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Compliance

Feds (still) charging for COVID fund misuse; make sure you're safe

It may have been years since you thought of COVID relief funds, but are you sure you've fulfilled your COVID loan and grant obligations? Government prosecutors are still coming after some recipients and charging fraud. Make sure your records and payment history are buttoned down in case they come for you.

On Sept. 14, 2026, the Department of Justice (DOJ), the Small Business Administration (SBA) and the SBA's Inspector General announced that they, along with more than 40 U.S. Attorney's Offices and 20 federal and state investigative agencies, launched a "Heartland Fraud Surge" of indictments over the summer.

This joint effort is described as part of "Operation No Doze," a "surge of criminal enforcement actions targeting fraud in SBA's small business COVID-era loan programs," specifically related to the Paycheck Protection Program (PPP) and Economic Injury Disaster Loan (EIDL) program, which some physician practices used to defray COVID-related expenses and shortfalls (*PBN 4/6/20*, *4/13/20*).

The announcements boasted fraud takedown amounts between $102,397 and $55.9 million and hinted that more were to come: "With demand letters going out to suspected fraudsters, we're also sending a clear message that they must repay their debts or face Treasury collections and possible federal law enforcement," says SBA Administrator Kelly Loeffler.

PPP loans were forgiven by the SBA if the borrower could demonstrate they'd spent the money on appropriate COVID-related expenses; EIDL loans were not forgiven, though SBA did offer payment assistance where needed (*see resources, p. 4*). The

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recent fraud prosecutions DOJ and SBA cite involve allegedly false representations of eligibility, need, expenditure and other causes.

What of the CMS programs?

PPP and EIDL were not the only COVID programs for which health care providers were eligible. CMS convened the Provider Relief Fund (PRF) and the Accelerated and Advanced Payment (AAP) Program for health care providers and suppliers, based on $100 billion earmarked in the 2020 Coronavirus Aid, Relief and Economic Security (CARES) Act (*PBN 4/13/20*).

And it's possible that, if you received money from these programs and aren't absolutely certain that you fulfilled your requirements for them, you're not out of the woods yet.

The PRF began as an unnamed CARES Act distribution of $30 billion to Medicare providers on April 10, 2020, with payments based on an approximate 6.2% of each provider's total Medicare fee-for-service payments in 2019 (*PBN 4/20/20*). Unlike the AAP, these were payments, free and clear — but providers were required to keep records on them and meet detailed reporting requirements showing that they had used the money "to prevent, prepare for and respond to coronavirus," or return it.

For AAP, announced on March 28, 2020, most providers and suppliers were able to request up-front payment on 100% of their estimated Medicare charges over a three-month period "based on historical payments," with the understanding that they'd pay it back within 120 days with 10.25% interest, later reduced to 9.5% (*PBN blog 3/30/20*).

CMS made $34 billion in payments before shuttering AAP on April 28, when they steered applicants to the PRF instead (*PBN 4/30/20*). CMS later cut the interest rate to 4% and delayed the AAP recoupment requirement, only starting to collect on March 30, 2021 (*PBN 4/19/21*). But the recoupment requirement remained.

There have been no publicized legal actions on those payouts in years. However, Alexander Gorelik, a senior associate with Taft Stettinius & Hollister LLP in Washington, D.C., notes that the DOJ set up a COVID-19 Fraud Enforcement Task Force in May 2021 with an open brief to investigate and prosecute programs like these — and, though its most recent annual report was issued in 2024, it has never been decommissioned.

As recently as April 1, 2026, in an announcement of PPP-related charges against a man in Pennsylvania, DOJ reminded readers that its Fraud Section "leads the Criminal Division's efforts to combat fraud related to the [COVID-19] pandemic, particularly with respect to the resources made available by Congress through" the CARES Act for programs including PPP, EIDL "*and the Provider Relief Fund*" (emphasis added).

Provider relief payments remain "'fishing grounds' for the various task forces and initiatives that the DOJ

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and various agencies have set up to pursue fraud in these programs," Gorelik says. "And, frankly, they are likely to remain in focus for the agencies and the subject of prosecutions for quite some time."

What's your exposure?

The statute of limitations on PPP- and EIDL-related fraud was extended to 10 years by the PPP and Bank Fraud Enforcement Harmonization Act and the COVID-19 EIDL Fraud Statute of Limitations Act in 2022. (Note: There is a bill before Congress proposing to extend the statute on all "violations relating to pandemic-era programs" to 10 years, but it's been stalled since January 2025.)

The current statute of limitations for False Claims Act (FCA) violations related to PRF and AAP would be, as with all FCA claims, six to 10 years, depending on circumstances.

Venson Wallin, national health care compliance and regulatory leader for the BDO Healthcare Center of Excellence & Innovation, believes "the likelihood of a fraud investigation of a PRF or AAP recipient is less likely than it may have been two or three years ago, but I would not say it is not possible. A *qui tam* case could be initiated that would involve an investigation into the recipient regarding its receipt of PRF and/or AAP funds."

If you were just sloppy with records and reporting compliance, you might not have to worry about criminal fraud charges, "which generally require proof that the defendant knowingly engaged in fraudulent conduct, rather than simply making an honest mistake," says Phillip Zagotti, a certified public accountant and attorney with the North Star law firm in Houston. But FCA prosecutions don't require proof of intent to defraud.

Also note, says Sean B. O'Connell, managing shareholder in Baker Donelson's Washington, D.C., office, that the FCA "provides for damages and civil penalties, and in a significant number of cases the government seeks a settlement reflecting a multiple of the alleged loss. Thus, a borrower that already repaid a PPP loan should not assume that its potential exposure is zero simply because the principal has been returned."

Even if you aren't hauled into court, Zagotti says, "a practice can receive an SBA repayment or demand letter, or have a loan referred to Treasury for collection."

3 steps to take now

If providers haven't "misrepresented aspects of their eligibility or utilized the funds for unintended purposes," Gorelik says, they probably "should not lose sleep over the government's review — unless they receive any formal follow-up communications from the government regarding those requests, such as a Civil Investigative Demand letter."

Even assuming good faith, a late inquiry from the feds could be at least a hassle and at worst a nightmare. Experts advise that you have a few things buttoned down just in case:

Check your bank statements and bookkeeping. Hopefully you segregated expenses related to COVID, as required by the programs, and can definitively state which money went to what cause if asked.

Chris Cornella, vice president of business development at U.S. Professional Funding and U.S. Medical Funding in Incline Village, Nev., reminds you that if you took money from multiple programs, you'll have to show you weren't double-dipping. "Compliance with one will not excuse you from compliance with others, and multi-program cases are what prosecutors are focusing on currently," he says.

Check your records. "At this point," Gorelik says, "the aim should be on preserving any records that the practice had regarding those applications and guidance that they received either from the government or their advisory support." Yours may be in storage. Ensure you can get a hand on them if you need to.

For instance, if you got money from PPP and had it forgiven, Cornella suggests you be prepared to show your original application for forgiveness "and check whether the payroll costs documentation confirms the amount of forgiven funds. PPP made the borrower prove proper usage of the funds; the best way to defend yourself is having clean paperwork rather than clean intentions."

Jose Vela Jr., a member of the Clark Hill law firm in Houston, advises gathering all the relevant materials, which may include "payroll numbers, employee counts, eligibility calculations, certifications, bank records, use of the money, supporting documents." If you find

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a problem, "do not wait for a government subpoena, search warrant, or visit from federal agents. Preserve the records and have experienced counsel determine what happened, who knew about it, and what needs to be done. Don't speak to the government without consulting experienced counsel first."

Have your counsel do a deep dive. If you're really concerned, O'Connell says, "consider having counsel conduct a focused, privileged review. It should locate the original loan and forgiveness applications and the documents supporting them, but it should also gather the contemporaneous emails, memoranda and other communications showing how the practice reached its decisions," including what advisors consulted on the application and what they advised.

If the evidence shows that a borrower "identified an issue, disclosed the relevant facts to a competent adviser and reasonably followed the advice it received," O'Connell says, "that can present a very different case from one in which a borrower ignored an obvious eligibility problem or withheld relevant information." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- U.S. Small Business Administration, "COVID-era programs": *www.sba.gov/loans/covid-era-programs/*
- Press release, "DOJ's Fraud Division, SBA, and SBA OIG Target $245M in COVID Loan Fraud Enforcement Activity as State Partnerships Continue Expanding," Sept. 14, 2026: *www.justice.gov/usao-wdtn/pr/dojs-fraud-division-sba-and-sba-oig-target-245m-covid-loan-fraud-enforcement-activity*
- DOJ, U.S. Attorney's Office, Middle District of Pennsylvania, "Luzerne County Man Charged With Pandemic Fraud Offenses," April 1, 2026: *www.justice.gov/usao-wdtn/pr/dojs-fraud-division-sba-and-sba-oig-target-245m-covid-loan-fraud-enforcement-activity*
- 119th U.S. Congress, "S.121 - Recover Fraudulent COVID Funds Act," Jan. 16, 2025: *www.congress.gov/bill/119th-congress/senate-bill/121/text*

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Physician payments

Q&A: Practices brace for modifier 25 cuts with anxiety, questions

Questions swirl as physician practices wait for CMS' final decision on the modifier 25 proposal that the agency announced within the proposed 2027 Medicare physician fee schedule. For further insight, *Part B News* reached out to Greg Field, CEO of Jiro Health, which recently published an analysis of the proposal's potential financial impact.

Jiro Health, a public benefit corporation that builds practice intelligence for clinicians and practices, is offering free, one-to-one impact briefings to help practices understand their potential exposure. (*See benchmark, p. 5, for additional analysis.)*

Part B News: *What are you hearing from practices with regard to CMS' modifier 25 proposal?*

Field: The biggest thing we are hearing is anxiety. Even very sophisticated practices are having a hard time figuring out what the proposal would mean for them. They are trying to understand the total financial impact, which providers and services would be hit hardest, and what they may need to change before 2027.

Most simply do not have that visibility today. The national numbers may get their attention, but they need to understand their own exposure. National figures provide context, but they cannot tell an individual practice which providers, services and encounter patterns are driving its exposure.

PBN: *How significant could the impact be?*

Field: For some groups, it could be very significant. Our modeling shows many practices facing substantial six-figure annual reductions.

Nationally, we estimate $889 million in annual payment reductions, including $395.4 million tied to dermatology, $83 million to orthopedics and $82.2 million to otolaryngology. But the specialty totals do not tell the whole story. Two practices in the same specialty can face very different impacts depending on their Medicare volume, service mix and same-day encounter patterns.

(continued on p. 6)

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Benchmark of the week

Nearly $900M reallocation at stake over modifier 25 proposal: Analysis

Practices that frequently report claims with modifier **25** could be on the short end of a massive redistribution of professional fees in CY 2027. In the balance hangs nearly $900 million in payments, according to analysis from Jiro Health.

CMS announced it would reduce payments for same-day services on claims appended with modifier 25 by up to 50% in the proposed 2027 Medicare physician fee schedule (*PBN 7/27/26*). The reduction would apply when a physician reports a procedure with a 0-, 10- or 90-day global period for the same patient on the same day as an office/other outpatient E/M service (**99202-99205**, **99211-99215**). CMS would pay the higher-dollar service at 100% and reduce the lower-paying service by 50%.

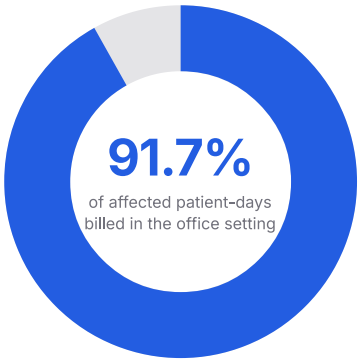
If finalized, that payment policy would have significant implications for private practices and independent physicians, says Greg Field, CEO of Jiro Health, which released a practice impact analysis titled "Who Pays for CMS's Modifier 25 Proposal?" in September.

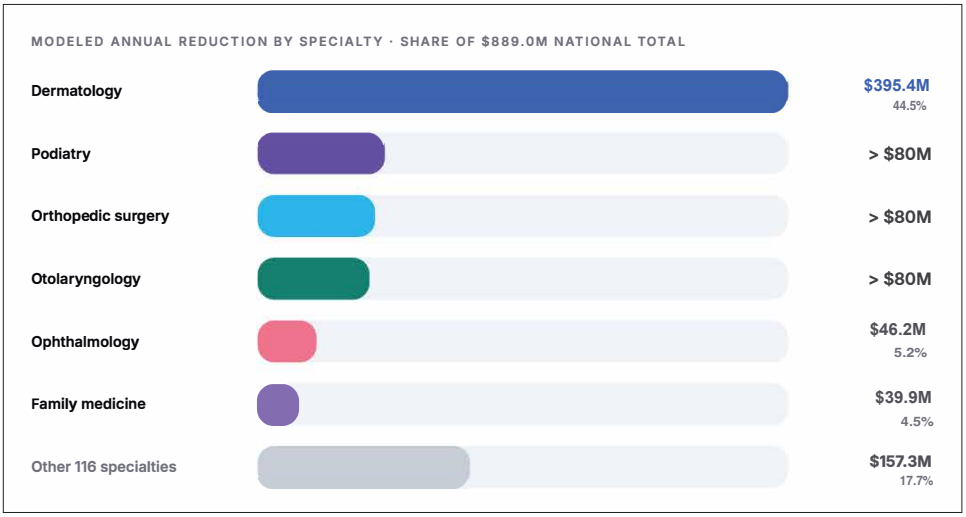
The Jiro impact analysis, based on Medicare fee-for-service claims from October 2024 through September 2025, estimates that the modifier 25 proposal would reallocate $889 million, with a stark effect on private practices and specific specialties. Private practices and solo physicians would account for 82%, or $724 million, of the payment reductions. Six specialties, with dermatology taking the largest hit, would account for 82% of the modeled reductions. Dermatology organizations at the 90th percentile of modeled exposure would face approximately $214,000 in annual reductions, according to Jiro.

But modeled exposure varies widely both across specialties and among practices within the same specialty, depending on Medicare volume, service mix and same-day encounter patterns, Field says. Some organizations could face substantial six-figure annual reductions. (*For a Q&A with Field, see story, p. 4.*) CMS received thousands of comments pertaining to the modifier 25 proposal, and the final fee schedule is expected for release around November 1. — *Richard Scott* (*richard.scott@decisionhealth.com*)

Jiro's impact analysis of CMS' modifier 25 proposal

Measure	Modeled result
Annual Medicare FFS payment reallocated	$889.0M
Affected patient-days	23,113,875
Billing NPIs represented	67,018
Average modeled reduction per affected patient-day	$38
Share of affected patient-days billed in office setting	91.7%





Source: Jiro Health, "Who Pays for CMS's Modifier 25 Proposal?" Modeled data derived from Jiro analysis of Medicare fee-for-service claims, October 2024 — September 2025. https://jirohealth.com/reports/modifier-25-analysis.pdf

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(continued from p. 4)

That does not mean every practice is facing a crisis. It does mean practices should understand their own numbers now and revisit them when CMS publishes the final rule. — *Richard Scott* (*richard.scott@decisionhealth.com*) ■

Compliance

Combat 'turbocharged' AI data mining as investigators go tech-heavy

Practices must be on the defense as auditors and investigators use artificial intelligence (AI) to enhance the computer systems that hunt for signs of health care fraud. And it isn't just the government that is using AI to scour providers' data.

"We have a *qui tam* plaintiffs' lawyer industrial complex," and private equity firms are also getting into the act, warned Jay Dewald, head of health care investigations, United States, and head of litigation and disputes, with Norton Rose Fulbright's office in San Antonio, Texas.

Practices need to get out of the reactive mindset, monitor their claims data around the clock and fix any issues they identity, Dewald says.

Fraud investigators have used computer programs in the hunt for fraud for decades: Data mining and analytics programs have long sorted through huge numbers of claims and related data to flag suspicious billing patterns. From there a team of investigators "would look into and identify targets … that were clearly not explainable or at least a clear red flag," Dewald says. For example, they may turn up billing for medical supplies to someone who has already passed away or prosthetic limbs for patients who haven't had an amputation, Dewald explains.

However, AI has "turbocharged" data mining to go beyond traditional analytics, Dewald says. In addition to identifying outliers, investigators "can also take granular Medicare and Medicaid claims data to analyze some of the 'why' behind a particular outlier." That is, investigators can identify not only that there is a red flag, but some possible reasons for the red flag, Dewald says. That information allows fraud investigation teams to work faster, with greater accuracy and with higher confidence, he adds.

But risk isn't limited to investigators and prosecutors who might believe a practice violated laws such as the False Claims Act (FCA). Attorneys who specialize in *qui tam* or whistleblower cases advertise for plaintiffs and use AI to churn through claims to build a case, Dewald says. Because of the harsh penalties for FCA violations, it's like "offering potential plaintiffs a lottery ticket," he adds.

More recently, private equity firms have entered the whistleblower arena, and they too use AI to identify promising targets, he says.

In this increasingly hostile environment, practices can't afford a reactive mindset that involves traditional review techniques, such as a regularly scheduled check of a small sample of clinicians' documentation and claims and then digging deeper if they find a problem.

"If you think a retroactive spot check is sufficient, you're already being reactive," Dewald says. You want a proactive system that keeps a constant watch on your data and alerts you to issues that need further investigation, he adds.

Understand how AI can work for the defense

AI-enhanced data analytics also can be used to defend practices from compliance mistakes that might get flagged by a government investigation team or *qui tam* factory.

Consultants for health care practices and health care organizations can use AI proactively to improve compliance programs and reduce risk, explained Debra Rossi, CPC, CPMA, senior director in VMG Health's coding, compliance, and operational excellence division, during the DecisionHealth webinar "AI in health care auditing: Proactive and defensive strategies."

For example, consultants — and health care providers — can use AI analytics to cross-reference massive amounts of various sets of data and uncover discrepancies that can signal compliance errors that manual review might not catch or might take a long time to uncover, Rossi said.

"Real-time compliance monitoring through AI enables instant detection of compliance deviations, allowing organizations to address issues proactively, rather than reactively," Rossi said. In addition, these systems can have automated alerts that ping the compliance team so they can investigate and act on problems as soon as possible, she said.

Staff will still be essential to interpret the program's findings and make final judgement calls based on their ability to understand context-specific risks or interpret regulations. Scenarios may include, "for example, if we're

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looking to see if incident-to or split/shared rules were followed properly," Rossi said.

AI also plays a critical role through the claims process, explained co-presenter Pam D'Apuzzo, CPC, ACS-EM, ACS-MS, CPMA, managing director, coding audit and compliance for VMG Health.

In this role, AI acts as assistant intelligence by helping staff verify coding and claims accuracy, but people still need to validate its results, she said. On the other end of the claims cycle, programs can generate reports "that can help us appeal denials that we're getting from the payers," Rossi said and explained that many appeals letters are very generic and that's often why they're automatically denied.

"There's nothing there that really strengthens your position and helps you overturn the denial," Rossi said. However, some AI tools can scour records, highlight areas for consideration and "help craft a really detailed, specific-to-that-encounter, specific-to-that-patient appeal letter, which obviously puts us all in a much better position to be able to overturn a denial," she added.

The underlying message from all three experts is clear: Members of health care organizations need to understand how AI is being used to analyze claims data and be ready to take a proactive stance by tapping into those systems themselves. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

Billing

CMS updates COVID-19 vaccine pricing for 2026-2027 season

CMS recently released its 2026-2027 seasonal influenza and COVID-19 vaccine pricing file, providing updated Part B payment allowances for several COVID-19 vaccine products.

The file now includes the following CPT product codes and payment allowances for COVID-19 vaccines, effective Aug. 27, 2026:

- **91304** (Novavax): $232.218.
- **91319** (Pfizer): $103.330.
- **91320** (Pfizer): $230.405.
- **91321** (Moderna): $172.967.
- **91322** (Moderna): $172.967.
- **91323** (Moderna): $252.225.

COVID-19 vaccines are covered as preventive vaccines under Part B. When billing these claims, code selection should be based on the vaccine product, formulation, dose, patient age and date of service.

COVID-19 vaccine claims should also include the appropriate administration code(s). CPT code **90480** is used to report the administration of a single-dose COVID-19 vaccine via intramuscular injection, and its payment allowance for the 2026-2027 season remains $44.95.

When a COVID-19 vaccine is administered in a patient's home, and applicable requirements are met, both CPT code 90480 and HCPCS code **M0201** should be reported on the claim. HCPCS code M0201 can only be reported once per Medicare patient per date of service, even if the provider administers more than one Part B preventive vaccine in the same visit. The payment allowance for HCPCS code M0201 remains $39.90.

Revenue cycle teams should continue to monitor CMS' vaccine pricing web page, as the agency stated it will update the file periodically as more pricing information becomes available. CMS also posted a crosswalk with updated National Drug Codes for the 2026-2027 season. — *HCPro staff* (*pbnfeedback@decisionhealth.com*) ■

RESOURCES

- 2026-2027 seasonal influenza and COVID-19 vaccine pricing file: *www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing*
- CMS vaccine pricing: *www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing*

Ask Part B News

Keep tabs on payer LCD, provider documentation to head off visco denials

Question: *I am hoping you can help us figure out why Medicare is suddenly denying claims for viscosupplementation injections. Our patients are, for the most part, Medicare subscribers. Many of them have arthritis in multiple joints. Our practice is in Massachusetts.*

We were audited recently for 10 claims where the patients received Durolane, specifically, and all 10 claims were denied for lack of medical necessity. A customer service representative told me that the documentation had to provide quantifiable evidence of pain reduction and/or increased range of motion for a repeat injection. I don't know what would be considered adequate demonstration of medical necessity for an

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initial injection. Medicare can't tell me. Apparently it is not ongoing pain and failure of standard cortisone treatment or alternative non-surgical methods.

We are also getting denials for patients who receive bilateral knee injections followed by bilateral shoulder injections — one of the pairs of injections will be denied. Yet Medicare cannot tell me if the rule is only one pair of injections within a six-month period, even if in different parts of the body. I have reviewed their existing document on hyaluronan intraarticular injections and this information is simply not there.

Answer: One good place to check for this information is your Medicare administrative contractor's (MAC) local coverage determination (LCD) for visco knee injections. For your state, the MAC, WPS, policy to examine is:

- L39529 — Intraarticular Knee Injections of Hyaluronan: *https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39529&ver=5*

There, you will find specific guidance on how to meet the payer's requirements for medical necessity for both an initial and subsequent series of viscosupplementation injections in the knee.

Initial injection: The MAC, WPS, lists five conditions that all must be met for an initial visco-supplementation injection:

1. "The patient is symptomatic. Such symptoms may include pain which interferes with the activities of daily living such as ambulation and prolonged standing, or pain interrupting sleep, crepitus, and/or knee stiffness.
2. The clinical diagnosis is supported by radiologic evidence of osteoarthritis of the knee such as joint space narrowing, subchondral sclerosis, osteophytes and sub-chondral cysts.
3. If appropriate, other diagnoses have been excluded by appropriate evaluation and management services, laboratory and imaging studies (i.e., the pain and functional disability is not considered likely to be due to a diagnosis other than osteoarthritis of the knee).
4. The patient has failed at least 3 months of conservative therapy. Conservative therapy is defined as:
   - Nonpharmacologic therapy (such as but not limited to home exercise program, education, weight loss, physical therapy if indicated); and
   - If not contraindicated, simple analgesics and (e.g., acetaminophen) or NSAIDS per hyaluronan product prescribing information.
5. The patient has failed to respond to aspiration of the knee when effusion is present and intra-articular corticosteroid injection therapy when inflammation is a significant component of the patient's symptoms and intra-articular corticosteroids are not contraindicated."

Repeat injections: WPS then lists indications it would consider reasonable and necessary for a repeat series of injections. Those include:

- "Symptoms have recurred **AND**,
- At least 6 months have elapsed since the prior series of injections **AND**,
- There was significant improvement in pain and functional capacity achieved with the prior series of injections using a standardized assessment tool **OR**
- There is significant reduction in the doses of NSAID medications taken or reduction in the number of intra-articular steroid injections to the knees during the 6-month period following the injection(s)."

Regarding the denial of shoulder visco injections, under "Limitations," the LCD states that "Viscosupplementation of joints other than the knee(s) are considered not reasonable and necessary and are not subject to coverage." That could be why you're getting denials of the bilateral shoulder injections.

Your practice can use this audit as an educational opportunity to review documentation best practices with your surgeons as needed and remind them of Medicare's payment requirements. Show them the percentage of their procedures that are impacted by this policy to help demonstrate the impact of potential revenue loss from any future denials.

In addition, remind coding and billing staff of the importance of staying on top of the latest LCDs for your primary payers, including Medicare, to reduce your chances of any future denials based on targeted audits. — *Laura Evans, CPC* (*laura.evans@decisionhealth.com*) ■

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