Department of Health and Human Services
Office of Inspector General
Office of Audit Services

April 2026 | A-05-21-00036

Medicare Payments for Positive Airway Pressure Devices Used for the Treatment of Obstructive Sleep Apnea Generally Complied With Medicare Requirements

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REPORT HIGHLIGHTS

April 2026 | A-05-21-00036

Medicare Payments for Positive Airway Pressure Devices Used for the Treatment of Obstructive Sleep Apnea Generally Complied With Medicare Requirements

Why OIG Did This Audit

- The Medicare program covers positive airway pressure (PAP) device treatment as the first-line treatment for obstructive sleep apnea (OSA).
- For fiscal year 2017, the Comprehensive Error Rate Testing Program determined continuous PAP (CPAP) devices had the second highest improper payment amount in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) category, with estimated improper payments totaling $495 million for CPAP devices used for the treatment of OSA.
- Most of the errors occurred because DMEPOS suppliers did not provide sufficient documentation to support claims submitted for PAP devices.
- Due to the improper payment amounts and high documentation error rate, we conducted this audit to determine whether claims for PAP devices met Medicare requirements.

What OIG Found

CMS generally ensured that payments made to suppliers for PAP devices complied with Medicare billing requirements. Medicare payments to suppliers complied with Medicare billing requirements for 97 sampled PAP device claims. However, for the remaining 13 sampled PAP device claims, Medicare payments to suppliers did not comply with Medicare billing requirements. Specifically, Medicare made payments for PAP device claims that did not have the required documentation to support the services billed. In addition, some suppliers did not respond to OIG's request for documentation to support the PAP device claims that were billed to Medicare. As a result:

- Medicare paid for PAP device claims that did not have all the necessary documentation
- We estimated that Medicare paid approximately $15.2 million for improper PAP device claims during our audit period that did not meet Medicare billing requirements

What OIG Recommends

We recommended that CMS (1) establish and implement internal controls to prevent improper payments for replacement PAP devices and (2) provide outreach and education to suppliers on document requirements.

CMS did not indicate concurrence or nonconcurrence with the first recommendation. CMS concurred with the second recommendation and described steps it has taken and plans to take to strengthen supplier education.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Medicare program covers positive airway pressure (PAP) device treatment as the first-line treatment for obstructive sleep apnea (OSA). A PAP device prevents the decrease or complete halt of airflow that occurs during OSA. A continuous PAP (CPAP) device is a non-invasive technique for providing single levels of air pressure from a flow generator to prevent the obstruction of the airway that occurs during OSA. A bi-level PAP (BiPAP) device is similar to a CPAP, but it provides two levels of pressure to prevent obstruction that occurs during OSA. A BiPAP device is covered by Medicare for those enrollees with OSA where a CPAP has been tried and proven ineffective.[1]

The Comprehensive Error Rate Testing (CERT) program is used to measure improper payments in the Medicare Fee-for-Service program.[2] In the fiscal year 2017 CERT report, PAP devices, including CPAP (HCPCS E0601) and BiPAP (HCPCS E0470) devices, were the second highest improper payment amount of all services provided in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) category.[3] The CERT program estimated improper payments totaling $495 million for PAP devices, used for the treatment of OSA. Most of the errors were because the DMEPOS suppliers (suppliers) did not provide sufficient documentation to support claims submitted for PAP devices.

Based on the CERT estimated improper payment amount and high documentation error rate for PAP devices, we reviewed whether claims for CPAP and BiPAP devices paid between January 1, 2017, and December 31, 2019 (audit period), met Medicare requirements.[4] For this report, the term "PAP device" will refer to both CPAP and BiPAP devices used for the treatment of OSA.

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[1] CMS LCD, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, accessed on Aug. 14, 2025. This link is the archived version of the LCD that was in place during our audit period but has since been superseded.

[2] CMS estimates the Medicare fee-for-service program's improper payment rate through the CERT program by identifying improper payments that do not meet Medicare requirements. Improper payments consist of both overpayments and underpayments. CMS publishes specific overpayment rates and estimated overpayments for the top 20 Medicare Part B services with overpayments.

[3] When submitting claims for PAP devices, suppliers use Healthcare Common Procedure Coding System (HCPCS) codes. HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

[4] This was the most relevant claim data available at the start of our audit.

OBJECTIVE

Our objective was to determine whether Medicare payments made for PAP device claims used for the treatment of OSA complied with Medicare coverage requirements.

BACKGROUND

The Medicare Program

The Medicare program provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. CMS administers the program. Medicare Part B provides supplementary medical insurance for medical and other health services, including DMEPOS.

CMS contracted with two durable medical equipment Medicare administrative contractors (DME MACs) to process and pay Medicare Part B DMEPOS claims for four jurisdictions (A, B, C, and D), which include specific States and Territories.[5] Suppliers must submit claims to the DME MAC that serves the State or Territory in which a Medicare enrollee permanently resides.

DME MACs help CMS in its efforts to, among other things, process and pay for PAP device claims under Part B, respond to supplier inquiries, and educate suppliers about Medicare coverage requirements. In addition, DME MACs' responsibilities include applying system edits to determine whether claims are complete and reimbursable and performing medical reviews of claims to determine whether items provided to enrollees meet Medicare coverage requirements and are medically necessary.[6] These medical reviews may be conducted as part of CMS's Targeted Probe and Educate (TPE) program; we refer to these reviews as "TPE reviews." TPE reviews focus on specific suppliers that bill a particular item or service, typically evaluate 20 to 40 claims per supplier for an item or a service, and provide individualized education to suppliers based on the results of these reviews.[7] DME MACs analyze available data to identify items and suppliers for TPE reviews.

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[5] CGS Administrators, LLC, processes claims for DME MAC jurisdictions B and C. Noridian Healthcare Solutions, LLC, processes claims for DME MAC jurisdictions A and D.

[6] An edit is programming within the standard claim processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, acts on the claims, such as paying them in full, paying them in part, or suspending them for manual review.

[7] The TPE program's process typically includes up to three rounds of prepayment or post payment probe reviews, each of which may be followed by one-on-one education for providers that are found to be noncompliant (CMS, Medicare Program Integrity Manual, Pub. No. 100-08, chapter 3, § 3.2.5.).

Positive Airway Pressure Devices Used for the Treatment of Obstructive Sleep Apnea

OSA is a sleep-related breathing disorder characterized by repeated obstruction to the airway during sleep. OSA occurs when the upper airway becomes blocked, leading to brief pauses in breathing during sleep. To diagnose OSA, a practitioner orders a diagnostic sleep study, which can be performed in a facility or the patient's home. During this sleep study, the enrollee sleeps overnight while connected to sensors that continuously and simultaneously monitor and record various parameters of sleep, such as brain waves, blood oxygen levels, heart rate, breathing, and eye and leg movements. The data is reviewed by a board-certified sleep physician who interprets the results and provides a report to the treating practitioner. The treating practitioner uses the report to diagnose a variety of sleep disorders, including OSA, and develop a plan of care for the enrollee.

Medicare Coverage Requirements for Positive Airway Pressure Devices

DME MACs may define what items or services are covered by issuing local coverage determinations (LCDs), which specify what items are medically reasonable and necessary.[8] During our audit period, LCD L33718 identified the Medicare coverage requirements for PAP devices. Coverage requirements differ based on whether an enrollee is obtaining an initial, continued usage, or replacement of PAP devices. In addition, there are different coverage requirements for replacement devices based on whether the device is the first device covered by Medicare, replaced during the 5-year reasonable useful life (RUL), or after 5-year RUL.[9]

Initial Coverage: First 3 Months of Therapy

Initial coverage includes the first 3 months of therapy for Medicare enrollees who receive a PAP device for the first time. The DME supplier must have a documented face-to-face evaluation by the treating practitioner and a sleep test.[10] In addition, the DME supplier must make supporting documentation available upon request to determine the amounts due such provider, including a standard written order.[11] The sleep test results must support the diagnosis of OSA. Enrollees who meet these requirements qualify for a CPAP device for initial coverage. A BiPAP device is covered for enrollees with OSA who have tried a CPAP device and

[8] An LCD is a decision made by a MAC whether to cover a particular item or service on a contractor-wide basis in accordance with section 1862(a)(1)(A) of the Social Security Act.

[9] See footnote 1.

[10] Face-to-face evaluation has been updated to in-person evaluation in the current LCD.

[11] See footnote 1.

found it ineffective.[12] The treating practitioner is required to document the CPAP device as ineffective.[13]

Continued Coverage: Beyond the First 3 Months of Therapy

Coverage for an enrollee beyond the first 3 months of PAP device therapy requires that no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating practitioner must conduct a follow-up clinical reevaluation and document that the beneficiary is benefiting from PAP therapy. Documentation of clinical benefit must be demonstrated by objective evidence of continued usage coverage adherence of the PAP device and documentation from the face-to-face reevaluation that symptoms of OSA are improved.[14] If there is discontinuation of usage of the device at any time, the supplier is expected to ascertain this and stop billing for the device.[15]

Coverage for Replacement of a Positive Airway Pressure Device

A PAP device has an RUL of 5 years. An enrollee seeking replacement of a device that is older than the RUL is eligible for replacement. In the event of special circumstances, such as device loss, theft, or irreparable damage due to a specific incident, the device is eligible for replacement prior to the 5-year RUL.[16] If a PAP device is replaced during the 5-year RUL because of loss, theft, or irreparable damage, there is no requirement for a new clinical evaluation, sleep test, or trial period. If a PAP device is replaced following the 5-year RUL, there must be a face-to-face evaluation by the treating practitioner documenting that the enrollee continues to use and benefit from the PAP device, and a new written order. There is no requirement for a new sleep study or continued evidence of usage coverage adherence of the PAP device.[17]

Enrollees new to Medicare who are seeking coverage for either rental of a device, a replacement device, and/or accessories require documentation of a prior sleep test and a new

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[12] Proven ineffective treatment of a CPAP is defined as documented failure to meet therapeutic goals using a CPAP during a study designed to find the ideal air pressure for the CPAP or during home use despite optimal therapy.

[13] See footnote 1.

[14] Coverage adherence means that a Medicare beneficiary used the CPAP machine regularly for at least 4 hours per night and for at least 70 percent of nights during a consecutive 30-day period anytime during the first 3 months of initial usage.

[15] See footnote 1.

[16] See footnote 1.

[17] See footnote 1.

face-to-face evaluation. In addition, the DME supplier must make supporting documentation available upon request to determine the amounts due such provider, including a standard written order.[18] The prior sleep test must support the diagnosis of OSA. The treating practitioner also must document in the face-to-face evaluation that the PAP device continues to meet medical need.[19]

HOW WE CONDUCTED THIS AUDIT

Our audit covered 387,852 Medicare enrollees with associated paid claims for PAP device rental payments with service dates from calendar years (CYs) 2017 through 2019 totaling $111.9 million. The sampling frame consisted of enrollees with PAP device claims who did not have any claims for a qualified sleep study from 2013 through 2018.

We selected a random sample of 110 Medicare enrollees with payments for PAP devices totaling $32,480 for review.[20] We requested supporting documentation from the suppliers to determine whether the suppliers met Medicare coverage requirements for PAP device claims used for the treatment of OSA.[21]

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology, Appendix B describes our statistical sampling methodology, and Appendix C describes sample results and estimates.

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[18] Documentation that an enrollee had a sleep study prior to Medicare Part B enrollment that meets the Medicare Apnea hypopnea index (AHI)/Respiratory disturbance index (RDI) coverage criteria in effect at the time that the enrollee seeks Medicare coverage of a replacement PAP device can be used to meet coverage requirements. The AHI is the average number of episodes of apnea and hypopnea per hour. The RDI is the average number of respiratory disturbances per hour.

[19] See footnote 1.

[20] We reviewed only those claim lines billed with HCPCS codes E0470 or E0601.

[21] We identified one enrollee whose primary diagnosis was chronic obstructive pulmonary disease, not OSA. We counted this claim as a non-error. Devices where the primary diagnosis is not OSA require different coverage criteria that are outside the scope of our review.

FINDINGS

CMS generally ensured that payments made to suppliers for PAP devices complied with Medicare coverage requirements. Medicare payments to suppliers complied with Medicare coverage requirements for 97 sampled enrollees. However, for the remaining 13 sampled enrollees, Medicare payments to suppliers did not comply with Medicare coverage requirements. Specifically, for 11 sampled enrollees, Medicare made payments for PAP device claims that did not have documentation to support that the coverage requirements were met for the services billed. In addition, for two sampled enrollees, suppliers did not respond to OIG's request for documentation to support the PAP device claims that were billed to Medicare.

The internal controls CMS had in place failed to prevent suppliers from billing Medicare for PAP device claims that did not meet Medicare documentation requirements. The DME MACs placed responsibility on suppliers to conduct due diligence checks and ensure all required documentation was in place prior to billing for PAP devices. In addition, CMS did not have any internal controls in place to prevent suppliers from billing replacement devices that did not meet Medicare coverage requirements. The insufficient controls allowed Medicare to make improper payments for 13 sample enrollees that did not comply with Medicare requirements, totaling $4,307. On the basis of our sample results, we estimated that Medicare paid approximately $15.2 million for improper PAP device claims during our audit period that did not meet Medicare coverage requirements.[22]

SOME MEDICARE PAYMENTS FOR POSITIVE AIRWAY PRESSURE DEVICES USED FOR THE TREATMENT OF OBSTRUCTIVE SLEEP APNEA DID NOT COMPLY WITH MEDICARE COVERAGE REQUIREMENTS

Medicare Coverage Requirements

Section 1833(e) of the Social Security Act requires documentation to support the amounts due for payment to be made. LCD L33718 includes coverage requirements for PAP devices, such as a qualified sleep study, proof of a face-to-face evaluation by the treating practitioner, a written order, or objective evidence of adherence to use of the PAP device beyond the first 3 months of device therapy. Further, LCD L33718 specifies that documentation to demonstrate compliance with coverage requirements must be available upon request. These coverage requirements differ based on whether an enrollee is obtaining initial coverage, continued coverage, or coverage for a replacement of PAP devices for the treatment of OSA. There are different requirements for replacement devices based on whether the device is the first device covered by Medicare, replaced during the 5-year RUL, or after 5-year RUL.

[22] We estimated that Medicare improperly paid suppliers $15,186,204 for our audit period. The 90-percent confidence interval associated with this estimate ranged from $8,687,310 to $25,179,883.

No Support for Services Billed

The suppliers did not provide sufficient documentation to meet Medicare coverage requirements when submitting claims for PAP devices, resulting in overpayments of $3,919. Specifically, for 11 of the 110 sampled Medicare enrollees, the suppliers did not submit support for 1 or more of the following coverage requirements:[23]

- Proof of a face-to-face evaluation by the treating practitioner (9 enrollees)
- A qualified sleep study related to a new enrollee entering Medicare seeking a replacement device (5 enrollees)
- A standard written order (5 enrollees)

All 11 of these improper payments were for enrollees who received a replacement PAP device.

No Documentation To Meet Medicare Coverage Requirements

For 2 of the 110 sampled Medicare enrollees, the suppliers did not provide any documentation to meet Medicare coverage requirements for the associated claims, resulting in overpayments of $388. We contacted these suppliers multiple times and requested documentation; however, they did not respond to any of the requests. The failure of the supplier to provide documentation resulted in improper payments for these two enrollees.

CMS'S INTERNAL CONTROLS MAY NOT HAVE BEEN SUFFICIENT TO PREVENT IMPROPER PAYMENTS

CMS stated it had internal controls in place during our audit period to prevent improper payments for PAP devices. DME MACs issued LCD L33718 to specify coverage requirements to meet medical necessity for PAP devices.[24] In addition, CMS required the DME MACs to perform claim data analysis, medical review, and provider outreach and education as appropriate.

Based on our results of our review, the internal controls in place sometimes failed to prevent suppliers from billing Medicare for PAP device claims that did not meet Medicare coverage requirements. Specifically, CMS did not have any internal controls in place involving replacement PAP devices. The insufficient controls allowed Medicare to make improper payments to suppliers.

[23] The total exceeds 11 because 5 sample items contained more than 1 error.

[24] See footnote 1.

MEDICARE IMPROPERLY PAID $15.2 MILLION FOR POSITIVE AIRWAY PRESSURE DEVICES

On the basis of our sample results, we estimated that Medicare improperly paid $15.2 million for improper PAP device claims during our audit period that did not meet Medicare requirements for coverage.

RECOMMENDATIONS

- We recommend that CMS establish and implement internal controls to prevent improper payments for replacement PAP devices, which amounted to an estimated $15.2 million for our audit period.

- We recommend that CMS provide outreach and education to suppliers on coverage requirements for PAP devices used in treating OSA to prevent improper payments.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS did not explicitly state its concurrence or nonconcurrence with our first recommendation. CMS concurred with our second recommendation and described actions it planned to take to address the recommendation. After reviewing CMS's comments, we maintain that our recommendations are valid.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding technical comments, are included in their entirety as Appendix D.

CMS COMMENTS

CMS acknowledged OIG's findings that Medicare suppliers generally complied with billing requirements for initial and continued use claims, but some lacked support for one or more of the coverage requirements related to replacement PAP devices.

CMS did not explicitly state its concurrence or nonconcurrence with the first recommendation. CMS stated that OIG did not stratify its sample between initial and replacement claims, making it unclear whether replacement devices pose a greater program integrity risk. CMS explained that the errors identified involve documentation submission rather than issues that could be resolved through automated claim processing controls. In addition, CMS stated it will share the audit results with its contractors to help determine whether medical review of replacement PAP devices should be prioritized.

CMS concurred with the second recommendation that it provide outreach and education to suppliers on coverage requirements for PAP devices used in treating OSA to prevent improper payments. CMS highlighted existing outreach through webinars, in-person training, individualized TPE reviews, and published articles. CMS cited the publication of new Medicare

Learning Network materials in November 2025 and agreed to develop updated educational resources as needed to reinforce documentation requirements, especially as documentation relates to PAP replacement devices.

OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain that our first recommendation, that CMS establish and implement internal controls to prevent improper payments for replacement PAP devices, which amounted to an estimated $15.2 million for our audit period, is valid. Based on the results of our audit, we identified 11 errors related to replacement PAP devices that did not have documentation to support that the coverage requirements were met for the services billed. Although CMS had internal controls in place during our audit period to prevent improper payments for PAP devices, it did not have controls in place related to replacement PAP devices. Also, in interviews with CMS contractors, we identified that the contractors only reviewed PAP device claims for initial coverage. Our audit objective was not designed to determine whether replacement devices pose a greater program integrity risk; therefore, we did not utilize a sample design that stratified initial and replacement claims. However, the results of the audit indicated that CMS's internal controls did not prevent improper payments associated with replacement PAP devices. Therefore, CMS should take additional steps to ensure that claims made for replacement PAP devices meet Medicare requirements.

We acknowledge the actions that CMS has taken and plans to take to address our second recommendation.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 387,852 Medicare enrollees with associated paid claims for PAP device rental payments with service dates from CYs 2017 through 2019 totaling $111,923,893. We selected a random sample of 110 Medicare enrollees with PAP device payments totaling $32,480 for review. Of the 110 sampled enrollees, 1 had a paid claim for a BiPAP with a diagnosis code other than OSA. This enrollee was not reviewed and was treated as a non-error in our sample. We requested and reviewed supporting documentation from the suppliers to determine whether the suppliers met Medicare requirements when billing for PAP device claims for the treatment of OSA.

We did not review the overall internal control structure of CMS or the DME MACs. Rather, we limited our internal control review to the objective of our audit. Specifically, we interviewed officials from two DME MACs to gain an understanding of their claim processing and payment procedures, system edits, and ongoing monitoring, and we reviewed the LCD for PAP devices. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History (NCH) file, but we did not assess the completeness of the file.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and guidance
- Interviewed CMS program officials to obtain an understanding of the Medicare requirements related to PAP devices for the treatment of OSA
- Interviewed DME MACs' program officials and discussed the controls that were put in place to prevent improper payments
- Used CMS's NCH file to identify PAP device claims paid in CYs 2017 through 2019
- Selected a random sample of 110 enrollees who had PAP device payments during our audit period for detailed review (Appendix B)
- Requested and reviewed the supporting documents from the suppliers
- Used the results of the sample review to estimate the amount of Medicare payments made to suppliers that did not meet Medicare requirements (Appendix C)

- Discussed the results of our audit with CMS officials

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of a database of 387,852 Medicare enrollees with associated paid claims for PAP device rentals with service dates in CYs 2017 through 2019 totaling $111,923,893. The sampling frame consisted of enrollees with a diagnosis of OSA who had paid claims for PAP devices and did not have any claims for a qualified sleep study between 2014 and 2018.

SAMPLE UNIT

The sample unit was a Medicare enrollee, identified by their Medicare Beneficiary Identification Number (HIC).

SAMPLE DESIGN

We used a simple random sample. For each enrollee selected, we reviewed all claims associated with that enrollee during the audit period.[25]

SAMPLE SIZE

We selected a sample of 110 Medicare enrollees.

SOURCE OF RANDOM NUMBERS

The source of the random numbers was the OIG/Office of Audit Services' (OAS) statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We sorted the sampling frame in ascending order by enrollee HIC. We then consecutively numbered the items in the sampling frame. After generating the random numbers in accordance with our sample design, we then selected the corresponding frame items for review.

[25] See footnote 21.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of Medicare payments made to suppliers that did not meet Medicare coverage requirements. We used this software to calculate the point estimate and a two-sided 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Sampled Enrollees With Unallowable Payments	Value of Unallowable Payments for Sampled Enrollees
387,852	$111,923,893	110	$32,480	13	$4,307

Estimated Value of Unallowable Payments in the Sampling Frame (Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$15,186,204
Lower limit	8,687,310
Upper limit	25,179,883

APPENDIX D: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: January 29, 2026

TO: John D. Hagg
Acting Deputy Inspector General for Audit Services

FROM: Mehmet Oz, M.D.
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Medicare Payments for Positive Airway Pressure Devices Used for the Treatment of Obstructive Sleep Apnea Generally Complied With Medicare Requirements* (A-05-21-00036)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to ensuring that Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are billing for positive airway pressure (PAP) devices for the treatment of obstructive sleep apnea (OSA) in accordance with Medicare requirements.

CMS recognizes the importance of providing Medicare beneficiaries with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting pre-payment and post-payment reviews. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

Durable medical equipment Medicare administrative contractors (DME MACs) have set local coverage determinations (LCDs) and Articles to give suppliers and providers requirements and guidance respectively as to whether Medicare would pay for an item or service. The DME MACs implemented LCD L33718, which outlines coverage and documentation requirements specific to PAP devices for the treatment of OSA. These requirements differ based on whether the claim is billing for an initial, continued usage, or replacement device. As reflected in the OIG report, suppliers generally complied with billing requirements for initial and continued use claims (97 of 110 sampled), but some claims (11 of 110) lacked support for one or more of the coverage requirements relating to replacement of PAP devices. Of note, the majority of OIG's random sample of claims for PAP devices that did not have any claims for a qualified sleep study were related to replacement devices, and OIG did not stratify the sample by initial versus replacement devices. Therefore, it is unclear whether replacement PAP devices pose a greater program integrity risk.

Over the last five years, MACs provided hundreds of training instances relating to the billing of PAP devices, including replacement devices, using various events such as in-person trainings, webinars, and flyers. In addition, MACs provide individualized education through the Targeted Probe and Educate (TPE) program to identify and correct errors for suppliers identified with high claim error rates.

While OIG did not identify any instances of fraud, CMS is taking significant actions to crush fraud conducted by DMEPOS suppliers in addition to addressing improper payments in this area. More information about CMS efforts is available at cms.gov/fraud.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

We recommend that CMS establish and implement internal controls to prevent improper payments for replacement PAP devices, which amounted to an estimated $15.2 million for our audit period.

CMS Response

As reflected in the OIG report, suppliers generally complied with billing requirements for initial and continued use claims (97 of 110 sampled), but some claims (11 of 110) lacked support for one or more of the coverage requirements relating to replacement PAP devices. The majority of OIG's random sample of claims for PAP devices that did not have any claims for a qualified sleep study were related to replacement devices, and OIG did not stratify the sample by initial versus replacement devices. Therefore, it is unclear whether replacement PAP devices pose a greater program integrity risk. The errors OIG identified were related to documentation submission issues and cannot be addressed through automated controls. However, CMS will share this audit with CMS contractors to use in their risk analysis and work planning to determine if medical review for replacement PAP devices should be prioritized over other program integrity.

OIG Recommendation

We recommend that CMS provide outreach and education to suppliers on coverage requirements for PAP devices used in treating Obstructive Sleep Apnea (OSA) to prevent improper payments.

CMS Response

CMS concurs with this response. While CMS and DME MACs currently provide supplier education through in-person training, webinars, individualized TPE, and published articles, we acknowledge OIG's finding that documentation gaps were present among a small subset of suppliers. In November 2025, CMS published two Medicare Learning Network products for providers that include information on medical record documentation requirements for PAP devices.[1] CMS will develop updated educational materials as needed reiterating documentation requirements, especially as it relates to PAP replacement devices.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

[1] Medicare Provider Compliance Tips: Continuous Positive Airway Devices & Accessories (November 2025); Accessed at https://www.cms.gov/training-education/medicare-learning-networkr-mln/compliance/medicare-provider-compliance-tips/cpap-devices-accessories. Medicare Provider Compliance Tips: Respiratory Assist Devices (November 2025); Accessed at https://www.cms.gov/training-education/medicare-learning-networkr-mln/compliance/medicare-provider-compliance-tips/respiratory-assist-devices.

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