PUBLIC SUBMISSION

As of: 4/7/26, 11:54 AM
Received: April 05, 2026
Status: Draft
Category: Health Care Industry - PI015
Tracking No. mnl-xylf-t66a
Comments Due: May 18, 2026
Submission Type: Web

Docket: CMS-2026-1090
Good Cause Processes (CMS-10544)

Comment On: CMS-2026-1090-0001
Good Cause Processes (CMS-10544)

Document: CMS-2026-1090-DRAFT-0002
Comment on CMS-2026-1090-0001

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General Comment

When a beneficiary is reinstated after involuntary disenrollment, the claims spanning that coverage gap become the evidentiary record. If those claims carry ambiguous, physician-selected procedure codes, CMS cannot reliably determine what services actually occurred — or whether the non-payment was genuinely unforeseen.

I have developed a deterministic procedure coding system. Codes are generated automatically from data already present in the claim. No physician selects them. No judgment is exercised. No two providers can code the same service differently. Every element of every code traces directly to its source — nothing is opaque.

For Good Cause reinstatement review, this means CMS gains a precise, auditable picture of the clinical record during the disputed period. Fraud disguised as administrative error becomes detectable. Legitimate gaps become provable. The burden on beneficiaries — currently estimated at 36,490 annual hours — shrinks when documentation disputes disappear.

The system is complete, tested, and available at no cost.

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