has been on OIG's Work Plan since 2024, with OIG's objective "to determine whether Medicare Part B payments for services performed incident to physicians' services complied with Medicare requirements."[1]

Also, incident-to billing is figuring in some Targeted Probe and Educate (TPE) reviews of E/M billing (CPT codes 99214 and 99215) and transitional care management. As the Medicare administrative contractors (MACs), which run TPE, drill down on those codes, they're noting that incident-to billing is integral to them. "They're including

that in other audits," Wise said. "Given that, it continues to be a hot-button area."

Billing 85% vs. 100%

Services performed by APPs (and others) incident to the physician are billed at 100% of the Medicare Physician Fee Schedule (MPFS), if certain conditions are met. Otherwise, APPs' services are billed under their own NPI at 85% of the fee schedule.

Medicare requires physicians to see brand-new patients first and establish a plan of care before APPs take over in subsequent visits. If there's a change to the plan of care, the APP must bring in the physician again.

Physicians must provide direct supervision of incident-to services. Historically, to provide direct supervision, physicians were required to be in the office suite and immediately available to help the patient, but CMS now allows physicians to be off-site if they're available via audio-video communication (virtual supervision).

And incident-to services must be billed with the name of the supervising physician, who doesn't have to be the same physician who initiated the course of treatment.

Whether the physician should take over a visit because of a new course of treatment isn't black and white. "It comes up a lot," Wise said. Even when patients have what seems like a new problem, it may be an extension of the original problem that brought them in for diagnosis and treatment. That's the source of many questions from APPs, because the answer often is situation-dependent, she noted.

Wise said they turn to American Medical Association and National Comprehensive Cancer Network (NCCN) guidelines. For example, if the patient experiences itchiness with a particular treatment as anticipated in the treatment plan, the APP may wind up prescribing prednisone. That paves the way for incident-to billing because it's "logically connected to the treatment plan," she explained. "We look at NCCN guidelines as well because that's where it outlines what the expectations are for dose reductions, additional meds or treatment delays."

Some New Symptoms Are Anticipated

But APPs may find themselves in a pickle, especially if coding auditors are very conservative. For example, if patients complain of depression after a previous visit, some coding auditors may characterize the depression as a new symptom that requires pulling the doctor back in.

"You have to look at the big picture," Wise said. "The patient has cancer and is being treated for cancer, and potential depression is an obvious side effect, so it's a little bit of a judgment call." The same goes for fatigue. It's a "probable outcome of what they're going through."

Not everyone agrees that incident-to billing is a no-go when a patient comes in with a new problem. Although that's the perception generally, it's not true, according to attorney David Glaser, with Fredrikson & Byron.

The idea that APPs aren't allowed to bill 100% of the MPFS when a new problem crops up isn't mentioned in regulations or Medicare manuals with respect to incident-to billing. Physician practices should keep that in mind before they return overpayments based on new problems treated by APPs, he said.

Signature Depends on the MAC

Another risk area with incident-to billing is direct supervision. The compliance risks are more binary: "they're either available or they're not," Wise said. "We have to make sure we're very crisp in our documentation."

But there are gray areas with "immediately available." For example, if a supervising physician is on vacation and a colleague is filling in, it's possible the supervising physician isn't required to sign the documentation, although the physician must be identified in the documentation.

That's challenging because the workflow varies. One version: the APP signs the note, which is reviewed by the ordering ("demographic") physician, and maybe the note is signed by the supervising physician. "Your mileage may vary there," Wise said. "It is MAC-dependent."

You Can't Supervise During a Root Canal

There's also a risk if the supervising physician is out of the country. If the physician is in Europe and it's 3 a.m., for example, Wise said she can't make the argument they're immediately available.

Although CMS now allows virtual direct physician supervision, physician practices may skip it. "We're making a practice decision on whether or how much we want to do that," Wise noted. Sometimes it's obvious the physician isn't up for direct supervision. For example, physicians aren't immediately available when they're having a root canal with laughing gas or Novocain.

"You have to emphasize that this can't be a tool to generate more visits," Wise noted. "This is a tool that's meant to help the practice and the patients." If the supervising physician is indisposed, "it's not helping the patients."

She encourages physician practices to be clear that immediately available means the physician has the phone in their hand and a clear audio-video connection and can provide medical advice if necessary.

Contact Wise at tonja.wise@flcancer.com and Glaser at dglaser@fredlaw.com. ✧

Endnotes

1 U.S. Department of Health and Human Services, Office of Inspector General, "Medicare Part B Payments for Incident To Services," OAS-25-01-003, last modified November 15, 2024, https://bit.ly/4yoltWz.

CMS Flips the Script of RPM and RTM in Proposed 2027 MPFS Rule

In an apparent change of heart about remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM), CMS is floating revisions that would make it harder to bill for the services and reduce reimbursement, according to the July 16 proposed 2027 Medicare Physician Fee Schedule (MPFS) regulation.[1]

The proposals come after years of expanding RPM and RTM services, said attorney Thomas Ferrante, with Foley & Lardner LLP.

In the most significant change, CMS would require employees at physician practices to perform the monitoring portion of RPM/RTM, blocking the vendors who often help provide the services. And not long after adding codes, CMS would compress 17 RPM/RTM codes into four.

Other proposals would peel back support for RPM/RTM, Ferrante said. For example, RPM could only be provided to established patients (as a condition of payment) and "practitioners reporting RPM or RTM services must furnish a separately reportable initiating visit in association with the onset of RPM or RTM services," CMS said.

One possible reason for the pullback is a 2024 HHS Office of Inspector General (OIG) report, which called for greater oversight of RPM.[2] OIG cited the skyrocketing use of RPM, with Medicare payments 20 times higher in 2022 than 2019. Some of the increased billing flexibility, however, came down after the report.

'Everyone Is Surprised'

The proposals came out of left field. "Everyone is surprised," Ferrante said. CMS has been tweaking RPM/RTM coverage since 2018, which generally improved access, so the proposal "is a departure from that posture."

RPM involves the use of a device to remotely collect and transmit patients' data (e.g., weight, blood pressure and pulse oximetry) to their physician, who reviews the data and makes treatment decisions about the patient, such as adjusting their medication.

The data must be collected for 16 days over a 30-day period. There are three RPM components: enrollee education and device setup, device supply and treatment management, which requires at least 20 minutes of interactive communication with the caregiver or patient.

RTM, which involves adherence to at-home therapeutic interventions, has the same three components. There are different codes for three types of therapeutic monitoring: respiratory system, cognitive behavioral therapy and musculoskeletal system.

Vendors often help practices with RPM/RTM because their clinical staff is stretched thin "and maybe

CMS Transmittals and *Federal Register* Regulations, July 10–16, 2026

Transmittals

Pub. 100-04, Medicare Claims Processing

- Influenza Vaccine Payment Allowances - Annual Update for 2026-2027 Season, Trans. 13859 (July 16, 2026)
- File Conversions Related to the Spanish Translation of the Healthcare Common Procedure Coding System (HCPCS) Descriptions, Trans. 13867 (July 13, 2026)
- Reporting Face-to-Face Encounter Conducted by a Hospice Physician or Hospice Nurse Practitioner for Recertification via Telecommunications Technology on Hospice Claims, effective January 1, 2027, Trans. 13860 (July 10, 2026)

Pub. 100-05, Medicare Secondary Payer

- ECRS Update for Prescription Drug Inquiries (PDIs) to Prevent the Creation of Records with Invalid or Missing Information and to Reduce the Number of Records with Invalid Insurer Names, Trans. 13856 (July 10, 2026)

Pub. 100-06, Medicare Financial Management

- Notice of New Interest Rate for Medicare Overpayments and Underpayments -4th Quarter Notification for FY 2026, Trans. 13869 (July 14, 2026)

Pub. 100-20, One-Time Notification

- Expansion of the Supplemental Security Income (SSI) Ratio on the Inpatient Provider Specific File (PSF), Trans. 13877 (July 16, 2026)
- Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) Front End Updates for October 2026, Trans. 13865 (July 10, 2026)

Federal Register

Notice

- Civil Monetary Penalties Inflation Adjustments for 2026, 91 Fed. Reg. 43,405 (July 15, 2026)
- Medicaid and Children's Health Insurance Program (CHIP) Generic Information Collection Activities: Proposed Collection; Comment Request, 91 Fed. Reg. 43,643 (July 16, 2026)

Proposed Rule

- Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program, 91 Fed. Reg. 43,842 (July 16, 2026)

Request for Information

- Request for Information; Clinical Laboratory Improvement Amendments of 1988 (CLIA) Regulations, 91 Fed. Reg. 43,586 (July 16, 2026)

don't have the expertise or appetite to do the extra work of monitoring," Ferrante said. But that would change on a dime under the proposed regulation. Medicare would only pay for RPM/RTM services when they're provided by clinical staff employed by the practice. CMS explained that outsourcing RPM/RTM services may interfere with the billing practitioner's ability to provide adequate oversight, management or collaboration. Ferrante calls this "the most disruptive" of the changes.

Coding Changes Just Took Effect This Year

One of the curious things about this is CMS just cut physicians some slack with respect to the billing requirements. In the 2026 MPFS rule, CMS adopted CPT code revisions that allow practitioners to report RPM device supply for two to 15 days within a 30-day period and created a code for RPM treatment management for 10 minutes. Similar leeway came down for RTM codes.

Now CMS is "considering" whether to bundle 17 RPM/RTM codes into four. "We have concerns about the administrative burden of the numerous remote monitoring codes and proliferation of this code family," CMS said. "We also continue to work to implement recommendations from the recent OIG reports that we are concerned cannot be fully resolved with the current coding structure of the remote monitoring code family, such as ensuring that beneficiaries receive all components of the remote monitoring service," the proposed rule said.

If it happens, CMS would replace CPT codes 99453, 99445, 99454, 99091, 99470, 99457, 99458, 98975, 98984, 98976, 98985, 98977, 98986, 98978, 98979, 98980 and 98981 with four new HCPCS G codes.

That would reverse the flexibility CMS just adopted, Ferrante noted.

He predicts a slew of comments on the proposed rule "because there has been so much progress and expansion. It's a very large jump backwards."

Contact Ferrante at tferrante@foley.com.

Endnotes

1 Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program, 91 Fed. Reg. 43,842 (July 16, 2026), https://bit.ly/4vEOvjk.

2 Christi A. Grimm, *Additional Oversight of Remote Patient Monitoring in Medicare Is Needed*, Department of Health and Human Services, Office of Inspector General, OEI-02-23-00260, September 2024, https://bit.ly/4wLbH06.

NEWS BRIEFS

◆ **HHS has delayed the publication of the final updated HIPAA Security Rule, with a new release date of July 2027.**[1]

◆ **The HHS Office of Inspector General has updated its Work Plan.**[2]

◆ **Laboratory Corporation of America (Labcorp) agreed to pay $14.5 million to settle false claims allegations over billing for medically unnecessary urine drug testing (UDT) for some patients under a testing panel called "Toxassure Comprehensive," the U.S. Department of Justice (DOJ) said July 15.**[3] The Toxassure Comprehensive panel has both "presumptive" and "definitive" UDT methods, with presumptive tests detecting certain drugs subject to testing thresholds and definitive UDT identifying specific substances and their concentrations. Generally, Medicare pays a flat rate for lab-based presumptive testing regardless of the number of drug classes tested with CPT code 80307, and Medicare pays a flat rate for definitive testing of 22 or more drug classes per HCPCS Code G0483, DOJ said. In the settlement, Labcorp admitted certain facts. For example, Labcorp ran many tests at the same time for the same patient on the same day using the same urine sample, billing Medicare with CPT code 80307 for the presumptive UDT and HCPCS Code G0483 for the definitive UDT. "In other words, Labcorp billed Medicare for both the all-inclusive presumptive CPT code and the highest-tier definitive HCPCS code each time the ToxAssure Comprehensive was performed," DOJ said.

Endnotes

1 U.S. Department of Health and Human Services, "HIPAA Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information," 0945-AA22, accessed July 17, 2026, https://bit.ly/3THa5pZ.

2 U.S. Department of Health and Human Services, Office of Inspector General, "Browse Work Plan Projects," accessed July 17, 2026, https://bit.ly/4yogFBK.

3 U.S. Department of Justice, Office of Public Affairs, "Labcorp Agrees to Pay $14.5M to Resolve False Claims Act Allegations," news release, July 15, 2026, https://bit.ly/3TmDOo4.