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Office of Evaluation and Inspections

ISSUE BRIEF

September 2026 | OEI-02-24-00310

Medicare Advantage Organizations and CMS Can Do More To Prevent Durable Medical Equipment Fraud in Medicare Advantage



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Why OIG Did This Review

- Fraud related to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) has been a long-standing issue in Medicare, putting millions of taxpayer dollars at risk each year. In one recent case alone, bad actors are accused of fraudulently billing Medicare for over \$10 billion in DMEPOS.¹ So far, CMS's efforts to prevent DMEPOS fraud have mainly focused on Original Medicare, not Medicare Advantage.
- Yet, Medicare Advantage is also at risk. With the recent growth in the number of enrollees, Medicare Advantage now accounts for more spending than Original Medicare. In addition, OIG has seen fraud schemes—similar to those affecting Original Medicare—also impacting Medicare Advantage.²

What OIG Found

This issue brief focuses on fraud risks related to DMEPOS suppliers in Medicare Advantage. Medicare Advantage organizations (MAOs) and CMS take steps to screen fraudulent suppliers and prevent them from billing Medicare Advantage. However, gaps exist in this screening that can be exploited by bad actors. Specifically, we found:

Gaps in MAO screening:

- MAOs conduct some screening checks of in-network suppliers but **fewer checks of out-of-network suppliers**.

Gaps in CMS screening:

- CMS **does not screen all DMEPOS suppliers before they bill Medicare Advantage** because they are not all enrolled in Medicare.
- CMS uses a fraud prevention tool (known as **the Preclusion List**) to prevent certain DMEPOS suppliers from billing Medicare Advantage; however, **the List has limitations** in preventing fraud.

Suppliers with the least screening—those that bill out of network and are not enrolled in Medicare—pose an increased fraud risk to the program.

What OIG Recommends

1. Ensure that MAOs strengthen checks of out-of-network DMEPOS suppliers.
2. Strengthen the use of the Preclusion List to prevent fraudulent DMEPOS suppliers from billing Medicare Advantage.
3. Require that all DMEPOS suppliers that bill Medicare Advantage be enrolled in Medicare, or seek statutory authority to do so if necessary.

CMS concurred with or stated that it would take into consideration all of our recommendations.

Primer on DMEPOS in Medicare Advantage

- Durable medical equipment, prosthetics, orthotics, and supplies include medical items and supplies—such as wheelchairs, knee braces, and diabetic testing strips—that allow Medicare enrollees to manage an illness or injury.
- More than half of all people in Medicare—about 34 million people—are now enrolled in Medicare Advantage. In Medicare Advantage, the Government pays private health insurance companies—known as Medicare Advantage organizations—to provide coverage for Medicare enrollees.
- MAOs may create networks of providers and DMEPOS suppliers. To become an in-network DMEPOS supplier, the supplier signs a contract with the MAO agreeing to the plan’s terms and conditions. Enrollees generally pay lower cost-sharing amounts when they receive DMEPOS from in-network suppliers.
- Other suppliers can still provide DMEPOS to Medicare Advantage enrollees. These suppliers do not contract with the MAO and are not a part of the plan’s network. These suppliers are known as “out-of-network” suppliers.
- Almost 40 percent of people in Medicare Advantage are enrolled in plans with broad coverage of out-of-network suppliers.³
- CMS does not require DMEPOS suppliers that bill Medicare Advantage—either in network or out of network—to be enrolled in Medicare.
- Suppliers’ network status and enrollment status are separate. For example, an out-of-network supplier can be either enrolled in Medicare or not enrolled in Medicare.
- CMS and MAOs share responsibility for preventing fraudulent DMEPOS suppliers from billing Medicare Advantage.

FINDINGS

This issue brief highlights vulnerabilities in CMS's and MAOs' efforts to screen DMEPOS suppliers and prevent fraudulent suppliers from billing Medicare Advantage. These vulnerabilities increase the risk of fraud in Medicare Advantage. The issue brief is based on an analysis of key documents, an analysis of Medicare Advantage data, and structured interviews with six selected MAOs, OIG investigators, and CMS staff. The six selected MAOs provide coverage for two-thirds of all enrollees in Medicare Advantage.

To deter fraud, MAOs conduct some checks of in-network suppliers but fewer checks of out-of-network suppliers

MAOs are responsible for preventing both in-network and out-of-network suppliers from fraudulently billing DMEPOS to their plans. To help prevent fraud, MAOs conduct some checks of all in-network suppliers; however, MAOs conduct fewer checks of out-of-network suppliers. As a result, some DMEPOS suppliers that bill out of network are subject to little scrutiny by MAOs prior to billing for DMEPOS.

Of note, 21,029 suppliers billed the six selected MAOs. Of these, 7,980 suppliers billed in-network for at least one of the MAOs. The remaining 13,049 suppliers always billed out of network.

MAOs conduct some checks of their in-network DMEPOS suppliers

MAOs are required to conduct certain checks of their in-network DMEPOS suppliers before they contract with them.⁴ One of these checks includes MAOs verifying that the DMEPOS supplier has a State license, if one is required.⁵ Another is MAOs verifying that the DMEPOS supplier either has been reviewed and approved by an accrediting body or meets the standards established by the MAO itself.⁶

MAOs are also required to confirm that suppliers are not on the Preclusion List and verify that they have not been excluded by OIG.⁷ The Preclusion List is a list of suppliers that MAOs are prohibited from paying. It is discussed in more detail below.

Some MAOs go beyond the required checks. The six MAOs we interviewed reported that they take additional steps to screen in-network suppliers. For instance, before contracting with suppliers, three MAOs confirm that the suppliers were not previously flagged or investigated for issues, such as concerning billing. Two MAOs check ownership information, and one MAO checks that the suppliers' addresses are legitimate business addresses.

MAOs conduct fewer checks of out-of-network suppliers

MAOs are not required to check whether out-of-network suppliers meet the same requirements as their in-network suppliers. Notably, MAOs are not required to check whether out-of-network suppliers meet State licensure requirements. They are also not required to verify that these suppliers are accredited. The only checks that MAOs must conduct for out-of-network suppliers are to confirm that they are not on the Preclusion List or excluded by OIG.⁸

The six MAOs confirmed that they generally did not check whether all out-of-network suppliers met the same requirements as in-network suppliers. For example, none of the MAOs reported checking whether out-of-network suppliers were accredited. In addition, just three of the six MAOs reported checking whether out-of-network suppliers had appropriate State licenses.

As a result, some DMEPOS suppliers that bill out-of-network are subject to little scrutiny by MAOs prior to billing for DMEPOS.

CMS does not screen all DMEPOS suppliers before they bill Medicare Advantage because they are not all enrolled in Medicare

Unlike with Original Medicare, CMS does not screen all DMEPOS suppliers that bill Medicare Advantage as not all such suppliers are enrolled in Medicare. Enrollment is an important safeguard against fraud because it allows CMS to prevent bad actors from billing the Medicare program. CMS requires all DMEPOS suppliers to enroll in Medicare before they can bill Original Medicare. The enrollment process includes screening checks that must be successfully completed before a supplier is allowed to bill Original Medicare.⁹ These checks include determining whether the suppliers' owners have had felony convictions in the last 10 years.¹⁰ CMS also conducts an on-site visit to ensure, among other things, that suppliers are open and have inventories of DMEPOS items and supplies. (See Exhibit 1.)

Exhibit 1: Key Medicare enrollment requirements

To be enrolled in Medicare, suppliers must:

- ✓ provide proof of a National Provider Identifier and practice location;
- ✓ provide documentation of any applicable State licenses;
- ✓ provide documentation of accreditation;
- ✓ purchase a surety bond;
- ✓ undergo a fingerprint-based background check; and
- ✓ have an on-site visit with a CMS contractor to verify that the supplier is operational and able to furnish Medicare covered items or services.

These requirements do not apply to suppliers billing Medicare Advantage that are not enrolled in Medicare.

However, DMEPOS suppliers that bill Medicare Advantage are not required to enroll in Medicare and therefore do not always undergo CMS's screening process.¹¹

MAOs may require their in-network suppliers to enroll as a condition of their contract. Notably, five of the six MAOs we interviewed opted to require in-network suppliers to enroll.

However, MAOs cannot require out-of-network suppliers to enroll in Medicare. Current law does not allow MAOs to deny payments to out-of-network DMEPOS suppliers that are not enrolled in Medicare.¹² Notably, for the 6 MAOs we reviewed, of the 21,029 suppliers that billed for DMEPOS, 1,342 were not enrolled. Therefore, MAOs do not get the benefit of CMS's checks of these out-of-network suppliers.

CMS uses the Preclusion List to prevent certain DMEPOS suppliers from billing Medicare Advantage; however, the List has limitations in preventing fraud

Instead of requiring all DMEPOS suppliers that bill Medicare Advantage to enroll in Medicare, CMS uses the Preclusion List as a fraud prevention tool. CMS places certain suppliers on this list to prevent them from billing Medicare Advantage. (See text box below.) MAOs are prohibited from paying DMEPOS suppliers that are on the Preclusion List.¹³

However, the Preclusion List is limited.¹⁴ Unlike with enrollment, which allows CMS to proactively screen each supplier and ensure that it meets certain requirements before it bills Medicare, CMS can only use the Preclusion List reactively to stop suppliers after a problem has been identified. This limitation hinders CMS's ability to prevent fraudulent billing.

Another limitation is that CMS has not used the Preclusion List to its full extent. All but one of the DMEPOS suppliers that CMS

has placed on the Preclusion List were previously enrolled in Original Medicare. CMS

MAOs are prohibited from paying DMEPOS suppliers on CMS's Preclusion List.¹⁵

- The Preclusion List includes DMEPOS suppliers that: (1) were enrolled in Original Medicare, (2) had their enrollment revoked for conduct that CMS determined was detrimental to the best interests of Medicare, and (3) are under an active re-enrollment bar.
- CMS may also place on the List suppliers that were not enrolled but engaged in conduct that was detrimental to the best interests of Medicare for which CMS could have revoked enrollment.

has used its authority only once to place on the List a DMEPOS supplier that was not enrolled but engaged in behavior for which CMS could have revoked enrollment.¹⁶ Further, CMS reported that generally it assesses whether a non-enrolled supplier should be precluded only if the supplier attempts to enroll. As a result, bad actors may intentionally circumvent the Preclusion List by never attempting to enroll in Medicare.

In addition, not every supplier that had its enrollment revoked in Original Medicare is on the Preclusion List, and as a result, some revoked suppliers are prohibited from billing Original Medicare but are allowed to bill MAOs. Notably, we identified 50 suppliers that had their enrollment revoked and were barred from re-enrolling but were not on the Preclusion List.¹⁷ CMS reported that these 50 suppliers did not meet the Preclusion List criteria, and that the majority of these suppliers were not included on the Preclusion List because they had their enrollment revoked for failing to meet Medicare DMEPOS enrollment standards, such as by not having any inventory.

At the same time, CMS staff noted that they see fraud schemes involving DMEPOS suppliers that have had their Medicare enrollment revoked and moved to Medicare Advantage. This raises concern that allowing these revoked suppliers to bill Medicare Advantage places Medicare enrollees and MAOs at risk.

See Exhibit 2 for an example of a revoked supplier billing Medicare Advantage.

Exhibit 2: Example of a revoked DMEPOS supplier that was billing Medicare Advantage

A **DMEPOS supplier**—in Texas—had its **enrollment revoked** in 2021 for not complying with Medicare’s DMEPOS supplier requirements and was barred from re-enrolling in Medicare for 3 years. Despite being prohibited from billing Original Medicare, this supplier was not on the Preclusion List and, therefore, was **allowed to bill Medicare Advantage**.

In 2023, this DMEPOS supplier **billed \$678,000** to Medicare Advantage.

DMEPOS suppliers with the least screening—those that bill out of network and are not enrolled in Medicare—pose an increased fraud risk to the program

As described above, gaps exist in MAOs’ and CMS’s approach to screening DMEPOS suppliers before they bill Medicare Advantage, putting the MAOs and program at greater risk of fraud. The most significant gap is with suppliers that are out of network *and* not enrolled in Medicare. These suppliers face the least amount of screening from MAOs and CMS, compared to other suppliers.

For the six selected MAOs, these suppliers billed far more per enrollee for certain high-risk DMEPOS compared to other suppliers. Further, MAOs and others have raised concerns about out-of-network and non-enrolled suppliers being involved in fraud.

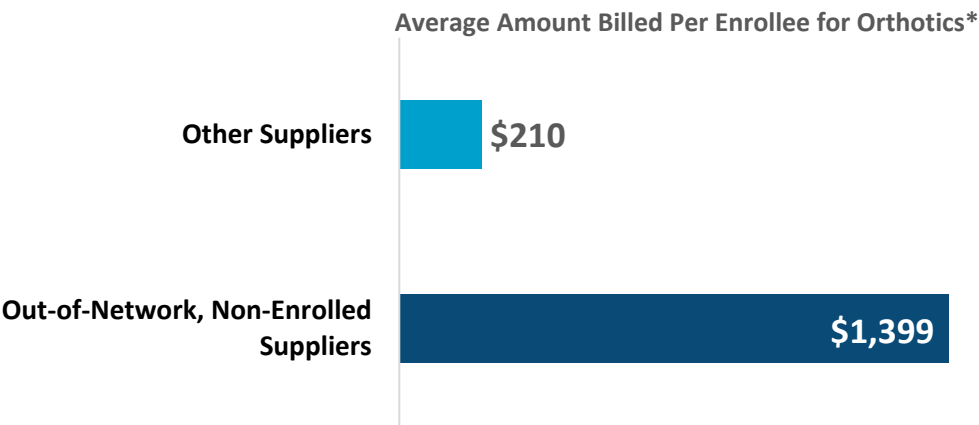
Out-of-network, non-enrolled suppliers billed far more per enrollee for certain high-risk DMEPOS than other suppliers

For the six selected MAOs, we identified 1,151 DMEPOS suppliers that always billed out of network and were not enrolled. These suppliers had billing patterns that differed from those of other DMEPOS suppliers, raising questions about inappropriate billing.

Specifically, these out-of-network, non-enrolled suppliers billed far more per enrollee for certain high-risk DMEPOS compared to other suppliers. The higher amounts were for orthotics, urinary catheters, and blood glucose monitor supplies, all of which have been identified by OIG and other law enforcement entities as common items in DMEPOS fraud schemes.¹⁸ For orthotics, these suppliers billed about seven times more per enrollee than other suppliers.¹⁹ (See Exhibit 3.) For urinary catheters and glucose monitor supplies, they billed about one and a half times more than other suppliers.²⁰

These differences in billing patterns raise the possibility that suppliers that are billing out of network and are not enrolled may be billing Medicare Advantage inappropriately.

Exhibit 3: Out-of-network DMEPOS suppliers that were not enrolled in Medicare billed about seven times more per enrollee for orthotics than other suppliers. This may indicate that these suppliers are billing inappropriately, as DMEPOS fraud schemes have involved orthotics.



*Note: The dollar amounts represent the average amount MAOs reported paying suppliers for each enrollee who received an orthotic in 2023.

Source: OIG analysis of Medicare Advantage encounter data and supplier network data for six selected MAOs, 2025.

Moreover, MAOs, OIG investigators, and CMS have raised concerns about out-of-network and non-enrolled suppliers being involved in fraud

Notably, MAOs reported specific concerns about out-of-network suppliers' involvement in DMEPOS fraud. Three of the six MAOs we interviewed reported that the DMEPOS fraud schemes impacting their plans often involved out-of-network suppliers. Further, two of these MAOs noted that out-of-network suppliers accounted for nearly all of the suppliers involved in current DMEPOS fraud schemes in Medicare Advantage.

OIG investigators and CMS staff reported further concerns about suppliers that are not enrolled in Medicare being involved in DMEPOS fraud in Medicare Advantage. OIG investigators noted that by not enrolling in Medicare, fraudsters can bill quickly. They found that bad actors can incorporate a DMEPOS company and get a National Provider Identifier within a few days, which allows them to start billing MAOs almost immediately. CMS staff noted similar trends, stating that, "in one scheme, these suppliers pop up relatively quickly, bill fast, and then exit."

In addition, according to OIG investigators, bad actors appear to be intentionally avoiding oversight by billing out of network and not enrolling in Medicare. (See Exhibit 4.) These insights, along with the differences in billing patterns, show that gaps in screening of DMEPOS suppliers that bill out of network and are not enrolled create a vulnerability that can be exploited by bad actors.

Exhibit 4: Example of a DMEPOS fraud scheme involving suppliers that were not enrolled and billed out of network²¹

In July 2026, two individuals were sentenced to a total of almost 25 years in Federal prison for their roles in a scheme that billed **\$34 million to Medicare Advantage plans for medically unnecessary DMEPOS**, including orthotic braces. These individuals intentionally **targeted** enrollees in **Medicare Advantage plans that offer out-of-network** coverage and pressured them into accepting medical equipment they did not need. The individuals then billed these enrollees' plans using DMEPOS suppliers that were not enrolled in Medicare.

CONCLUSION AND RECOMMENDATIONS

DMEPOS fraud has been a longstanding problem in Medicare, putting millions of taxpayer dollars at risk each year. In one case alone, bad actors are accused of fraudulently billing Medicare for over \$10 billion in DMEPOS.²²

One of the most cost-effective and efficient ways of addressing fraud is to prevent bad actors from billing in the first place. Consequently, CMS has placed increased emphasis on proactive, preventive efforts rather than relying on “pay and chase” fraud-fighting efforts to recover funds after payments have been made. As CMS makes this transition to a more proactive approach, it has taken a number of actions to address DMEPOS fraud in Original Medicare.²³

However, DMEPOS fraud is also impacting Medicare Advantage, and more attention is needed to prevent fraudulent DMEPOS suppliers from billing Medicare Advantage. The gaps in the screenings conducted by CMS and MAOs to prevent fraudulent DMEPOS suppliers from billing Medicare Advantage create vulnerabilities that can be exploited by bad actors.

We recommend that CMS take the following actions:

Ensure that MAOs strengthen checks of out-of-network DMEPOS suppliers

Our review found that MAOs conduct fewer checks of out-of-network suppliers than of in-network suppliers. As a result, some DMEPOS suppliers that bill out of network are subject to little scrutiny by MAOs. Suppliers not enrolled in Medicare raise a particular concern, as these suppliers are also not screened by CMS.

To ensure that bad actors are prevented from billing Medicare Advantage, CMS should work with MAOs to strengthen their checks of out-of-network DMEPOS suppliers, including those that are not enrolled in Medicare. For example, CMS could encourage MAOs to check that all out-of-network suppliers have appropriate licensing and accreditation. CMS could also encourage MAOs to check whether out-of-network suppliers are enrolled and take extra steps to screen suppliers that are not enrolled in Medicare.

Strengthen the use of the Preclusion List to prevent fraudulent DMEPOS suppliers from billing Medicare Advantage

Our review found that CMS could take steps to strengthen its use of the Preclusion List to better prevent fraudulent DMEPOS suppliers from billing Medicare Advantage.

We recommend that CMS reassess its criteria for placing suppliers on the Preclusion List.

CMS should use its existing authority, as appropriate, to place on the Preclusion List DMEPOS suppliers that are not enrolled in Medicare but have engaged in behavior that is detrimental to Medicare and, therefore, meet the criteria to be precluded. According to CMS, it has used this authority only once. CMS should take additional steps to identify non-enrolled suppliers that meet the Preclusion List criteria. For example, CMS could systematically examine encounter data (i.e., data about DMEPOS billed to MAOs) or other information provided by MAOs to identify non-enrolled suppliers to determine whether they meet the Preclusion List criteria. Taking such steps would help ensure that bad actors cannot intentionally circumvent the Preclusion List by never attempting to enroll.

CMS should also reassess its criteria for determining whether a revoked supplier should be placed on the Preclusion List. As discussed above, we identified 50 suppliers that had their enrollment revoked and were barred from re-enrolling but were not on the Preclusion List. CMS reported that the majority of these suppliers were not on the Preclusion List because their enrollment had been revoked for not meeting Medicare DMEPOS enrollment standards, such as not having inventory. Given the concerns about non-enrolled suppliers, CMS should reassess the criteria it uses to determine which suppliers are included on the Preclusion List to ensure that it is not placing MAOs or enrollees at risk.

OIG is conducting additional work on the Preclusion List which will provide more information about CMS's use of the Preclusion List.²⁴

Require that all DMEPOS suppliers that bill Medicare Advantage be enrolled in Medicare, or seek statutory authority to do so if necessary

CMS should require all DMEPOS suppliers—including those billing out of network—to enroll in Medicare in order to bill Medicare Advantage or, if necessary, seek the statutory authority to do so. Such a requirement would help protect Medicare enrollees and the program from fraud, waste, and abuse.

Requiring all DMEPOS suppliers to enroll in Medicare would mean that all DMEPOS suppliers undergo CMS's screening checks prior to billing Medicare Advantage. This would help ensure that all DMEPOS suppliers are licensed and accredited, as appropriate, and that they have had a site visit and background check. For enrollees, this would mean that suppliers serving Medicare Advantage enrollees have undergone the same screening as those serving Original Medicare enrollees.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with or stated that it would take into consideration all of our recommendations.

CMS concurred with our recommendation to ensure that MAOs strengthen checks of out-of-network DMEPOS suppliers. CMS noted that all MAOs are required to implement effective compliance programs to oversee provider networks, benefits, and payments and stated that it will notify MAOs of OIG's findings and this recommendation so that they take appropriate action.

CMS stated that it will take into consideration our recommendation to strengthen the use of the Preclusion List to prevent fraudulent DMEPOS suppliers from billing Medicare Advantage. It noted that it recently sought feedback in a Request for Information (RFI) on potential improvements to the Preclusion List.²⁵ In that RFI, CMS stated that it identified significant deficits in the effectiveness of the Preclusion List in preventing fraudulent billing in Medicare Advantage and that these gaps in the Preclusion List undermine program integrity efforts and allow bad actors to circumvent CMS oversight.

CMS also stated that it will take into consideration our recommendation to require that all DMEPOS suppliers that bill Medicare Advantage be enrolled in Medicare or seek statutory authority to do so if necessary. CMS noted that in its recent RFI it also sought feedback on whether requiring enrollment in Original Medicare could enhance program integrity. CMS is currently reviewing the RFI comments and stated that it will consider OIG's findings and recommendations when it determines appropriate next steps.

We ask that CMS—in its Final Management Decision—provide details on any plans and progress toward implementing our recommendations.

For the full text of CMS's comments, see Appendix A.

METHODOLOGY

This data brief is based on a review of key documents, an analysis of Medicare Advantage data, and structured interviews with six selected MAOs, OIG investigators, and CMS staff.

Document Review

We reviewed key CMS documents relevant to MAOs, Medicare enrollment, and the Preclusion List. These included statutes, regulations, and CMS guidance. We also reviewed DMEPOS fraud case information and related documents, such as indictments.

Analysis of Medicare Advantage Encounter Data

We conducted an analysis of Medicare Advantage encounters from the Part C Encounter data. Part C Encounter data contain information about health care services and items billed to Medicare Advantage organizations. We also used information from CMS's Provider Enrollment, Chain, and Ownership System (PECOS) and CMS's Preclusion List.

We analyzed encounter records for DMEPOS with dates of service from January 1, 2023, through December 31, 2023. To identify encounter records for DMEPOS, we used the DMEPOS encounter type code (i.e., 4800). We included all types of durable medical equipment, prosthetics, orthotics, and supplies in the analysis, except those for drugs and those related to vision services.²⁶ We then identified all suppliers that billed Medicare Advantage for DMEPOS in 2023.

Next, we determined the extent to which CMS placed certain DMEPOS suppliers on the Preclusion List. To do this, we identified the suppliers that billed Medicare Advantage in 2023 and were eligible to be on the Preclusion List (i.e., they had their Medicare enrollment revoked and were placed under a re-enrollment bar, meaning they were prohibited from re-enrolling in Medicare). We then determined whether CMS had placed these suppliers on the Preclusion List.

Analysis of MAO Data

We requested data about network suppliers from a purposive sample of six MAOs. To select these six MAOs, we considered several characteristics. We selected MAOs of varying sizes on the basis of their total enrollment and the amount of DMEPOS billed to each MAO by suppliers that were not enrolled in Medicare. We also considered the types of plans that each organization offered to ensure a mix of plan types, e.g., Preferred Provider Organization (PPO) plans and Health Maintenance Organization (HMO) plans.

These six selected MAOs covered about two-thirds of all enrollees in Medicare Advantage in 2023.

From each of the six MAOs, we requested a list of all DMEPOS suppliers in their networks for calendar year 2023. We matched the network suppliers to the Medicare Advantage encounter data and Medicare enrollment data in PECOS. We used these data to determine which suppliers billed these six MAOs out of network and which billed in network. In total, we identified 21,029 suppliers that billed at least one of the 6 MAOs for DMEPOS. Of these, 7,980 suppliers billed in network for at least one of the MAOs. The remaining 13,049 suppliers did not bill in network for any of the six MAOs (i.e., they always billed out of network). We also determined which suppliers were enrolled in Medicare.

We then analyzed these data to determine any differences in DMEPOS billing between out-of-network suppliers that were not enrolled in Medicare and other suppliers. We focused this analysis on certain types of DMEPOS items, including orthotics, glucose monitor supplies, and urinary catheters. For each of these types of DMEPOS, we also calculated the average amount billed per enrollee.²⁷ We then compared the amounts billed by out-of-network suppliers that were not enrolled to those billed by all other suppliers.

Structured Interviews

We conducted structured interviews with the six selected MAOs and CMS. These included interviews with staff from CMS's Center for Program Integrity and CMS's Investigations Medicare Drug Integrity Contractor (I-MEDIC). We asked about the nature of DMEPOS fraud schemes, the checks CMS and contractors conduct on suppliers prior to billing for DMEPOS, and checks on suppliers that bill out of network, among other topics.

We also conducted interviews with special agents and other staff in OIG's Office of Investigations to better understand the nature of DMEPOS fraud schemes in Medicare Advantage.

Limitations

This data brief is based on analyses of Medicare Advantage data and interview data. We did not conduct a medical record review. Additionally, information about oversight and DMEPOS fraud reported by the six MAOs does not represent the views and experiences of all MAOs.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued in 2020 by the Council of the Inspectors General on Integrity and Efficiency.

APPENDIX A

Appendix A: Agency Comments

Following this page are the official comments from CMS.

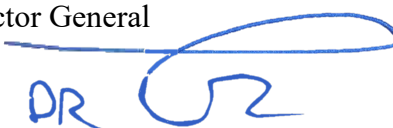


Administrator

Washington, DC 20201

DATE: July 29, 2026

TO: Ann Maxwell
Deputy Inspector General for Evaluation and Inspections
Office of Inspector General

FROM: Dr. Mehmet Oz 
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Issue Brief: *Medicare Advantage Organizations and CMS Can Do More to Prevent Durable Medical Equipment Fraud in Medicare Advantage* (OEI-02-24-00310)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft issue brief.

Medicare covers medically necessary Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items that are furnished by Medicare enrolled DMEPOS suppliers and meet other requirements specified in statute and regulation. Suppliers are tasked with submitting the claim and supplying the item. DMEPOS has been a frequent target of fraud and has a high improper payment rate. However, CMS is taking decisive steps to prevent fraudulent Medicare billing by DMEPOS companies.

In March 2025, CMS launched the Fraud Defense Operations Center (FDOC), better known as the Medicare War Room. In its first year, the Medicare War Room has become one of the most powerful weapons in the fight against fraud, waste, and abuse in Medicare history, stopping billions of dollars from reaching bad actors. The Medicare War Room is a cross-functional strike force uniting elite data analysts, investigators, health policy experts, legal advisors, and law enforcement under one roof with a single mission: stop fraud before taxpayers lose a single dollar. By harnessing rigorous, data-driven intelligence, the Medicare War Room detects threats in real time, coordinates rapid intervention, and shuts down inappropriate billing before it ever hits Medicare's books. In its first year, the Medicare War Room suspended over \$2.1 billion in potentially fraudulent payments including over \$1.9 billion for suspect DMEPOS billing.¹ CMS has subsequently revoked the Traditional Medicare billing privileges for nearly 100 of those suppliers and added 21 of them to the Medicare Advantage Preclusion List, which will preclude Medicare Advantage organizations from making payments to those suppliers.

In fact, due to the bold actions this administration has taken to crush fraud, CMS delivered unprecedented results in Fiscal Year (FY) 2025, protecting taxpayer dollars and holding bad actors accountable like never before. Total Medicare program integrity savings surged 59 percent, from \$26.3 billion in FY 2024 to \$41.9 billion in FY 2025. CMS prioritized "stop and caught" activities over "pay and chase" methods like recoupment. Cost avoidance activities, such as revocations or automated claim denials, accounted for 68 percent of all FY 2025 savings.

¹ This data includes March 31, 2025-March 31, 2026, and are therefore subject to change.

In February 2026, CMS announced a six-month moratorium on new Medicare enrollment for certain DMEPOS suppliers. A moratorium is a temporary suspension or halt on the enrollment of new providers or suppliers in specific categories or geographic areas. CMS implements moratoria as a program integrity measure by stopping enrollment of new providers in areas or categories where there is a significant potential for fraud, waste, and abuse. This moratorium applies to all applications for initial enrollment and changes in majority ownership for medical supply companies that require an initial enrollment. The moratorium allows CMS to explore additional safeguards to further mitigate longstanding instances of fraud, waste, and abuse perpetrated by certain DMEPOS companies.

Also in February 2026, CMS issued a Request for Information (RFI) to collect stakeholder input on ways to better prevent, identify, and address fraud, waste, and abuse that could be considered as part of an upcoming Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) Rule.² The comment period closed on March 30th and CMS is reviewing over 500 comments received. Topics within the RFI included the Preclusion List, Medicare Advantage enrollment requirements, and reducing risks from non-participating DMEPOS suppliers in Medicare Advantage. One of the questions posed in the RFI was whether Medicare Advantage plans support a requirement for all providers and suppliers to enroll in the Traditional Medicare program as a condition of billing Medicare Advantage plans.

In March 2026, CMS released a publicly available list of revoked Medicare enrollments. This dataset contains a point-in-time list of providers and suppliers whose Medicare enrollment has been revoked and who remain under an active re-enrollment bar. It is designed to help users identify revoked Medicare enrollments that were still subject to a bar on re-entering the program. This additional transparency allows patients and payers, including Medicare Advantage organizations, to understand which providers have been subject to such administrative enforcement action by the government.³

As demonstrated above, CMS continues to build on its broad strategy to combat fraud, waste, and abuse through data-driven prevention and real-time enforcement. CMS is making significant progress in its fight to crush fraud and appreciates OIG's work and partnership in this area.

The OIG's recommendations and CMS's responses are below.

OIG Recommendation

The OIG recommends that CMS ensure that MAOs strengthen checks of out-of-network DMEPOS suppliers.

CMS Response

CMS concurs with this recommendation. Medicare Advantage organizations contract with facilities, providers, and suppliers to provide services. Some plans offer an out-of-network benefit for some or all covered benefits. Out-of-network providers and suppliers do not have a contract with the Medicare Advantage plan and may or may not be enrolled in Traditional Medicare. All Medicare Advantage organizations are required to adopt and implement effective compliance programs to oversee provider networks, benefits, and payments. Compliance

² Additional information regarding the RFI is available at: <https://www.govinfo.gov/content/pkg/FR-2026-02-27/pdf/2026-03968.pdf>.

³ Data is available at: <https://data.cms.gov/search?keywords=Revoked+Medicare+Providers+and+Suppliers&sort=Relevancy>

programs must include measures that prevent, detect, and correct non-compliance with CMS's program requirements, as well as measures that prevent, detect, and correct fraud, waste, and abuse. CMS will notify Medicare Advantage organizations of OIG's findings and this recommendation so that they take appropriate action.

OIG Recommendation

The OIG recommends that CMS strengthen the use of the Preclusion List to prevent fraudulent DMEPOS suppliers from billing Medicare Advantage.

CMS Response

CMS reviewed the 50 suppliers identified by OIG in this report and determined that at the time of revocation, the criteria for inclusion on the Preclusion List criteria was not met.

As stated above, CMS recently sought feedback from Medicare Advantage organizations and other stakeholders on potential improvements to the preclusion list. CMS is currently reviewing the comments that were received. CMS will take the OIG's findings and this recommendation into consideration when determining appropriate next steps. CMS may pursue regulatory changes as deemed appropriate.

OIG Recommendation

The OIG recommends that CMS require that all DMEPOS suppliers that bill Medicare Advantage be enrolled in Medicare or seek statutory authority to do so if necessary.

CMS Response

As stated above, CMS recently requested feedback on solutions related to non-participating DMEPOS suppliers, and whether requiring enrollment in Traditional Medicare could enhance program integrity. CMS is currently reviewing the comments that were received. CMS will take the OIG's findings and this recommendation into consideration when determining appropriate next steps. It is important to note that requiring that all DMEPOS suppliers that bill Medicare Advantage be enrolled in Medicare, as directly described in this recommendation, would likely require additional statutory authority. CMS may pursue regulatory changes, or seek statutory authority, as deemed appropriate.

ENDNOTES

¹ See Department of Justice (DOJ), “11 Defendants Indicted in Multi-Billion Health Care Fraud Scheme, the Largest Case by Loss Amount Ever Charged by the Department Of Justice” (press release, June 30, 2025). Accessed at <https://www.justice.gov/usao-edny/pr/11-defendants-indicted-multi-billion-health-care-fraud-scheme-largest-case-loss-amount> on Sept. 17, 2025.

² See DOJ, “Two Healthcare Executives Convicted for Exploiting Elderly Medicare Advantage Beneficiaries in \$34 Million Fraud Scheme” (press release, Jan. 7, 2026). Accessed at <https://www.justice.gov/usao-sdfl/pr/two-healthcare-executives-convicted-exploiting-elderly-medicare-advantage> on Jan. 21, 2026. See also DOJ, “Madison Man Sentenced to 37 Months in Prison for Conspiracy to Defraud the United States” (press release, Jan. 24, 2025). Accessed at <https://www.justice.gov/usao-sdms/pr/madison-man-sentenced-37-months-prison-conspiracy-defraud-united-states> on Mar. 16, 2026.

³ For more information about Medicare Advantage plan types, see CMS, *Understanding Medicare Advantage Plans*. Accessed at <https://www.medicare.gov/publications/12026-understanding-medicare-advantage-plans.pdf> on Sept. 23, 2025. For more information about the number of people enrolled in each plan type, see CMS, *2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Accessed at <https://www.cms.gov/oact/tr/2024> on Sept. 23, 2025.

⁴ 42 C.F.R. § 422.204(b)(1).

⁵ State licensure requirements generally vary by product. Multiple States do not require a license to provide durable medical equipment. For more information about State licensure requirements, see Palmetto, *DMEPOS Licensure Database*. Accessed at [Link for Palmettogba.com](https://linkforpalmettogba.com) on Sept. 23, 2025. See also Novitas Solutions, *DMEPOS Licensure Database*. Accessed at <https://DMEPOS-licensure-db.novitas-solutions.com/app/home> on Sept. 23, 2025.

⁶ CMS deemed eight accreditation organizations for DMEPOS suppliers. For more information, see CMS, *DMEPOS Accreditation Organizations*. Accessed at <https://www.cms.gov/files/document/DMEPOS-accreditation-organizations.pdf> on Nov. 5, 2025. See also 42 C.F.R. § 422.204(b)(1)(ii).

⁷ For further information, see CMS, *Preclusion List*. Accessed at <https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/preclusion-list> on Sept. 23, 2025. Separate from the Preclusion List, OIG has the authority to exclude individuals and entities from federally funded health care programs for a variety of reasons, including conviction for Medicare fraud or Medicaid fraud. Those that are excluded cannot receive payment from Federal health care programs for any items or services they furnish, order, or prescribe. 42 U.S.C. § 1320a-7.

⁸ 42 C.F.R. § 422.224.

⁹ 42 C.F.R. § 424.510 (enrollment requirements), 42 C.F.R. § 424.516 (additional enrollment requirements), and 42 C.F.R. § 424.518 (screening levels).

¹⁰ CMS can deny enrollment if the supplier or certain specified individuals (including any owner) was, within the preceding 10 years, convicted of a Federal or State felony offense that CMS determines is detrimental to the best interests of the Medicare program and its enrollees. 42 C.F.R. § 424.530(a)(3).

¹¹ Of note, CMS requires certain institutional providers, such as hospitals and skilled nursing facilities, to be enrolled in Medicare in order to provide covered items and services to enrollees in Medicare Advantage plans. See 42 C.F.R. § 422.204(b)(3).

¹² Federal laws require MAOs to pay for DMEPOS furnished by out-of-network suppliers when the item is covered under the enrollee's plan and mandate that out-of-network suppliers accept the MAOs' payment as payment in full. 42 U.S.C. §§ 1395w-27(f)(1) and 1395w-22(k)(1).

¹³ 42 C.F.R. § 422.224. CMS, *Preclusion List*. Accessed at <https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/preclusion-list> on Sept. 23, 2025.

¹⁴ 42 C.F.R. § 422.2.

¹⁵ CMS may also place a supplier on the Preclusion List if it has been convicted of a felony in the prior 10 years.

¹⁶ CMS has the authority to place a DMEPOS supplier on the Preclusion List if it is not enrolled but has engaged in behavior for which CMS could have revoked Medicare enrollment and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the Medicare program. However, CMS reported having used this authority to place just one DMEPOS supplier on the List.

¹⁷ OIG is conducting additional work looking at the Preclusion List, see OIG Active Work Plan, [*Audit to Determine Whether CMS Oversight of Its Preclusion List Ensured That Certain Revoked Providers Did Not Receive Payment for Medicare Part C and Part D Services*](#) (A-02-24-01013), forthcoming.

¹⁸ See DOJ, "Federal Indictments & Law Enforcement Actions in One of the Largest Health Care Fraud Schemes Involving Telemedicine and Durable Medical Equipment Marketing Executives Results in Charges Against 24 Individuals Responsible for Over \$1.2 Billion in Losses" (press release, Apr. 9, 2019). Accessed at <https://www.justice.gov/archives/opa/pr/federal-indictments-and-law-enforcement-actions-one-largest-health-care-fraud-schemes> on Sept. 17, 2025. See also DOJ, "11 Defendants Indicted in Multi-Billion Health Care Fraud Scheme, the Largest Case by Loss Amount Ever Charged by the Department Of Justice" (press release, June 30, 2025). Accessed at <https://www.justice.gov/usao-edny/pr/11-defendants-indicted-multi-billion-health-care-fraud-scheme-largest-case-loss-amount> on Sept. 17, 2025. See also DOJ, "Chief Compliance Officer Convicted of \$50M Medicare Fraud Scheme" (press release, June 8, 2023). Accessed at <https://www.justice.gov/archives/opa/pr/chief-compliance-officer-convicted-50m-medicare-fraud-scheme> on Sept. 23, 2025. See also OIG, *Consumer Alert: Urinary Catheter Scams* (updated Apr. 30, 2024). Accessed at <https://oig.hhs.gov/fraud/consumer-alerts/consumer-alert-catheter-scam/> on Sept. 25, 2025. See also OIG, *Fraud Alert for People with Diabetes*, Mar. 13, 2012. Accessed at <https://oig.hhs.gov/fraud/consumer-alerts/fraud-alert-people-diabetes/> on Sept. 23, 2025.

¹⁹ On average, out-of-network, non-enrolled suppliers billed for a higher number of orthotic devices per enrollee and billed for more expensive devices than other suppliers, i.e., suppliers that were in network and/or enrolled in Medicare and suppliers that were out of network and enrolled.

²⁰ These suppliers billed an average of \$137 per enrollee for glucose monitor supplies and \$2,554 per enrollee for urinary catheters. Both amounts were about one and a half times more than the averages billed by other suppliers.

²¹ See DOJ, “Healthcare Executive and Telemarketing Company Owner Sentenced to Prison for Exploiting Elderly Medicare Advantage Beneficiaries in \$35 Million Fraud Scheme” (press release, July 30, 2026). Accessed at <https://www.justice.gov/usao-sdfl/pr/healthcare-executive-and-telemarketing-company-owner-sentenced-prison-exploiting> on Aug. 4, 2026.

²² See DOJ, “11 Defendants Indicted in Multi-Billion Health Care Fraud Scheme, the Largest Case by Loss Amount Ever Charged by the Department of Justice” (press release, June 30, 2025). Accessed at <https://www.justice.gov/usao-edny/pr/11-defendants-indicted-multi-billion-health-care-fraud-scheme-largest-case-loss-amount> on June 4, 2026.

²³ In December 2025, CMS made a number of changes to increase oversight of DMEPOS fraud in Original Medicare, such as revising the accreditation process and imposing additional oversight when a DMEPOS supplier has a change in majority ownership. See 90 Fed. Reg. 55342 (Dec. 2, 2025).

²⁴ See OIG Active Work Plan, [*Audit to Determine Whether CMS Oversight of Its Preclusion List Ensured That Certain Revoked Providers Did Not Receive Payment for Medicare Part C and Part D Services*](#) (A-02-24-01013), forthcoming.

²⁵ 91 Fed. Reg. 9803 (Feb. 27, 2026).

²⁶ To exclude encounters for drugs, we used CMS’s Berenson-Eggers Type of Service (BETOS) Codes. We also excluded all encounters for procedure codes beginning with “V,” which indicates that the service is for vision services. Vision services are only covered under limited circumstances in Original Medicare but may be covered more broadly under Medicare Advantage plans’ supplemental benefits.

²⁷ These calculations are based on the amounts the MAOs reported paying for these services. They may not include the enrollee cost-sharing amounts.

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