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

Contents

Publisher's Note
RMC will not be published next week. The next issue will be dated August 17, 2026.

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

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

Weill Cornell Medicine Enters Into Compliance Agreement With Feds Over Patient Sex Abuse

Two years after one of its former urologists was convicted of unlawful sexual activity with patients, Weill Cornell Medicine (WCM) in New York City has entered into a "voluntary compliance agreement" under the Americans with Disabilities Act (ADA) in connection with the sex abuse, the U.S. Attorney's Office for the Southern District of New York said July 27.[1]

The agreement ends a criminal investigation of WCM over its failure to detect, prevent and respond to urologist Darius Paduch's sexual abuse of patients.[2] For a decade, Paduch abused patients as young as 13 and was sentenced to life in prison.

WCM has already paid $1 billion to settle claims from Paduch's victims. For that and other reasons, including its cooperation with the investigation, WCM was spared additional fines.

But the agreement requires WCM to establish an Institute for Safe Patient Care and Patient Empowerment to detect, prevent and report sexual abuse and spend $10 million a year for three years to "support and grow this initiative."

'Systems Need to Be Very Vigilant'

The U.S. attorney's office investigated WCM under Title III of the ADA, which prohibits places of public accommodation from discrimination based on a disability. Victims of Paduch's sex abuse had certain genetic conditions and sexual and erectile dysfunction "that constitute a disability under the ADA," the U.S. attorney's office said.

The ADA defines "disability" as "a physical or mental impairment that substantially limits one or more major life activities." That includes the operation of a major bodily function, such as reproductive functions.

"Large systems need to be very vigilant to prevent catastrophic events from happening for so long," said attorney Drew Stevens, with Parker Hudson. He recommends health systems audit their own policies and procedures against the WCM compliance reforms on chaperones, reporting and investigating, "and make sure everyone is adequately trained."

ADA Is the 'Legal Hook'

Stevens noted that the ADA is "the legal hook they built into this agreement" because the ADA's definition of a disability is very broad. "Disability discrimination is a very active area of enforcement and compliance, and this settlement agreement with Cornell intersects with disability discrimination because of the type of practice this physician had," he said. "Otherwise, it's the same risk of sexual abuse, harassment and misconduct that forms the basis of the Michigan State University settlement" over sex abuse by physician Larry Nassar, who was an employee at the time.

Michigan State agreed to compliance reforms in a 2019 settlement with the U.S. Department of Education under Title IX of the Civil Rights Act, which prohibits sex discrimination at schools and colleges. The university also put $500 million in a fund for Nassar's sexual assault victims.[3] A number of settlements with other universities over a physician's alleged sex misconduct have come down in the past five years.[4]

Generally, institutions facing sexual misconduct allegations could potentially

fall under the Trump administration's new Civil Rights Fraud Initiative, which combats discrimination subsidized by federal funds, Stevens said. That's where the False Claims Act may come into play. "It's a real risk," he noted. "But traditionally the enforcement mechanism" is a compliance agreement and a civil money penalty.

Stevens said compliance, patient safety and legal departments at health systems should collaborate to develop the kinds of procedures in the agreements, including chaperone policies and "clear lines of communication" when reports come in about alleged sexual abuse.

"This is one of the more horrific types of claims to investigate," Stevens said. "It requires partnering with outside counsel to conduct counsel-led investigations of the allegations" similar to investigations of sexual harassment.

WCM, which is a medical school that also provides clinical services, acknowledged in the agreement the inadequacy of its policies and programs during Paduch's tenure and promised not to contradict the "acknowledged conduct."

'Under the Guise of Medical Treatment'

According to the agreement, Paduch joined WCM in 2003. He was a fellow at the WCM Center for Male Reproductive Medicine & Microsurgery, an associate professor of reproductive medicine and urology and a practicing urologist in WCM's urology department, where he became director of sexual health and medicine. He treated adults and children, specializing in male infertility, Klinefelter Syndrome and erectile and sexual dysfunction.

From 2009 to 2019, Paduch sexually abused patients, some of them boys as young as 13 years old. Many of the 50 victims identified by the government were minors, some with cognitive and expressive delays.

"Paduch watched his patients masturbate, manually masturbated his patients, digitally probed and penetrated their rectums, and used vibrators on them," the agreement said. "Paduch also invited patients to his home or his boat, where he engaged in similar sexual abuse under the guise of medical treatment."

The sexual misconduct continued partly because of "legacy" policies at WCM, according to the agreement. While the chair of the urology department was responsible for investigating staff and patient complaints, department chairs weren't required to escalate complaints of patient sexual misconduct. There were no centralized resources or training on this kind of complaint and "no standardized processes or requirements for documenting investigative findings of such complaints."

Chaperone Requirement Wasn't Enforced

Although allegations about Paduch reached the (now former) chair of the urology department, they weren't investigated, documented, internally escalated or externally reported.

Word of Paduch's behavior started to get around. For example, WCM got a copy of a complaint filed by a former patient with a state medical board. About a month later, a WCM employee was assigned to look into the complaint. But the former urology chair didn't mention previous complaints about Paduch to the employee, who had no experience or training in sex abuse investigations.

In another instance, another urologist told the former urology chair that a patient said Paduch "manually masturbated him to help him gain an erection for a physical exam," something Paduch denied. The former urology chair then required Paduch to have a chaperone, but the requirement wasn't written and Paduch didn't stick to it, the agreement states.

In 2018, an adult male patient emailed the former urology chair, alleging that Paduch tried to "cultivate an inappropriate personal relationship outside of the office with the patient by purporting to want to be a father figure" and sent "lewd" messages.

The former urology chair referred the complaint to the WCM employee to investigate and revealed there had been other complaints about Paduch "but not the nature or substance of those complaints." Although

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Paduch denied any sex misconduct or masturbating, he admitted to inviting the patient to his house and boat and to buying pornography subscriptions for his patients. After an investigation of the complaint, WCM fired Paduch in April 2019.

When a lawsuit was filed against WCM in 2022 over Paduch's sexual misconduct, WCM's board and executive management learned about the allegations and hired a law firm to do an internal investigation. WCM fired the former urology chair.

Reforms Got Under Way in 2020

WCM has had significant reforms underway since 2020 and agreed to continue and enhance them. Among other things, the compliance agreement requires WCM to continue to enforce:

- A chaperone requirement "with clear guidance and routine compliance oversight and monitoring."
- Policy changes, such as a policy on escalating sexual misconduct allegations from patients. It includes "an expansive definition of sexual misconduct" and "a central unit of trained professionals to investigate these complaints."
- A centralized reporting system for documenting and tracking safety events and patient complaints.
- A policy that requires an immediate initial inquiry of sexual misconduct allegations.
- A program to "identify professionalism lapses and 'red flag' behaviors for early intervention."

By May 1, 2027, WCM will assess its sexual misconduct prevention programs and identify opportunities for improvement.

In a statement, WCM said "This resolution is a significant step forward for us in addressing our former faculty member's misconduct. Today, Weill Cornell Medicine is a safer organization. Under new executive leadership, we have enacted significant reforms in patient safety and reporting protocols to ensure we provide the very best care to all those who place their trust in us."

Contact Stevens at dstevens@phrd.com and Danehower at kim.danehower@bmhcc.org. ✧

Endnotes

1. U.S. Department of Justice, U.S. Attorney's Office for the Southern District of New York, "FRE Confidential Settlement Document Voluntary Compliance Agreement between The United States of American and Weill Cornell Medicine," July 26, 2026, https://bit.ly/4fHjIlj.
2. U.S. Department of Justice, U.S. Attorney's Office for the Southern District of New York, "Weill Cornell Medicine Resolves Criminal Investigation With Agreement To Maintain And Enhance Remedial Measures And Procedures To Prevent Sexual Abuse Of Patients," news release, July 27, 2026, https://bit.ly/3RlOaUP.
3. Michigan State University, "MSU Makes $500 Million Settlement Payment to Survivor Fund," news release, December 4, 2018, https://bit.ly/4fHjqW9.
4. Corey Williams, "U. of Michigan settlement latest in school sex abuse payouts," Associated Press, January 20, 2022, https://bit.ly/4w4IxIT.

CRUSH Rule May Supercharge Oversight; Data 'Is Your Primary Firewall'

In about two months, CMS said it will propose a regulation on "crushing" fraud that may be a turning point for program integrity.[1] The regulation could change the way the government screens providers and reviews claims, raising the stakes for clean claims and data that supports them.

The forthcoming Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) is expected to supercharge data-driven oversight of admissions, DRG coding and other risk areas, said Penny Jefferson, director of clinical documentation integrity services at the University of California Davis Medical Center.

"CRUSH changes the timing of the risk conversation," Jefferson said at a July 14 webinar sponsored by RACmonitor.com. The government will eye claims earlier in their lifecycle and evaluate them "over rolling time periods" instead of doing mostly periodic audits (see checklist, pages 5-6).[2]

Documentation, not appeals, is "your primary firewall," she said. "You may not control whether your data is analyzed, but you control whether your documentation explains your data."

She anticipates more visibility into short-stay admissions, cost outliers, one-level DRG upgrades and high-scrutiny diagnoses, among other things, as part of a hospital's risk profile.

The best defense is admission-level documentation, concurrent review, compliant query practice, pre-bill validation and disciplined self-monitoring before the claim leaves the building. "The goal is to make the record defensible before the claim becomes part of the external data profile," Jefferson said.

'A Broader Regulatory Umbrella'

CMS gave a hint at what's coming in a Feb. 17 request for information (RFI) about CRUSH.[3] "The RFI gives us a blueprint for where CMS is looking," Jefferson said.

The RFI asked for ideas in various areas, such as ways to "modify provider enrollment (including revocation), medical review, investigation, audit, payment suspension, and other program integrity oversight policies to provide CMS with increased authority and flexibility to expeditiously prevent bad actors from engaging in fraud, waste, and abuse" and revise requirements or policies

to promote payment accuracy and prevent fraud. CMS also asked about the kinds of analytics, methodologies or data-driven approaches that would most effectively identify indicators of potential fraud, waste or abuse.

Nothing in the RFI implies the replacement of audit contractors, such as recovery audit contractors, Jefferson said. "Think of CRUSH as a broader regulatory umbrella built over the existing program integrity structure."

A Data-Driven Enforcement Pipeline

Although CRUSH hasn't been proposed yet, Jefferson envisions a data-driven enforcement pipeline based on CMS and HHS Office of Inspector General (OIG) practices:

- **Data collection.** "Every claim your organization submits contributes to data profiles," including DRGs, level of service, site of care and provider identifiers, Jefferson said.
- **Benchmarking.** "Your organization can be benchmarked against similar organizations," she said.
- **Pattern analysis.** She said AI-driven tools can identify outliers, such as unusual code clustering, spikes in high DRG values "or patterns that change faster than the clinical population appears to change." For example, a slow rise in respiratory failure capture over time may reflect a growing ICU population, better documentation or changes in CMI," Jefferson said.
- **Risk prioritization.** Jefferson said facilities and providers may be prioritized for review based on risk indicators.
- **Documentation review.** When a case is selected, the medical record "either explains the pattern or it doesn't," Jefferson said.
- **Action.** Findings could result in claim denials, prepayment reviews, recoupment, revocation of billing privileges, payment suspensions or referral to OIG or the U.S. Department of Justice.

"I don't think people realize the magnitude of what's to come," Jefferson said.

Although the CRUSH RFI doesn't identify specific targets, Jefferson expects reviewers to continue to focus on categories already visible through claims data, OIG reports and historical audit findings.

One of them is inpatient admissions, especially for short stays. Hospitals with a high rate of short-stay admissions compared to their peers should know about it before payers, auditors and investigators do. Jefferson recommends reviewing short stays, particularly for chest pain, syncope, transient ischemic attack, abdominal pain, cellulitis, chronic obstructive pulmonary disease and heart failure.

"Every one of them becomes defensible or indefensible based on the documentation underneath," she noted. "The pattern may get noticed but the record decides what happens next." (She noted the conditions are ripe for an internal hospital risk assessment because CMS hasn't tipped its CRUSH hand yet.)

Reviewers Are Asking a Series of Questions

Many charts have big gaps. "The order may say 'admit to inpatient,' but the note doesn't explain why," Jefferson said. Reviewers are looking for more than an inpatient order; they're asking a series of questions: did the physician document that inpatient care was necessary for this patient at this time? What clinical risks required hospital level of care? What active treatment, monitoring, instability or risk supported the expectation of a two-midnight stay? "Medical records need to reflect a provider's reasoning," Jefferson noted.

Short-stay admissions should be reviewed concurrently. If your hospital's clinical documentation integrity (CDI) team is reviewing short stays two or three days after admission, "you may already be past the most important documentation moment. The admission note is where the medical-necessity rationale should be built."

Sepsis also has a target on its back. "It's high weight, high volume and a diagnostic complication, subject to definitional tension," she said. "A medical record that carries forward the word 'sepsis' without organ dysfunction, clinical indicators and treatment response or the physician's reasoning is very vulnerable."

Other targets include:

- Malnutrition. The risk includes coding severe malnutrition for a nutritional assessment without a clear physician assessment, clinical indicators or the physician documenting the significance of the diagnosis
- Coding encephalopathy and acute respiratory failure as major complications and comorbidities (MCCs), which can hike reimbursement. "Encephalopathy means more than altered mental status in a problem list," Jefferson said. "Acute respiratory failure needs evidence of true clinical acuity, not just oxygen use."
- High-cost cardiac procedures such as transcatheter aortic valve replacement, left ventricular assist devices and electrophysiology cases.
- Capture of wound care and chronic conditions in post-acute settings.
- A single CC or MCC.

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Checklist for Documentation Defensibility, Coding Integrity

Here's a pocket self-review tool for documentation defensibility, coding integrity, site-of-care risk and enterprise monitoring. It was developed by Penny Jefferson, director of clinical documentation integrity services at the University of California Davis Medical Center. It may help hospitals prepare for CMS's Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH), which are expected in October (see story, p. 3).[1] Contact Jefferson at pjefferson@health.ucdavis.edu. ✧

Scoring	Green: in place, monitored, documented	Yellow: inconsistent, informal, or partially monitored	Red: no reliable process or unclear ownership
Area	**Minimum Readiness Checks**	**R/Y/G**	**Owner / Due Date**
1. Data Profile and Risk Assessment	[ ] Benchmark CC/MCC capture by service line, provider, specialty, facility, and trend period. [ ] Trend high-scrutiny DRGs: sepsis, respiratory failure, malnutrition, encephalopathy, cardiac procedures. [ ] Monitor cost outlier and one-level DRG upgrade frequency by DRG, service line, provider, and payer. [ ] Identify sudden spikes, clustering, provider variation, and payer-specific utilization or coding variation.	G Y R ___	Owner: _____ Due: _____
2. Documentation Defense Rubric	[ ] Medical necessity: level of care is supported for this patient, this day, this setting. [ ] Clinical specificity: reported diagnoses are supported by indicators, treatment, evaluation, and provider assessment. [ ] Cause-and-effect linkage: relationship is documented when required for complications or related conditions. [ ] Contemporaneous: clinical reasoning appears at or near the time of care, not reconstructed after denial/audit.	G Y R ___	Owner: _____ Due: _____
3. Chart Validation Sample	[ ] Pull 20 charts per high-risk DRG or targeted risk area for focused review. [ ] Score each record against the four documentation standards above. [ ] Trend findings by DRG, provider/service line, documentation gap, query opportunity, and corrective action. [ ] Repeat review quarterly or after material changes in templates, tools, service line patterns, or payer denials.	G Y R ___	Owner: _____ Due: _____
4. Site of Care and Medical Necessity	[ ] Review short-stay inpatient admissions, especially one-to-two-midnight medical stays. [ ] Confirm admission documentation explains expected trajectory and why observation/outpatient care was not sufficient. [ ] Align CDI, UR, case management, and physician advisor workflow for high-risk admissions. [ ] Monitor retrospective status changes and post-denial documentation patterns.	G Y R ___	Owner: _____ Due: _____
5. High-Risk Clinical and Coding Areas	[ ] Sepsis: source, organ dysfunction, lactate/clinical trend, treatment, response, and reasoning. [ ] Respiratory failure: true acuity, support requirements, clinical indicators, and treatment intensity. [ ] Malnutrition and encephalopathy: physician documentation, clinical support, treatment significance, and linkage. [ ] High-cost procedures, transfers, discharge destination, readmissions, cost outliers, and one-level upgrades.	G Y R ___	Owner: _____ Due: _____
6. Pre-Bill Review and Claim Protection	[ ] Use pre-bill review for selected high-risk DRGs, high-dollar cases, and unresolved documentation gaps. [ ] Confirm CDI/coding alignment before final coding on high-risk claims. [ ] Escalate unclear medical necessity, clinical validation, or query concerns before billing. [ ] Document hold, resolution, and release processes for cases that fail pre-bill review.	G Y R ___	Owner: _____ Due: _____
7. Query Compliance and CDI Practice	[ ] Base queries on documented clinical evidence and write them in a compliant, non-leading manner. [ ] Review templates against current AHIMA/ACDIS compliant query guidance. [ ] Train CDI to distinguish clarification from unsupported diagnosis pursuit. [ ] Monitor query response patterns, denied diagnoses, and CDI education opportunities.	G Y R ___	Owner: _____ Due: _____

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8. PA, UR, Denial and Audit Intelligence	[ ] Involve physician advisors early enough to strengthen the contemporaneous record. [ ] Ensure PA notes contain specific clinical rationale, not conclusory language only. [ ] Track denials by DRG, diagnosis, service line, provider, payer, and reason. [ ] Use denial trends as early warning signals for education, workflow changes, and corrective action.	G Y R ___	Owner: _____ Due: _____
9. Governance and Enterprise Readiness	[ ] Create a cross-functional readiness structure: CDI, coding, HIM, UR, compliance, revenue cycle, PA, finance, quality, operations. [ ] Develop a one-page facility risk profile reviewed with compliance and finance leadership. [ ] Identify legitimate outlier service lines and confirm the record can explain the organization's statistical profile. [ ] Review technology-assisted coding, CDI, or documentation workflows for organizational oversight and compliance.	G Y R ___	Owner: _____ Due: _____

Priority Action Rule: Treat any Red item in medical necessity, short-stay review, high-risk DRG documentation, pre-bill review, query compliance, denial analysis, or compliance escalation as high priority.

Endnotes

1. Nina Youngstrom, "CRUSH Rule May Supercharge Oversight; Data 'Is Your Primary Firewall,'" *Report on Medicare Compliance* 35, no 28 (August 3, 2026).

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- Medicare Advantage prior authorization approvals that don't align with inpatient criteria for the documented clinical picture.

"None of these data elements are new," she noted. "What is new is the degree to which these elements can be connected, compared and prioritized continually."

Four Documentation Standards

She cited four documentation standards that serve as a hospital's "internal defense rubric."

- Medical necessity: Medical records must explain why the level of care was billed for that specific patient.
- Clinical specificity: Clinical indicators must support diagnoses. Terminology (e.g., "patient has sepsis") and physician attestations are not enough.
- Linking cause and effect: Jefferson said "a causal relationship shouldn't be assumed unless it's documented" or coding guidelines allow the relationship to be presumed. For example, listing acute kidney injury and sepsis is not as supportive of a code as documenting "acute kidney injury due to sepsis."
- Contemporaneous documentation: Clinical reasoning should be documented during or near the time of care, Jefferson said. "It shows what the physician was thinking in real time."

She added that queries support clarification when documentation is conflicting, incomplete, imprecise or clinically inconsistent.

Same Diagnosis, Different Charts

Jefferson recommends pulling a sample of high-risk DRGs and scoring their medical records against the defense rubric. Here's an example of different charts for a patient with a sepsis diagnosis, one defensible and the other vulnerable to challenge.

In the first chart, the problem list says sepsis on day one, a diagnosis that's copy forwarded every day. The basis of the diagnosis was a positive screening alert rather than organ dysfunction or a lactate trend. Although the patient gets antibiotics, the condition isn't linked to the diagnosis and nothing in the chart explains the acuity behind a claim for sepsis.

"If the claim is reviewed, the hospital may struggle to defend the diagnosis," Jefferson said.

In the second chart, the attending physician documents the suspected source of the condition, including a drop in lactate after resuscitation. The patient's organ dysfunction is charted, with sepsis linked to acute hypoxic respiratory failure, and daily notes show the evolution of the assessment. "The record now tells the story," she explained. The patient's acuity is visible, specific, linked and timely.

Although the charts may look the same to the analytics initially, "to the reviewer they're completely different."

Strengthening the Hospital's Infrastructure

With ongoing audits and investigations and the pending CRUSH, Jefferson suggested hospitals fortify their revenue cycle "infrastructure." Here are key steps:

- Assess: Conduct your own CRUSH-like risk assessment. "Know your own profile before external reviewers define it for you."
- Prioritize concurrent CDI review. "Position your resources for where the risk lives," Jefferson said.

- Consider admission-focused CDI reviews of inpatient admissions for procedures where medical necessity is time-sensitive.
- Verify claims before they're out the door. That includes a pre-bill checkpoint for high-risk DRGs and denial pattern dashboards.
- Sustain things through people and governance. "A generic policy memo rarely changes behavior," she noted. It's more powerful to show physicians how their documentation patterns compare to their peers. "We always want to get to what's in it for them."

Protecting your organization requires "enterprise management," Jefferson noted. Compliance can't own this alone and the same goes for CDI, coding or utilization management. "The organization needs one shared risk profile."

Contact Jefferson at pjefferson@health.ucdavis.edu. ✧

Endnotes

1. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) (CMS-6098)," Unified Agenda, RIN 0938-AV97, updated 2026, https://bit.ly/4pJfpFm.
2. Nina Youngstrom, "Checklist for Documentation Defensibility, Coding Integrity," *Report on Medicare Compliance* 35, no. 28 (August 3, 2026).
3. Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH), 91 Fed. Reg. 9,803 (Feb. 27, 2026), https://bit.ly/4w1L7zp.

DOJ Declines to Prosecute Company Under CEP, but Indicts Its Founder

The twin goals of the new corporate enforcement and voluntary self-disclosure policy (CEP) and the longtime commitment to holding individuals accountable for wrongdoing were on display when the U.S. Department of Justice (DOJ) said July 29 it has declined to prosecute a company for healthcare fraud but indicted its founder.[1]

Because of the declination, Campus Eye, a management services organization that provided billing and other services to an optometry practice and ambulatory surgery center (ASC), doesn't have to worry about criminal charges of healthcare fraud, kickbacks and conspiracy. It does, however, have to pay $1 million to payers it ripped off, according to DOJ's declination letter to Campus Eye's attorneys.[2]

Campus Eye had voluntarily self-disclosed the misconduct to DOJ and cooperated with its investigation.

"DOJ is trying to signal its commitment to giving a higher level of certainty to companies about what outcome will result if they voluntarily self-disclose misconduct," said attorney Matthew Krueger, with Foley & Lardner LLP.

Separately, E. Bruce DiDonato of Princeton, New Jersey, the founder of the optometry practice and ASC, was indicted "for his role in orchestrating diagnostic testing and kickback schemes" before and after he and outside investors formed Campus Eye in December 2021 and he took the reins as CEO, DOJ said.

The Campus Eye case "is an instance in which DOJ is giving the company a declination but conditioning it" partly on the company's help investigating people who were allegedly involved in the fraud, said Krueger, a former U.S. attorney in Wisconsin.

First Healthcare Declination Under New CEP

This is DOJ's first declination in the healthcare space under its CEP, which was revised last year and expanded from the Criminal Division to the entire department March 10.[3]

DOJ said it won't criminally prosecute companies that voluntarily disclose wrongdoing if they meet

CMS Transmittals and *Federal Register* Regulations, July 24-30, 2026

Transmittals

Pub. 100-20, One-Time Notification

- Send 'Reason for Denial' Value in Prior Authorization Data to the Integrated Data Repository (IDR), Trans. 13,888 (July 29, 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, Trans. 13,889 (July 30, 2026)

Pub. 100-08, Medicare Program Integrity

- Revisions to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) and Exhibit 46 in the Exhibits Chapter of Publication (Pub.) 100-08 (Medicare Program Integrity Manual), Trans. 13,890 (July 30, 2026)

Pub. 100-06, Medicare Financial Management

- Update to the Internet Only Manual (IOM) Publication (Pub.) 100-06 Chapter 8, Contractor Procedures for Provider Audits Trans. 13,891 (July 30, 2026)

Federal Register

Notice

- Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—April Through June 2026, 91 Fed. Reg. 46,923 (July 27, 2026)

Update

- Medicare Program; Updates to the Master List of Items Potentially Subject to Face-to-Face Encounter and Written Order Prior to Delivery and/or Prior Authorization Requirements; Updates to the Required Face-to-Face Encounter and Written Order Prior to Delivery List; and Updates to the Required Prior Authorization List, 91 Fed. Reg. 47,972 (July 30, 2026)

certain conditions, such as fully cooperating with the investigation, and they lack aggravating factors (e.g., pervasive misconduct, substantial harm). That's a more ironclad guarantee than the 2022 version, which only dangled the presumption of declination. DOJ now also offers incentives for "near miss" voluntary disclosures.

The CEP instructs prosecutors to base declination on a variety of factors, such as the nature and seriousness of the offense; the pervasiveness of wrongdoing in the corporation, including corporate management's complicity; the corporation's history of similar misconduct; and its cooperation.

Although DOJ will look favorably on companies that self-disclose, it's always a gamble, Krueger said. "Those factors aren't black and white," he noted. Because prosecutors have discretion in how they apply the CEP, "I don't think a company can bank on a declination because DOJ will still make that assessment of aggravating circumstances."

Campus Eye Was Sold to Private Equity

In the declination letter, DOJ said its National Fraud Enforcement Division and the U.S. Attorney's Office for the District of New Jersey are resolving their investigation into Campus Eye.

But DiDonato isn't off the hook. According to DOJ, between 2015 and March 2023, DiDonato allegedly conspired with others to bill Medicare for unnecessary diagnostic eye tests. DiDonato allegedly paid kickbacks and bribes to ophthalmologists in return for their referrals of patients who required eye surgeries, "and then subjected the patients to diagnostic tests that were duplicative of tests they had previously received or were unnecessary for the type of surgery being performed."

He allegedly hid the kickbacks and bribes in sham agreements that referred to the payments as consulting fees.

DiDonato then turned around and sold Campus Eye to private equity investors partly based on the Medicare reimbursement, DOJ said.

'Companies Are Independent Actors'

The Campus Eye case is a reminder that "companies are independent actors apart from their founders, board members and officers," Krueger said. In the face of potential corporate wrongdoing, the board should ensure the corporation's interests are represented by separate counsel and "the decision makers aren't implicated in the wrongdoing."

If senior officers are implicated, he recommends forming a board subcommittee to decide how to proceed. "Probably the biggest decision is whether to voluntarily disclose conduct to DOJ on behalf of the company," Krueger noted. The subcommittee's decisions shouldn't be affected by the self-interest of potentially culpable senior officers.

Contact Krueger at mkrueger@foley.com. ✧

Endnotes

1. U.S. Department of Justice, Office of Public Affairs, "Fraud Division Resolves Fraud Investigation of Eye Care Group Under New Corporate Enforcement Policy; Health Care Executive Charged for Alleged Fraud and Kickbacks," news release, July 29, 2026, https://bit.ly/4fvMFMV.
2. U.S. Department of Justice, National Fraud Enforcement Division, and U.S. Attorney's Office for the District of New Jersey, "Campus Eye Management Holdings, LLC and Campus Eye Management LLC," declination letter, July 28, 2026, https://bit.ly/4wwKYVv.
3. U.S. Department of Justice, "Corporate Enforcement and Voluntary Self-Disclosure Policy," March 10, 2026, https://bit.ly/4z56uCC.

NEWS BRIEFS

Correction: The correct name of a law firm mentioned in an article in the July 27, 2026, *RMC* is Troutman Pepper Locke, not Pepper Troutman Locke.

◆ **OSF Healthcare System and its affiliated covered entities agreed to pay $552,250 in a settlement with the HHS Office for Civil Rights (OCR) over alleged violations of HIPAA privacy and security rules in connection with ransomware, OCR said July 30."**[1] OSF didn't admit liability in the settlement.

◆ **In a report posted July 31, the HHS Office of Inspector General (OIG) said Hospice of the Valley-West in Phoenix, Arizona, got $8.6 million in Medicare overpayments**.[2] The hospice didn't agree.

Endnotes

1. U.S. Department of Health and Human Services, Office for Civil Rights, "OSF Healthcare System Resolution Agreement and Corrective Action Plan," July 1, 2026, https://bit.ly/4fPtug3.
2. U.S. Department of Health and Human Services, Office of Inspector General, *Hospice of the Valley - West Received at Least $8.6 Million in Medicare Overpayments*, A-09-23-03004, July 2026, https://bit.ly/4xeawH4.