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Part B News
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Practice management

Providers still get hired without valid licenses; don't skimp on verification

Despite technological advances in tracking, medical organizations continue to hire unlicensed and improperly credentialed non-physician practitioners and even physicians. Make extra certain your checklist for new hires — and in some cases existing staff — is thorough and complete.

Computerization of records and the growth of companies that specialize in records verification and compliance management may suggest that outlaw providers are a thing of the past. But recent examples show that providers and even people pretending to be providers still get hired as medical staff.

On Nov. 13, for example, Thomasina E. Amponsah was sentenced to 38 months in federal prison after she "used stolen nursing licenses to obtain employment as a registered nurse (RN) and licensed practical nurse (LPN)," the U.S. Attorney for Maryland says, despite the fact that Amponsah "never held a nursing license or credential of her own."

In May, according to the Ventura County, Calif., District Attorney Nitun "Nate" Dayalghai Ahir was arraigned for practicing medicine without a license while out on bail for a *previous* charge of practicing medicine without a license for representing himself as a doctor at Regen Spine & Nerve in Ventura.

And on Aug. 6, Autumn Bardisa of Palm Coast, Fla., was arrested after allegedly "impersonating a registered nurse by utilizing another individual's license number and submitting false documentation to be employed as an advanced nurse technician at AdventHealth Palm Coast Parkway," a hospital in Palm Coast, according to the local sheriff's office.

Take the 2026 Predictions Survey!

A flurry of payment and policy changes are coming in 2026, from significant place of service (POS) pay disparities to revamped incident-to billing rules and much more. How will your practice react to the changes in the new year? Take the ***Part B News 2026 Predictions Survey*** and let us know about the changes, challenges and opportunities you're facing. Take the survey now: www.surveymonkey.com/r/PBN2026predictions.

The sheriff also said that when applying for the job Bardisa had "provided a license number matching an individual with her first name, Autumn, but with a different last name. Bardisa attempted to explain the discrepancy, stating that she had recently gotten married and had a new last name."

Too busy to check?

When a provider is hired without proper licensing — whether on the egregious grounds described here, or through an innocent slip-up — not only the employee but also the practice may be subject to discipline and even lawsuits and criminal charges.

In September, for example, the owners of Advance Visiting Physicians P.C. in Farmington Hills, Mich., settled with the U.S. Attorney's Office for Eastern Michigan for $250,000 to get out from under False Claims Act charges including alleged "home health visits performed by unlicensed and unsupervised foreign doctors" for which they charged Medicare and Medicaid. While practices may be unaware of their providers' licensing issues, they may still be on the hook when these issues are uncovered.

How does lack of compliance like this happen? Often due to "understaffed HR departments, rushed hiring during staffing shortages, and overreliance on self-reported credentials," suggests Daniel Harwin, Esq., attorney and founding partner at FHV Legal with locations in Ft. Lauderdale and Coral Gables, Fla.

Mario Serralta, attorney and founder of Mario Serralta & Associates in Miami Lakes, Fla., says many medical organizations "simply ask for surface-level documentation rather than checking with state licensing boards. In my own practice of medical malpractice, I've seen offices take a photocopy of a license or an accreditation that is simply outdated and not verified as to whether the credential is active, suspended or revoked."

Take all the steps

Elizabeth L.B. Greene, a partner with the Mirick O'Connell firm in Worcester, Mass., offers a checklist of primary source verification (PSV) through which you should run candidates for employment:

- Professional licensure;
- Education (including degree and institution verification);
- Additional training (e.g., residence and/or fellowship);
- Board certification by the applicable board;
- DEA registration and any state equivalent, e.g., the MCSR registration in Massachusetts;
- National Practitioner Data Bank (NPDB) query for adverse event and malpractice claims;
- Employment history;
- Federal payer exclusion screening via OIG' s list of excluded individuals (LEIE) and the General Services Administration's SAM.gov site.

Greene reminds you that "documents provided solely by the practitioner, absent PSV verification, are

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insufficient to protect the practice." Your queries should be conducted at the source sites via the practice's authorized account, and by direct written verification from prior employers and educational institutions, "which can be by email, provided the response is from the official institution's domain," she adds.

Greene also says you should resolve any red flags you encounter, such as:

- Unexplained mismatched names or dates of birth across or within documents;
- Inconsistent employment dates or frequent job changes;
- Unverifiable degrees, licensure or credentials;
- Gaps in training;
- Expiration or restriction of licensure or certifications;
- Attendance at non-accredited schools;
- False-appearing documents;
- Refusal to sign credentialing releases.

A lack of cooperation from the candidate may also be considered a red flag, says Geny Augustine, M.D., a family physician with Solace Health in Phoenix: "When someone's requested to verify credentials or any information over a brief phone call, and they insist on providing it via email instead — usually for 'good' reasons, such as saving time or avoiding hassling people — that's a red flag."

Serralta also advises you to reverify licenses every 12 months, as their status may change without your awareness. Providers are responsible for their own license upkeep and sometimes miss their deadlines, which can leave you on the hook (*PBN 3/11/19*).

Beyond the license

Your providers don't just have to have a valid license; they also have to meet other standards for health professionals in your jurisdiction. The big one for Medicare is enrollment, a process that requires dedicated personnel and regular monitoring, especially considering that new rules keep popping up, such as the "stay of enrollment" CMS uses for disciplinary purposes that was added in 2024 (*PBN 4/8/24*). CMS Conditions of Participation for providers are also specific and vary among 20 provider and supplier organization types, from ambulatory surgical centers (ASC) to transplant centers.

Greene says your credentialing and privileging processes should be conducted in accordance with applicable federal and state laws, including specialty board regulations, state and federal controlled substances regulations, and OSHA standards. Also watch for divergence between Medicare and private payer enrollment requirements.

Serralta recommends criminal background checks as well. "I've had medical malpractice cases where a provider's license appeared clean on paper, but all it would have taken was an internet search to learn of red flags like fraud, prior misuse of identity or charges related to battery — things that ought to matter when you entrust someone with patient care." Serralta says that, like the licensure check, this should be refreshed at least every 12 months.

Richard F. Cahill, J.D., vice president and associate general counsel for The Doctors Company, a division of TDC Group, suggests you get the candidate to attest to their claims up front: "The application form and any written offer should clearly state that materially false or misleading statements made during the interview process will lead to termination," he says. If there's trouble down the line, this will show that you were expecting the truth. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- U.S. Department of Justice, "Baltimore County Woman Sentenced for Impersonating Nurses and Aggravated Identity Theft," Nov. 13, 2025: *www.justice.gov/usao-md/pr/baltimore-county-woman-sentenced-impersonating-nurses-and-aggravated-identity-theft*
- Ventura Country (Calif.) District Attorney's office, "Thousand Oaks Man Re-Arrested and Arraigned for Practicing Medicine Without a License," May 5, 2025: *www.vcdistrictattorney.com/wp-content/uploads/2025/05/Thousand-Oaks-Man-Re-Arrested-and-Arraigned-for-Practicing-Medicine-Without-a-License.pdf*
- Flagler County (Fla.) Sheriff's Office, "FCSO Arrests Palm Coast Woman for Posing as a Registered Nurse and Treating Over 4,400 Patients Without a License," Aug, 6, 2025: *www.flaglersheriff.com/cmsfiles/2025-142-FCSO-Arrests-Palm-Coast-Woman-for-Posing-as-a-Registered-Nurse-and-Treating-Over-4-400-Patients-Without-a-License.pdf*
- CMS, "Conditions for Coverage (CfCs) & Conditions of Participation (CoPs)," last update Sept. 10, 2024: *www.cms.gov/medicare/health-safety-standards/conditions-coverage-participation*

Coding

Focus on longitudinal relationships in G2211 documentation

Questions about add-on code **G2211**, known as the visit complexity or longitudinal care code, cropped up throughout the CPT & RBRVS 2026 Annual Symposium. The answers to questions about documentation, timing and specific scenarios that support the add-on code can be summarized in one sentiment: Focus on "longitudinal relationships."

The guidance emphasized that documentation must show that the practitioner is doing work designed to create an ongoing, involved and trusting relationship with the patient.

While several presenters encouraged attendees to read the FAQs that CMS created for the code, they also provided detailed answers to the following questions that were submitted during the symposium.

Question: *When is it appropriate to report G2211 and what documentation is required to support the code?*

Answer: You can append the add-on code to an appropriate E/M visit "anytime there is a longitudinal relationship" between the practitioner and the patient, said Lindsey Baldwin, director of CMS' division of practitioner services, during the symposium's first question-and-answer session. CMS has not issued specific documentation requirements for the code, Baldwin said, but she did provide examples of the type of information that would support the code.

"We would expect that information that's included in the medical record or the claims history for that particular patient and practitioner combination," Baldwin elaborated.

According to Baldwin, examples of supporting documentation include:

- Diagnoses.
- The assessment and medical plan of care.
- Other services performed by the practitioner for that patient.

Baldwin's statement also indicates that practices will need to take a longitudinal approach to additional documentation requests from auditors because the chart for a single visit might not give the full picture of the practitioner's relationship with the patient.

Question: *Would it be appropriate to add G2211 to claims when a neurologist sees a patient once a year for stable migraine and doesn't make any changes to the patient's prescriptions?*

Answer: That scenario is unlikely to meet the requirements for G2111, said Earl Berman, M.D., MALPS-L, FACP, contractor medical director for CGS Administrators, during the same question-and-answer session.

"I would say [the scenario] is not a G2211 and that's a general answer with a general example," he said, while encouraging people to reach out to their Medicare administrative contractor by using the contractor medical director enquiry box.

"There has to be a care plan, it has to be longitudinal, it has to be a visit that's the focal point for an ongoing complex, serious condition," he explained.

For a once-a-year visit for a stable condition when the practitioner doesn't make any changes and probably doesn't have a care plan for the encounter, "the likelihood of that specific example being a G2211 is small," Berman said." A once-a-year visit might satisfy it if all the other conditions [are met], but it is still unlikely," he added.

"CMS went to significant lengths … to describe some things with primary care … the diagnosis or the conditions being treated on a given day doesn't matter because it is really about that longitudinal relationship-building as was mentioned today about building trust," added Peter Hollmann, M.D., AMA/Specialty Society Relative Value Scale Update Committee member.

Berman replied that this was an important point. He reiterated the importance of building trust, so that patients take practitioner advice seriously. Berman also praised the evolution of addressing the need to develop trusting relationships with patients, which he called the "best paradigm."

Question: *Would G2211 be appropriate when the patient is expected to return for a follow up? Consider the following scenarios:*

1. *The patient has a cystic mass on the verge of becoming inflamed. The practitioner prescribes cephalexin and instructs the patient to return for an excisional biopsy. Can it be billed for the*

(continued on p. 6)

Benchmark of the week

Claims rates for E/M modifiers 57, 24 hold steady, but denials inch up

Utilization of the operation-related modifiers **24** (Unrelated evaluation and management service by the same physician during a postoperative period) and **57** (Decision for surgery) has held relatively stable in recent years, and 2024 was no exception.

Utilization of modifier 24 was slightly less than 1.6 million claims in 2024, according to the latest available Medicare claims data, which was roughly the same as 2022 and 2023. Claims with modifier 57, which fell slightly from 911,846 claims in 2022 to 870,698 claims in 2023, rebounded modestly to 885,264 claims in 2024 (*PBN 1/13/25*).

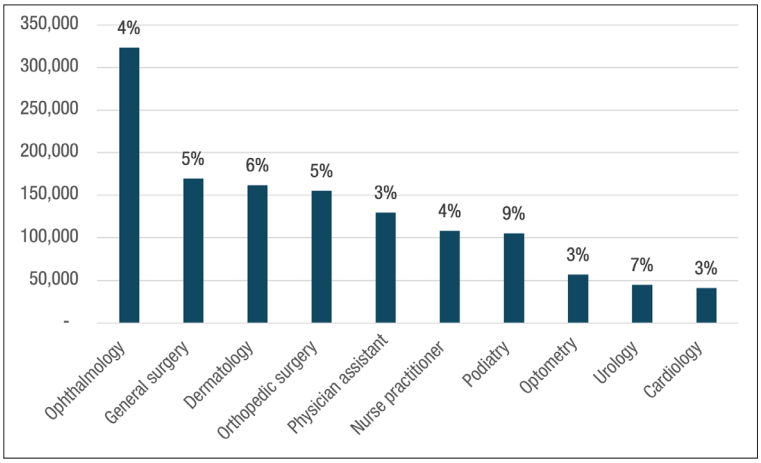
The E/M codes reported most often with the 24 and 57 modifiers also remained stable: For 24, top codes were established office visits **99213** and **99214** and subsequent hospital inpatient service **99232**; for 57, top claims included initial hospital inpatient codes **99222** and **99223**, along with 99214. Claims with those modifiers for the top three codes represented 64% and 47% of total claims, respectively.

Overall denial rates with the modifiers held low at 5%, but not quite as low as in 2023, when the denial rates were 3% for 24 and 4% for 57.

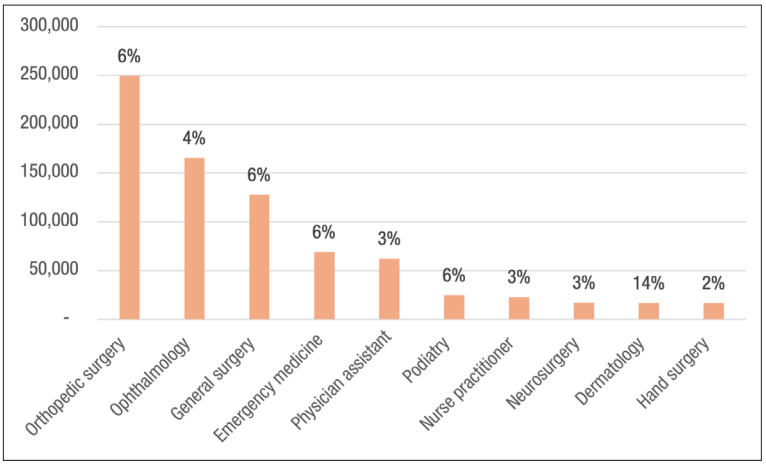
The top specialties for each modifier shifted places a bit in 2024. In 2023, for example, the top codes with 24 were headed by ophthalmology, followed by dermatology, physician assistant, and podiatry; as you can see in the data, ophthalmology is now followed by general surgery, dermatology and orthopedic surgery, with podiatry falling to sixth place.

Denial rates for specialties with 24 were fairly clustered under 10%; the only real clunker was allergy/immunology, at 43%. Several codes had 0% denials with 24, most significantly peripheral vascular disease with 4,527 claims; 57 had more outliers, such as dermatology with a 14% denial rate across 17,215 claims, hospitalists and gastroenterology (each at 20%) and pulmonology (16%). — *Roy Edroso* (*roy.edroso@decisionhealth.com*)

Modifier 24 utilization, top 10 specialties, 2024, with denial rates



Modifier 57 utilization, top 10 specialties, 2024, with denial rates



Source: Part B News *analysis of 2022-2024 Medicare claims data*

(continued from p. 4)

initial visit because the patient is expected to return for the excision?

2. *A one-month follow up basal cell carcinoma lesion removal. The patient will return in six months for a recheck.*

Answer: "I understand the need to follow up, but it does appear that [these scenarios are] more transactional in nature," said Ann Marie Sun, M.D., contractor medical director, Noridian Healthcare Solutions, during a question-and-answer session for contractor medical directors.

Rather than focus on timing or specific diagnosis codes, Sun urged practitioners to ask themselves if they are that patient's doctor or, rather, are they transactionally performing services for a patient?

The latter type of doctor isn't necessarily thinking about the patients outside of the visit.

"You may or may not ever see them again," Sun elaborated. "You're not necessarily thinking about their social determinants of health, their family, what's going on in their lives … even if it is related to a more complicated condition that maybe it's a single condition that a specialist is following," she said. "If the patient doesn't know whether they'll see you again or not … I don't know if there's really any longitudinal relationship in that."

Sun also emphasized that CMS created the code to capture the time that it takes to build patient trust and relationship and communication that isn't built into the existing E/M encounter codes.

"I think it's great that CMS is trying to reward that relationship so patients will trust their doctors again," she said. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCE

- CMS FAQs for G2211: *www.cms.gov/files/document/hcpcs-g2211-faq.pdf*

Correct Coding Initiative

Take note of the next NCCI edits, expect new codes later in 2026

You'll have to wait a while longer for National Correct Coding Initiative (NCCI) edits for 2026-effective codes. However, the latest quarterly NCCI update will include new medically unlikely edits (MUE) for a variety of HCPCS codes that went into effect in July and October 2025.

"There were no additions to the Medicare practitioner services procedure to procedure [PTP] edits," according to the quarterly NCCI PTP update file posted Dec. 2. It is likely that CMS was thrown off schedule during the latest government shutdown. That means you will not find edits for the new codes that will go into effect Jan. 1, 2026.

Anticipate guidelines with code details

However, you can predict some edits by checking available guidance for new codes. For example, the 2026 CPT manual states that you can't report new remote physiologic management (RPM) code **99470** (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes), in conjunction with revised codes **99457** and add-on code **99458**, which describe at least 20 minutes of service. That means you can expect an edit that blocks you from reporting the 10-minute and 20-minute codes for the same patient on the same day.

Remember to check the revised edits that will go into effect Jan. 1, 2026. The biggest set of revisions will allow anesthesia coders to unbundle bilateral thoracic fascial plane blocks (**64468-64469**) from 27 anesthesia codes by flipping the modifier indicator from "0" to "1." Two more revisions loosen up reporting for cardiovascular services. Providers will be able to report endovascular repair codes **34709** and **34717** together.

Another revision will allow ob/gyns to report transcervical ablation of uterine fibroids code **58580** with surgical hysteroscopy including removal of leiomyomata (**58561**). Note that the CPT instruction, which currently states you can't report the ablation code in conjunction with the hysteroscopy code, will be revised in the 2026 CPT codebook to state, "Do not report 58580 in conjunction with 58561, when both services are performed for the same lesion."

New MUEs for recent HCPCS codes

Check the upcoming MUE update for edits for HCPCS codes that went into effect in 2025. In addition to billing limits for a variety of new drug codes, you'll find an MUE of 1 for codes that include the E/M

add-on for infectious disease (**G0545**), post-operative management (**G0559**) and advanced primary care management codes **G0556-G0558**.

You can also use your 2026 CPT codebook to predict some MUEs you'll see next year. For example, the descriptor and additional guidance for RPM code 99470 indicates you would only report it once per day. The guidelines for **62331**, the new add-on code for minimally invasive lumbar decompression, tells coders, "Do not report 62331 more than once per operative session," which signals an MUE of 1 for the code.

The 2026 NCCI manual was not available when this article was published. Watch the *Part B News blog* for early news on its release. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com) with additional analysis by *Laura Evans, CPC* (laura.evans@decisionhealth.com) ■

RESOURCES

- NCCI Practitioner Services PTP Quarterly Additions, Deletions, and Revisions (ZIP), effective Jan. 1, 2026: www.cms.gov/files/zip/medicare-ncci-2026q1-practitioner-quarterly-additions-deletions-revisions-ptp.zip
- NCCI Practitioner Services MUE Quarterly Additions, Deletions, and Revisions (ZIP), effective Jan. 1, 2026: www.cms.gov/files/zip/medicare-ncci-2026q1-pra-quarterly-additions-deletions-revisions-mue.zip

Billing

Do extra housekeeping as post-shutdown payments clear

As Medicare payment ramps back up after the recent government shutdown, Ahzam Afzal, CEO and co-founder of Puzzle Healthcare in Detroit, points out some things to watch for as the claims and payments come through.

Afzal says you "may see brief timing variability with the MACs as queues clear, but this is essentially a return to standard cash flow. Medicare fee-for-service payments come from the Medicare Trust Funds (HI/SMI) — not annual discretionary appropriations — so Medicare claim operations generally continued even when other parts of the government slowed down."

As claims return to normal, pay attention to these details:

- Closely watch MAC bulletins and remittance advice as the backlog clears for any processing quirks.
- Make sure the claims you submit are clean: modifiers are accurate, NPIs and TINs match, and medical necessity is well-documented.

CCI version 32.0 scorecard

Changes effective January 1, 2026. (For more on CCI version 32.0 edits, see related story, p. 6.)

Code range	CCI code pairs added	CCI code pairs deleted	CCI code pair revisions	MUEs added	MUEs deleted	MUEs revised
00000 – 09999	0	273	54	0	0	0
10000 – 19999	0	6	0	0	0	0
20000 – 29999	0	591	0	0	2	0
30000 – 39999	0	3,830	1	0	20	0
40000 – 49999	0	0	0	0	0	0
50000 – 59999	0	598	1	0	2	0
60000 – 69999	0	29	0	0	0	1
70000 – 79999	0	464	0	0	9	0
80000 – 89999	0	6	0	0	0	0
0001U – 0284U	0	896	0	18	9	0
90000 – 99999	0	2,141	0	2	17	0
0001T – 0999T	0	2,475	0	40	21	0
A0000 – V9999	0	74	0	127	4	2
Totals	**0**	**11,383**	**56**	**187**	**84**	**3**

Note: Code range is based on the comprehensive code of the edit.

Source: Part B News *analysis of CCI version 32.0 changes,* www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits

- Monitor days in accounts receivable for the next few cycles; small timing swings are standard as contractors normalize.
- If you held claims, stage releases over 24-48 hours to prevent avoidable rejections due to volume spikes.
- Coordinate with revenue cycle management teams and clearinghouses so that auto-postings and reconciliations track to catch-up electronic funds transfers (EFT).
- Follow cash-flow discipline and avoid large disbursements until your first two Medicare EFTs land as expected.

Note also, Afzal says, that in the wake of the shutdown "telehealth will need closer eligibility and coding checks given the post-waiver landscape," and act accordingly (*PBN 11/24/25*). — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

Practice management

Interstate compact could increase PA telehealth opportunity

A developing multistate compact is on track to increase physician associates' ability to perform telehealth encounters — and further the rise of the practitioners formerly known as "mid-levels."

The general trend toward non-physicians handling more U.S. health care is well observed. In its 2025 Q2 Physician Flash Report, the Kaufman Hall consultancy found that the percentage of total provider full time equivalent (FTE) hours performed by advanced practice providers (APP), such as physician associates (PA) and nurse practitioners (NP), rose to 39%, up from 38.3% the previous year.

Nurse practitioners tend to get most of the press, partly because they've grown so numerous. There are 258,230 NPs, according to 2022 U.S. Bureau of Labor Statistics (BLS) data, and the BLS expects the field to grow by 46% by 2033. BLS puts physician associates at 140,910, with anticipated growth of 20%. Both NPs and PAs work mostly in physician practices.

Now a recent development might expand the reach of PAs via telehealth nationwide.

PA compact in progress

The American Academy of Physician Associates (AAPA) is currently accepting responses to a request for proposals on a "data system" for a PA Licensure Compact that would allow PAs to provide telehealth across a growing number of state lines.

The compact would be similar to the Interstate Medical Licensure Compact (IMLC) that currently allows providers in 44 states to practice telehealth across each others' state lines (*PBN 2/24/25*). The main difference, according to Timothy Terranova, executive director of the Maine Board of Licensure in Medicine, is that while the IMLC helps physicians obtain licenses from each state, "the PA Compact is a privilege model which allows a PA to practice in other states via the mutual recognition of the PAs qualifying license."

Nineteen states have already signed onto the compact. To participate, PAs must meet a number of requirements, including current certification by the National Commission on Certification of Physician Assistants (NCCPA), no felony or misdemeanor conviction, and no limitation or restriction of license within two years prior to applying for a compact privilege.

The data system will provide "a streamlined process for states to be able to verify and share this information," Terranova says. Eric M. Fish, a partner with Hooper Lundy Bookman in Washington, D.C., explains that a process that maintains the flow of data between state regulatory agencies can "ameliorate barriers of regulatory inefficiency and lead to improvements in access to care and license portability. In some cases, the IMLC has issued licenses in less than three days, and I expect that the PA Compact model of endorsement will be equally as effective."

AAPA found recently that 49% of PAs used telemedicine in their clinical work within the last year, largely motivated by the pandemic (*PBN 5/19/25*). (In 2019 they were at 9%.) Pitches for the PA Compact RFP are being accepted through Dec. 19. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- "Q2 2025 metrics, Physician Flash Report," Kaufman Hall: *www.kaufmanhall.com/sites/default/files/2025-08/KH-PFR_Report-Q2-2025-Metrics.pdf*
- Physician Assistant Compact Commission, "Statement of Objectives for an Occupational Licensure Compact Data System": *https://www.pacompact.org/siteassets/pa-licensure-compact/pdf/pa-compact-commission-data-system-rfp.pdf*