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Part B News
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In this issue

PBN Perspectives

FCA investigations based on DEI coming; check language, compliance

There are signs that the Trump administration is coming after private businesses they consider to be practicing "illegal diversity, equity and inclusion (DEI)" with False Claims Act (FCA) investigations, a technique the government likes to use against health care practices suspected of wrongdoing. No medical targets have been named so far, but it might be a good idea to review your DEI practices to make sure they don't attract unwanted attention.

On Feb. 2, Bradley Arant Boult Cummings LLP associate Gavin Bell and counsel Lyndsay E. Medlin, both of the firm's Charlotte, N.C., office, posted the story, "DOJ Is Ramping Up FCA Investigations of DEI Practices in the Private Sector," a review of U.S. Department of Justice activities in relation to what President Trump calls, e.g. in Executive Order 14731, "illegal DEI."

That term is described, however elliptically, by a July 29, 2025, memo from U.S. Attorney General Pam Bondi to all federal agencies, which claims that "in recent years, the federal government has turned a blind eye toward, or even encouraged, various discriminatory practices, seemingly because of their purportedly benign labels, objectives, or intentions. No longer."

The memo includes examples such as "a federally funded entity's DEI policy [that] prioritizes candidates from 'underrepresented groups' for admission, hiring, or promotion, bypassing qualified candidates who do not belong to those

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groups, where the preferred 'underrepresented groups' are determined on the basis of a protected characteristic like race."

The post from Bell and Medlin notes that while until recently "the government's DEI enforcement actions were civil rights actions — not FCA cases — focused almost exclusively on educational institutions and state and local governments," a Dec. 28, 2025, Wall Street Journal report says the DOJ is planning to use FCA to come after enforcement targets that "include 'industries ranging from automotive and pharmaceuticals to defense and utilities.'"

"Any company who receives federal funds subject to these certifications has potential exposure if the government believes it still considers diversity when hiring," Bell and Medlin add. And that doesn't exclude physician practices.

"Absolutely, the health care space is a likely target," the authors tell *Part B News*, "even more so than the private companies currently under investigation. Providers and health care systems submit claims to the federal government on a daily basis, which already contain certifications conditioning receipt of Medicare money on compliance with certain laws/requirements."

Trump's EO "directed all federal agencies to include terms in contracts and grant awards requiring the recipient to certify that it does not operate programs promoting DEI," Bell and Medlin say. "Thus, if a health care entity has direct contracts with or grants from the federal government, it may have already made a certification that could lay the foundation for a DEI FCA investigation."

But is it material?

Trump's DOJ has already come after at least one health care entity, albeit a government one, on grounds of discriminatory behavior: On Feb. 4, the DOJ's Civil Rights Division head Harmeet K. Dhillon informed Baltimore Mayor Brandon Scott that the DOJ was investigating whether the "Baltimore City Health Department (BCHD) is engaged in a pattern or practice of discrimination based on race, color, or national origin," a violation of Civil Rights Acts, on the grounds that "BCHD 'separated employees by race' to hold 'racial equity training.'"

This case differs, however, from the kind the DOJ might approach as a DEI/FCA case, Bell and Medlin tell *Part B News*. "The direct division of people based on a protected class is the issue, and [BCHD's] actions here seem to have been criticized regardless of where community members fell on the political spectrum," they say. (DOJ says its investigation is "based on publicly available information.")

"The investigations under the FCA, on the other hand," Bell and Medlin say, "target a wider range of practices, initiatives that many companies have been promoted and engaged in for years."

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But experts say even under those circumstances, applying an FCA charge to heath care entities on DEI grounds would take some doing.

Bell and Medlin say that to pursue such a claim, "DOJ would have to argue that a health care entity's DEI practices were so illegal as to taint the claims to Medicare for medical services — even if the claims themselves would have been medically necessary and not tainted by kickbacks."

Braden Perry, partner with the Kennyhertz Perry law firm in Kansas City, Mo., thinks that'd be a tough lift.

"FCA exposure is rarely about the mere existence of a DEI program," Perry says. "The legal risk usually turns on whether statements made to the government, such as compliance certifications or conditions of payment, can be portrayed as inaccurate, misleading or materially incomplete."

David M. Glaser, a shareholder with the Fredrikson & Byron law firm in Minneapolis, points to the precedent of the U.S. Supreme Court's 2016 ruling in Universal Health Services, Inc. v. United States ex rel. Escobar with regard to materiality: "A misrepresentation about compliance with a statutory, regulatory or contractual requirement must be material to the government's payment decision in order to be actionable under the False Claims Act."

Per that ruling, Glaser says, if the government says you're not in compliance with anti-discrimination laws, and thus violated a certification by representing yourself as compliance with all federal laws, "the defense is going to be, that's not material to treating their strep throat or their myocardial infarction. We provided exactly the service we said we did; the government got what it paid for. That is a strong argument."

Take down red flags

Nonetheless, Glaser expects the DOJ to go for it if it finds suitable health care cases:

"It's hard to think any major enforcement issue that ever just skips health care," he says. "And if there's anything we've learned from this administration, it's that they like to pick a fight that is going to get attention — like with Harvard," one of several prominent universities Trump has targeted with demands for payment to settle alleged anti-discrimination offenses.

"I would worry more if I were a large academic medical center than I would than if I were a three-person ENT practice," Glaser says. He also "absolutely" expects the administration to focus on jurisdictions it has already targeted for other reasons, such as Minneapolis, Chicago and Los Angeles, sites of well-publicized anti-ICE protests.

Given the aggressiveness of the DOJ's stance, if you have anything that might be construed as a DEI program — such as employment outreach or anti-discrimination training — you might want to tread carefully and implement some countermeasures.

Watch your language. One obvious way to protect yourself is in descriptions of your programs, particularly those that are public-facing.

"I could totally see a government regulator searching for the phrase 'DEI' or 'affirmative action' in Google to see what comes up," Glaser says. "So from a risk management practice, there's a lot to be said for minding your language."

Show your compliance. You might also prepare proactively by looking at the alleged DEI offenses in the Bondi memo and seeing where you might be able to counter any such claims against your organization.

"The memo lays out the government's position," Glaser says. "That suggests they will prioritize the issues raised in the memo. There certainly isn't any immunity created for other issues, but it would be reasonable to assume that the government is less interested in other topics."

Take the Bondi bit about any policy that "prioritizes candidates from 'underrepresented groups' for admission, hiring or promotion." Glaser says that "if you're recruiting for a new employee, you can send your interviewer to an HBCU [historically black college or university]. If you go to 10 schools and one of them happens to be an HBCU, that's legal; I don't think anyone could successfully challenge that. But if you recruited exclusively, or even predominantly, at HBCUs, I could see the government trying to criticize that."

Ultimately, though, if your organization believes in the principles of DEI, you have to decide how far to beg off these in order to protect yourself.

"In any lawsuit there's always the risk of losing — and with FCA the penalties are astronomical," Glaser says. "It depends on your risk tolerance and how

important you feel your program is. Personally, I would continue to focus on the [social] determinants because it feels very important, and worth fighting for. But that is my personal risk tolerance and I don't expect all clients to take the same risks I might." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- Gavin Bell, Lyndsay E. Medlin, "DOJ Is Ramping Up FCA Investigations of DEI Practices in the Private Sector," Feb. 2, 2026: www.jdsupra.com/legalnews/doj-is-ramping-up-fca-investigations-of-8912486/
- Presidential Executive Order, "ENDING ILLEGAL DISCRIMINATION AND RESTORING MERIT-BASED OPPORTUNITY," Jan. 21, 2025: www.whitehouse.gov/presidential-actions/2025/01/ending-illegal-discrimination-and-restoring-merit-based-opportunity/
- Federal Register version, above, Jan. 31. 2025: www.federalregister.gov/documents/2025/01/31/2025-02097/ending-illegal-discrimination-and-restoring-merit-based-opportunity
- Memo from U.S. Attorney General Bondi to federal agencies, "GUIDANCE FOR RECIPIENTS OF FEDERAL FUNDING REGARDING UNLAWFUL DISCRIMINATION," July 29, 2025: www.justice.gov/ag/media/1409486/dl?inline=&utm_medium=email&utm_source=govdelivery
- Wall Street Journal, "Justice Department Using Fraud Law to Target Companies on DEI," Dec. 28, 2026: www.wsj.com/politics/policy/trump-doj-dei-fraud-investigations-93213d52?mod=mhp
- Letter from DOJ to Baltimore Mayor Brandon Scott, "Investigation of the Employm3nt Practices of the Baltimore City Health Department, Pursuant to Section 707 of Title VII of the Civil Rights Act of 1964 as Amended," Feb. 4. 2026: www.justice.gov/crt/media/1426671/dl?inline

Coding

Train staff on 3 high-impact changes to lower extremity revascularization coding

Start with the three key changes to the lower extremity revascularization (LER) codes when you train staff on this major update, before you delve into more detailed guidance. The revisions warranted their own presentation during the CPT & RBRVS 2026 Annual Symposium, which brought the following changes to light:

1. Stratification based on complexity.
2. Territorial expansions.
3. Technology update.

LER coding is based on the vessel that is treated and the technology used to treat it, explained Benjamin Lerner, M.D., FACS, DFSVS, a member of the coding committee for the Society for Vascular Surgery, during the presentation. However, the complexity of the lesion treated will also now contribute to coding.

"All three of these components are reflected in the base codes and in the add-on codes and must be reported and the documentation should support that," Lerner said. In addition, you'll start with a base code for the initial intervention in any vascular territory and report a corresponding add-on code when the provider treats additional vessels in that territory, he added.

The following codes illustrate the new structure for primary codes in the iliac territory (emphasis added):

- **37254** (Revascularization, endovascular, open or percutaneous, **iliac vascular territory**, with **transluminal angioplasty**, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; **straightforward lesion**, **initial vessel**).
- **37256** (… ; **complex lesion, initial vessel**)
- 37258 (Revascularization, endovascular, open or percutaneous, **iliac vascular territory**, with **transluminal stent placement**, **including transluminal angioplasty** when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; **straightforward lesion**, **initial vessel**).
- **37260** (… ; **complex lesion, initial vessel**).

Each primary code is followed by an add-on code that can be reported per additional vessel in the territory. For example, **37255** is the add-on code for 37254, **37257** is the add-on code for 37256 and so on.

Make sure everyone involved in performing or reporting these services has access to the full descriptors and guidance for these codes as you walk them through the changes.

(continued on p. 6)

Benchmark of the week

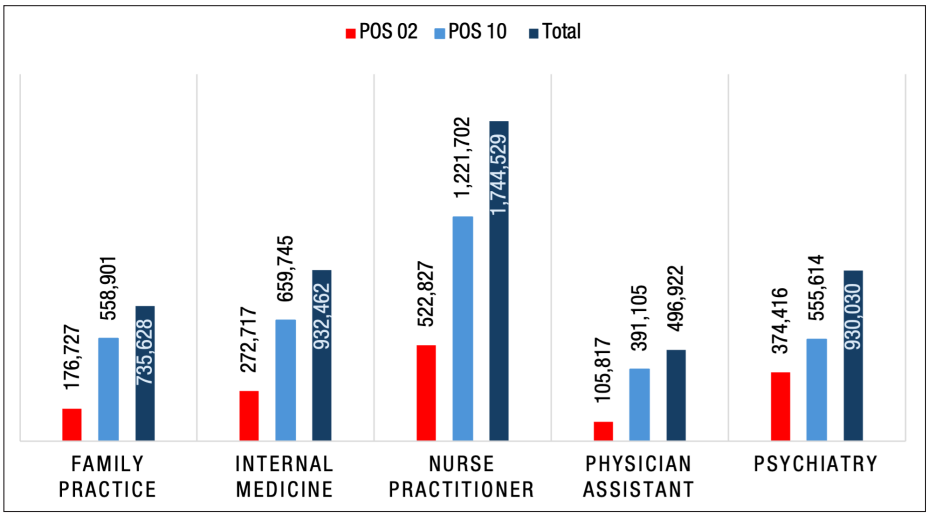
E/M claims shows smooth switch to new telehealth reporting rule

Physicians and advanced practice providers (APP) readily made the switch to reporting telehealth services based on the patient's location in 2024, the first year it was mandatory for Medicare patients. However, a review of Medicare Part B claims data shows that some providers started to use place of service **10** (Telehealth provided in patient's home) when it became available for Medicare billing effective April 1, 2022.

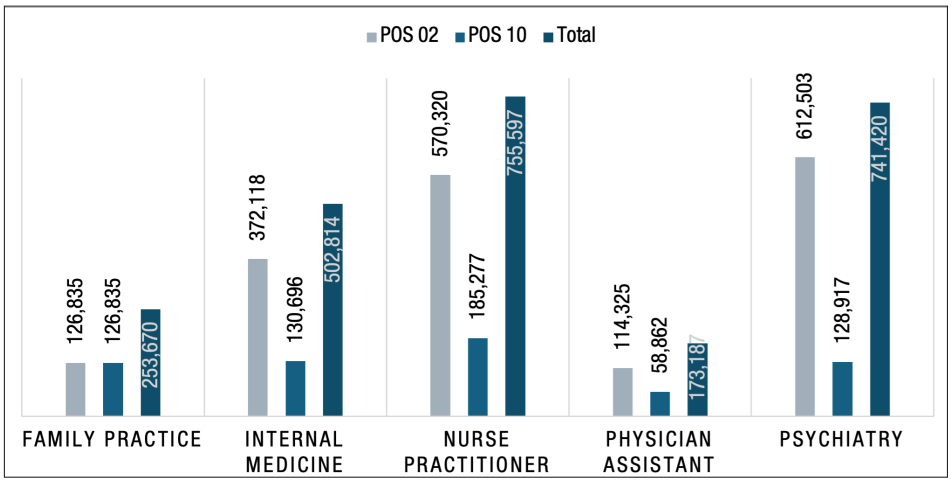
For example, providers reported 895,655 claims for office/other outpatient E/M services (**99202-99215**) with place of service 10 and more than 2.6 million claims with revised place of service **02** (Telehealth provided other than in patient's home) in 2022. In 2024, providers logged more than 5.1 million claims with place of service 10. Claims with place of service 02 fell to 272,876.

The following charts provide more detail on how providers adopted the new system by focusing on Part B claims data for the top billers of the most-billed service codes. The charts compare the total claims for the top five specialties that reported office/other outpatient E/M visits with place of service 02 and 10, in 2024 and in 2022, when Medicare introduced the revised definition for place of service 02 and the new place of service 10. The data for 2022 shows the entire reporting year. It is possible providers submitted some claims with place of service 10 before the April 1, 2022, availability date. — *Julia Kyles, CPC (julia.kyles@decisionhealth.com)*

Top specialties by Telehealth place of service 02 & 10, 2024



Top specialties by Telehealth place of service 02 & 10, 2022



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

(continued from p. 4)

A straightforward test for complexity

Documenting and coding LER based on territory and technology are familiar concepts, but the new code set introduces coding based on type of lesion:

- **Straightforward lesion:** Any stenosis, or narrowing of the vessel, that is less than 100%.
- **Complex lesion:** "An occlusion is the absence of flow beyond a lesion," Lerner said.

Co-presenter Sean Roddy, M.D., society for vascular surgery, AMA CPT Advisory Committee member, tied the definition of a complex lesion to the medical record. A complex lesion "means there's an area on the angiogram that will be recorded in the medical record such that there is no flow past a lesion," he said.

"It truly must have a statement in the medical record, in the territory that's being reported that that artery is completely blocked. With that you're allowed to bill the complex [code]," Roddy explained. Terms such as "near total occlusion" or "partial occlusion" still mean there's blood flow and should be coded with a straightforward code, he added.

The presenters seemed to have anticipated questions and perhaps disbelief from physicians and qualified health care professionals because the strict binary approach to coding doesn't match up with treatment.

"While we recognize this might not reflect precisely what clinical practice is, we feel this will allow for the most accurate coding and for differentiation of the difficulty of increasingly complex lesions," Lerner said. Even though some stenoses are not straightforward to treat, for the purposes of coding when there is any blood flow beyond the lesion it is straightforward, he said.

Because of this high bar for the complex codes, most procedures will be coded as straightforward procedures, Roddy said.

Have a question? Ask PBN

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email askpbn@decisionhealth.com with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

Territorial expansions

The new code set also divides the femoral-popliteal (fem-pop) territory into the common femoral/profunda and superficial femoral artery (SFA)/popliteal vessels, Lerner said.

But the bigger news is the addition of a new inframalleolar territory. Before 2026, "any disease of a tibial vessel which extended below the ankle was reported with a tibial code," Lerner said. That included, for example, deleted code **37228** (Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty).

Under the new code set you'll have a fourth territory, which includes the dorsalis pedis and plantar vessels. You'll report treatment of straightforward stenoses with primary code **37296** (Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel) and add-on code **37297** when appropriate.

You'll report treatment of occlusions, which represent a 100% blockage of blood flow, with primary code **37298** (… ; complex lesion, initial vessel) and add-on code **37299** when appropriate.

Remind your team that angioplasty is the only intervention in this territory with Category I CPT codes. Other procedures should be reported with unlisted code **37799**, Lerner explained during a follow-up question-and-answer session.

Technology update

You'll have a new add-on code for interventions that include intravascular lithotripsy (IVL). This is a "novel technology which uses soundwaves and acoustic vibration," Lerner said. But teach staff that it is restricted to treatments in the iliac or the fem-pop territories (emphasis added):

- **37262** (Intravascular lithotripsy[ies], **iliac vascular territory**, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy[ies] within the same artery [List separately in addition to code for primary procedure]).

- **37279** (Intravascular lithotripsy[ies], **femoral and popliteal vascular territory**, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy[ies] within the same artery [List separately in addition to code for primary procedure]).

The procedure can be reported with any primary code, including angioplasty codes, from the appropriate code group and for each vessel treated, Lerner explained. For example, if the provider uses IVL in the three vessels of the iliac territory, coders should report three units of 37262. To prevent denials, ask billing staff to make sure the correct add-on code is appended to the correct primary code. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com) ■

Ask Part B News

Subletting a doctor's office? Make sure you're covered, not coasting

Question: *I saw a recent article in the New York Times that discussed, among other things, physicians subletting their or other doctors' offices. The story had a real estate focus, though, and didn't get into the legal and regulatory requirements for physicians who do this. What should prospective sublessees be thinking about?*

Answer: The Times article, "'Like a Timeshare': Doctors Get Creative as Rents Climb," does indeed talk about physician subleases. Some seek to sublease parts of their space so they can "expand their practices without huge financial commitments," or defray costs by subleasing days they're not seeing patients; potential clients seek to sublet to diversify locations or for other reasons.

It's a real estate story, and reporter Jane Margolies doesn't get much into laws specific to health care providers that these transactions might entail. *Part B News* checked in with some lawyers about what such sublessees should consider.

Get it in writing. In some ways, says Ericka L. Adler, shareholder and practice group manager, health care at the Roetzel & Andress law firm in Chicago, subletting a doctor' office is like any other commercial sublet: You need to have the sublease — and assurance that the sublessor's landlord has given permission — in writing.

Get your story straight. Paul D. Werner of the Buttaci, Leardi & Werner firm in Princeton, N.J., thinks it's a good idea to a sublessee to be absolutely clear with their sublessor *and* the landlord about what kind of services and procedures they'll be doing in the office.

"Because medical office space is often subject to ground leases with larger groups, there can be prohibitions on the type of tenant [that can sublet]," Werner says. "For example, the sublessor may be providing services that fall squarely within their lease and the ground lease that 'resides' above it — but a prospective subtenant may want to provide services that are prohibited by the ground lease because they 'compete' with other services in the building."

Equipment is extra. Maybe your sublessor is "throwing in" use of their medical equipment. But that's not entirely their decision. Often, such equipment is itself leased, and sometimes the lessor doesn't allow third-party use.

Even if the equipment company will give permission, Werner says they'll absolutely want to know who's using it before doing so. For one thing, "they want to be sure the party using it can afford to replace it if it breaks," he says. So this, too, needs to be settled in writing.

Carry your own insurance. As someone running a business, you need to have your own liability insurance, even if the sublessor has their own. "Think of it as two distinct businesses," Adler says. "Make sure your own business has insurance. You may be told you'll be covered by their policy, but we always recommend that our clients have their own coverage."

"As the provider subleasing, you carry the same professional liability insurance coverage as if you were the main tenant," Werner says. "You would also carry all the same business insurance coverage, as well as general liability coverage that would specify that you are the subtenant — and would likely name the landlord as an additional insured."

If it seems duplicative, Werner says, so be it. "To the extent, for example, a patient of the subleasing party falls on the premises, they may not know or care that their doctor, etc., was simply a subtenant. So that subleasing party can expect to be named in the lawsuit, if there is one."

Make sure it doesn't look like an inducement. Stark Law and the Anti-kickback statute (AKS) apply to all providers who receive federal money, and the government looks hard at any exchange of items of value for business purposes that might look like a payoff for referrals or other quid pro quo. Rent definitely counts, including sublease rent.

"The subleasing arrangement is not an issue in and of itself, but because of past instances of inappropriate

use of the relationship it is something that is carefully scrutinized," Werner says. "We have done a lot of work in this space, and I have been involved in many litigations that centered around the relationship between the sublessor and sublessee."

"Make sure you meet the exceptions and/or safe harbors that relate to how you rent space and equipment," Adler says. A key metric is fair market value (FMV). If you seem to be charging, or getting charged, less that what the market will bear, the feds may get suspicious.

"This dictates what that lease will look like for the use of space, equipment, personnel and anything else you're using," Adler says. Fair market value is calculated by a number of factors, such as time of usage and square footage. If it's a small, short-term deal, you may be tempted to do the math yourself, but "to be absolutely sure you're compliant for federal law purposes, it's always a good idea to go out and get a third party who specializes in providing fair market value analysis to give you that in writing," Adler says.

Werner adds that the lease agreement needs to be for at least one year "and the rent amount may not vary." Also note: Even if you're not seeing Medicare patients, there are state laws that mimic federal laws, so check that before skipping out on this analysis on that basis.

HIPAA goes both ways. If you sublet, your patients' protected health information (PHI) and your sublessor's will be sharing an office, which means you'll need to change your risk analysis accordingly.

Check your other legal obligations. Do you keep controlled substances in your main office? Expect to have them at the sublet? Jay DeVoy, a partner with Holland & Hart in Las Vegas, reminds you that the "DEA and state law requirements for the safe keeping, inventory and control of drugs and controlled substances that may be kept on site" go right with you to that other office, as do any other regulatory and legal requirements under which you currently operate. — *Roy Edroso* (roy.edroso@decisionhealth.com) ■

(*For more on subleasing medical offices, see the* Part B News *blog,* https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=201148.)

RESOURCE

- New York Times, "'Like a Timeshare': Doctors Get Creative as Rents Climb," Jan. 17, 2026: www.nytimes.com/2026/01/17/business/doctors-office-leasing-rent.html

Value-based care

The list of ASM participants is out. Are you in?

CMS is forging ahead with the ambulatory specialty model (ASM), a mandatory quality of care program set to launch Jan. 1, 2027, and run through 2031.

The most recent step was the release of the initial list of physicians who will participate in the first year of the heart failure model or the low back pain model (*see resources, below*).

CMS selected participants from the following specialties.

- Heart failure cohort: Cardiology.
- Low back pain cohort: Anesthesiology. interventional pain management, neurosurgery, orthopedic surgery, pain management and physical medicine and rehabilitation (physiatry).

A physician's specialty is based on "the specialty designation on the majority of a clinician's Medicare Part B claims," CMS explained.

Specialists can check the list for their national provider identifier (NPI) or first and last name. Practice staff can also search the organization's legal name to determine if more than one physician is on the participant list. Qualified health care professionals (QHP) are excluded from the program.

If a physician is not listed, they're in the clear for 2027. CMS might remove some providers from the final 2027 list or add more participants in upcoming years.

A physician who is on the list should complete the ASM contact information form. A member of the practice can also perform this task.

On the FAQ page, participants can review the five quality measures for each cohort and the two improvement activities that will apply to both groups. Requirements for the promoting interoperability measure are available in the Code of Federal Regulations. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com) ■

RESOURCES

- List of ASM participants: https://data.cms.gov/cms-innovation-center-programs/disease-episode-based-payment-models/ambulatory-specialty-model-participants/data
- ASM contact information form: https://forms.office.com/pages/responsepage.aspx?id=we3c-6lwS0G_pcMGP8M5Xh6k-sPLRUoZMl1zxO90fjl9UOEVMTVhMRkQyRkRFUlZIMU1aUF-NYQ0hDTy4u&route=shorturl