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

October 2025 | OAS-24-09-005

Medicare Improperly Paid Suppliers $22.7 Million Over 7 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Enrollees During Inpatient Stays

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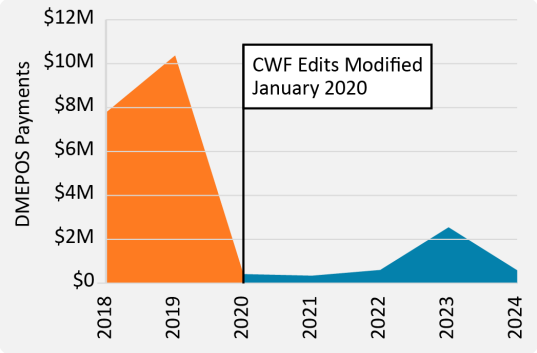
Why OIG Did This Audit

- A prior OIG audit found that Medicare improperly paid suppliers $34 million for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items provided to enrollees during inpatient stays from 2015 through 2017.
- Generally, Medicare should not pay a supplier for DMEPOS items provided to an enrollee during an inpatient stay. Instead, all items must be provided directly by the inpatient facility or under arrangements between the facility and the supplier.
- Because of the large overpayment amount identified in our prior audit, we conducted this followup audit to determine whether Medicare payments to suppliers for DMEPOS items provided to enrollees during inpatient stays from 2018 through 2024 complied with Medicare requirements.

What OIG Found

Medicare payments to suppliers for DMEPOS items provided to enrollees during inpatient stays did not comply with Medicare requirements:



- None of the $22.7 million in payments for DMEPOS items covered by this audit should have been paid. In addition, suppliers may have incorrectly collected up to $5.9 million in deductible and coinsurance amounts from enrollees or from someone on their behalf.
- Prior to January 2020, the system edits were not working properly. However, after CMS modified the edits in January 2020, improper payments substantially decreased. From January 2020 through December 2024, $4.5 million was improperly paid (about 20 percent of the $22.7 million). Because improper payments continue to be made, further review of the edits may be necessary to determine whether refinements are needed.

What OIG Recommends

We made five recommendations, including that CMS direct the DME Medicare contractors to recover from suppliers up to $22.7 million in identified improper payments and recommend that the suppliers refund to enrollees up to $5.9 million in deductible and coinsurance amounts. We also recommend that CMS review its system edits to determine whether any refinements are necessary to prevent improper payments to suppliers for DMEPOS items provided to enrollees during inpatient stays. The full recommendations are in the report.

CMS concurred with four recommendations. CMS did not concur with the recommendation to review system edits.

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INTRODUCTION

WHY WE DID THIS AUDIT

A prior Office of Inspector General (OIG) audit found that Medicare improperly paid suppliers $34 million for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items provided to enrollees during inpatient stays from 2015 through 2017.[1] Medicare overpaid suppliers because the system edits that should have prevented or detected the overpayments were not adequate. One of our recommendations was that the Centers for Medicare & Medicaid Services (CMS) correct the system edits to fully prevent and detect overpayments to suppliers for DMEPOS items provided during inpatient stays. CMS concurred with this recommendation, and in January 2020, CMS modified its claims processing system edits to prevent or detect overpayments for DMEPOS claims billed during inpatient stays.

Because of the large overpayment amount identified in our prior audit, we conducted this followup audit to determine whether Medicare payments to suppliers for DMEPOS items provided to enrollees during inpatient stays with dates of service from 2018 through 2024 complied with Medicare requirements.

OBJECTIVE

Our objective was to determine whether Medicare payments to suppliers for DMEPOS items provided to enrollees during inpatient stays complied with Medicare requirements.

BACKGROUND

Medicare Program and the Role of Medicare Contractors

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, as well as DMEPOS items. Medicare enrollees are responsible for certain out-of-pocket costs, such as deductibles and coinsurance, for both Part A and Part B services.

CMS administers Medicare and contracts with Medicare Administrative Contractors (MACs) in each Medicare jurisdiction to, among other things, process and pay Medicare Part A claims submitted for hospital services.[2] CMS also contracts with durable medical equipment Medicare administrative contractors (DME MACs) to process and pay Medicare Part B claims for DMEPOS

[1] OIG, *Medicare Improperly Paid Suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Beneficiaries During Inpatient Stays* (A-09-17-03035), Nov. 29, 2018.

[2] Seven MACs process Medicare Part A claims for 12 jurisdictions.

items. Two DME MACs process claims for four jurisdictions (each DME MAC has two jurisdictions), which include specific States and territories. Suppliers must submit claims to the DME MAC that services the State or territory in which a Medicare enrollee permanently resides.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Durable Medical Equipment

Durable medical equipment (DME) is generally defined as equipment that can withstand repeated use, serves primarily a medical purpose, is not generally useful to a person in the absence of an illness or injury, and is appropriate for use in an enrollee's home.[3] Examples of DME items are oxygen and respiratory equipment and supplies, wheelchairs, and walkers.

Prosthetics and Orthotics

Prosthetics are devices that replace all or part of: (1) an internal body organ or (2) the function of a permanently inoperative or malfunctioning internal body organ.[4] Examples of prosthetics are artificial limbs, parenteral and enteral nutrition supply kits, breast prostheses for postmastectomy patients, and devices that replace all or part of the ear or nose.[5]

Orthotics are rigid and semirigid devices, often called braces, which are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.[6] Examples of orthotics are leg, arm, back, and neck braces.

Supplies and Related Drugs

Supplies include those items that are necessary for the effective use of DME. Wound-care supplies or fillers are used for openings on the body caused by surgical procedures, wounds, ulcers, or burns. Examples of wound-care supplies or fillers are adhesive tape, roll gauze, and bandages.[7] Related drugs may be drugs and biologicals that can be: (1) put directly into the DME to achieve the therapeutic benefit of the DME or to assure the proper functioning of the

[3] *Medicare Claims Processing Manual,* Pub. No. 100-04 (Claims Manual), chapter 20, § 10.1.1.

[4] Claims Manual, chapter 20, § 10.1.2.

[5] Patients who cannot be sustained through oral feeding rely on either parenteral or enteral nutrition therapy, depending on their medical condition. Medicare guidelines classify enteral and parenteral nutrition items as prosthetic devices.

[6] *Medicare Benefit Policy Manual,* Pub. No. 100-02 (Benefit Manual), chapter 15, § 130.

[7] Wound-care items (or surgical dressings) are covered under the Surgical Dressings Benefit (Social Security Act (the Act) § 1861(s)(5); Benefit Manual, chapter 15, § 100). DME MACs process and pay for these items. For this audit, we considered surgical dressings "supplies."

equipment or (2) prescribed to be taken orally or through injections.[8] Examples of drugs include inhalation drugs and tumor chemotherapy agents used with an infusion pump.

Medicare Payments to Suppliers for DMEPOS Items Provided During Inpatient Stays

Medicare Part A pays inpatient facilities, such as acute-care hospitals (ACHs), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and critical access hospitals (CAHs) using a Prospective Payment System (PPS) rate specific to each type of facility. Critical access hospitals are reimbursed on a reasonable cost basis.[9] Under each payment method, Part A payments made to a facility are payments in full for all inpatient hospital services provided, including DMEPOS items. (See Appendix B for descriptions of the types of inpatient facilities covered by this audit.)

The DME benefit is limited to items that are furnished for use in an enrollee's home.[10] Because an institution that is used as a home may not be an inpatient facility (i.e., ACHs, LTCHs, IRFs, IPFs, and CAHs), Medicare does not make a separate payment for DME when an enrollee is in one of these institutions.[11] Therefore, Medicare Part B should not pay a supplier for items furnished to an enrollee when the enrollee is still an inpatient (i.e., has not been formally discharged to home).[12] Instead, the supplier, under arrangements with the inpatient facility, can look to the inpatient facility for payment for the item it provided to the enrollee who was an inpatient.[13]

Common Working File Edits in the Medicare Claims Processing System

Before payment, all DMEPOS claims are sent to CMS's Common Working File (CWF) for verification, validation, and payment authorization.[14] The CWF edits are designed to prevent or detect overpayments for DMEPOS items provided during inpatient stays. Once the CWF has processed a claim for payment, it electronically transmits information to the DME MAC about

[8] Benefit Manual, chapter 15, §§ 50.2 and 110.3.

[9] The Act § 1814(I); 42 CFR §§ 412.1 and 412.23.

[10] The Act § 1861(n).

[11] 42 CFR § 410.38.

[12] Claims Manual, chapter 3, § 10.4.

[13] Federal regulations define "arrangements" as those "which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the [enrollee] or any other person to pay for those services" (42 CFR § 409.3). CMS does not specify the arrangements between two parties.

[14] The CWF is the enrollee benefits coordination and prepayment claim validation system for Medicare Parts A and B. To prevent duplicate payments, the CWF checks incoming claims against all other claim types previously processed and stored in claims history (Claims Manual, chapter 27, § 10).

potential errors on the claim. The DME MAC is responsible for recovering the overpayment for any DMEPOS items provided during an inpatient stay.

HOW WE CONDUCTED THIS AUDIT

Our audit covered DMEPOS items that suppliers provided to enrollees who were patients of inpatient facilities. Specifically, our audit covered $22.7 million in Medicare Part B payments to 13,478 suppliers for 114,323 DMEPOS items provided to enrollees during inpatient stays from January 1, 2018, through December 31, 2024 (audit period).[15] To identify these items, we first identified Medicare Part A inpatient claims from inpatient facilities with service dates during our audit period.[16]

We used enrollees' information and service dates from the inpatient claims to identify claims for 114,323 DMEPOS items that overlapped with the inpatient claims (i.e., DMEPOS claims that had service dates between, but not including, the admission and discharge dates on the inpatient claims).[17] For the purpose of this audit, we considered all these DMEPOS items as billed during inpatient stays.

We did not verify whether the inpatient facilities paid the suppliers that provided the DMEPOS items or included those items on their Medicare Part A claims. We did not use a medical reviewer to determine whether the DMEPOS items were medically necessary.

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.

[15] Because of the timing of our retrieval of claims data, the payment amount for calendar year 2024 may not include all payments for DMEPOS items provided to enrollees during inpatient stays. The data obtained were the most recent data available at the start of the audit.

[16] Our audit covered ACHs, LTCHs, IRFs, IPFs, and CAHs. Skilled nursing facilities (SNFs) are also considered inpatient facilities and are subject to the SNF Consolidated Billing requirements (Balanced Budget Act of 1997, Public Law 105-33 § 4432(b)). We did not include SNFs in our audit nor did we review the SNF Consolidated Billing requirements.

[17] We excluded from our audit any claims allowed to be billed and paid separately, including claims for: (1) enrollees who had exhausted their Medicare Part A benefits or did not have Part A benefits, (2) rental DMEPOS, and (3) DMEPOS items related to preventative services.

FINDINGS

Medicare payments to suppliers for DMEPOS items provided to enrollees during inpatient stays did not comply with Medicare requirements. Specifically, none of the $22.7 million in payments for 114,323 DMEPOS items that we reviewed should have been paid; suppliers should not have billed separately for these DMEPOS items provided to enrollees during their inpatient stays.[18, 19] In addition, the suppliers may have incorrectly collected up to $5.9 million in deductible and coinsurance amounts from 51,747 enrollees or from someone on their behalf.[20]

This audit covers periods both before and after CMS modified the CWF edits in January 2020. Before January 2020, the CWF edits were not working properly, which resulted in improper payments of $18.2 million for the 2-year period from January 2018 through December 2019 (about 80 percent of the total $22.7 million paid for the 7-year audit period). In response to our prior audit, CMS modified the CWF edits in January 2020, which substantially reduced improper payments. From January 2020 through December 2024, $4.5 million was improperly paid (about 20 percent of the $22.7 million). Although CMS's actions were effective in reducing improper payments, improper payments continue to be made to suppliers for DMEPOS items provided to enrollees during inpatient stays. Therefore, further review of the edits may be necessary to determine whether refinements are needed.

MEDICARE REQUIREMENTS AND GUIDANCE

Inpatient hospital services provided to Medicare enrollees are paid under Medicare Part A (the Act § 1812). These services include those provided during inpatient stays at ACHs, LTCHs, IRFs, IPFs, and CAHs (the Act § 1861). All items provided during a Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with a supplier and billed to Medicare by the inpatient hospital through its Part A claim. This requirement applies to all inpatient facilities, regardless of whether they are subject to a PPS. Medicare does not pay any supplier other than the inpatient hospital for services provided to the enrollee while the enrollee is an inpatient of the hospital (42 CFR §§ 412.404(d)(2), 412.509(b), and 412.604(e)(2)).

Medicare Part B coverage is limited under the DME benefit to those items that are furnished for use in an enrollee's home (the Act § 1861(n)). An institution that is used as a home may not be an inpatient facility (i.e., ACHs, LTCHs, IRFs, IPFs, and CAHs); consequently, Medicare does not make a separate payment for DME when an enrollee is in one of these institutions (42 CFR § 410.38). The institution is expected to provide all medically necessary DMEPOS during an enrollee's Medicare Part A-covered stay (Claims Manual, chapter 20, § 210).

[18] The improper payment amount was $22,671,778.

[19] As of the publication of this report, these overpayments included claims outside of the 4-year reopening period (42 CFR § 405.980(b)(2) (permitting a contractor to reopen within 4 years for good cause)).

[20] The deductible and coinsurance amount was $5,853,922.

DMEPOS items that an inpatient enrollee uses during a Part A-covered stay are included in the inpatient PPS rate and are not separately billable (Claims Manual, chapter 20, § 01). In addition, prosthetics and orthotics provided during inpatient care are also included in the inpatient PPS rate (Claims Manual, chapter 20, § 130.1, and chapter 3, § 10.4.A).

Enrollees generally share in the cost of Medicare Part B by paying deductibles and coinsurance (42 CFR § 489.30(b)).[21] CMS has a process in place to notify suppliers of associated deductible and coinsurance amounts so that suppliers can refund any amounts that may have been incorrectly collected from enrollees or from someone on their behalf (the Manual, chapter 30, § 50.13.2).[22]

MEDICARE PAYMENTS TO SUPPLIERS FOR DMEPOS ITEMS PROVIDED TO ENROLLEES DURING INPATIENT STAYS DID NOT COMPLY WITH MEDICARE REQUIREMENTS

Medicare payments to suppliers for the DMEPOS items we reviewed did not comply with Medicare requirements. Specifically, none of the $22.7 million in payments for DMEPOS items covered by this audit should have been made because DMEPOS items provided to enrollees during inpatient stays are not separately payable. Suppliers should not have been paid for any of the DMEPOS items identified in our audit because those costs were covered under the Part A payment made to the inpatient facilities. In addition, enrollees may have been held responsible for unnecessary deductibles and coinsurance of up to $5.9 million paid to suppliers for those items.

The example on the following page illustrates a situation in which a supplier provided DMEPOS items to an enrollee during an inpatient stay in an ACH and Medicare should not have paid the supplier.

[21] The deductible that enrollees pay for Medicare Part B coverage can change yearly. (The Part B deductible for 2024 was $240 (88 Fed. Reg. 71555 (Oct. 17, 2023)). Once the deductible is met, enrollees generally pay a coinsurance amount equal to 20 percent of the amount allowed by Medicare in excess of the deductible (42 CFR § 489.30(b)).

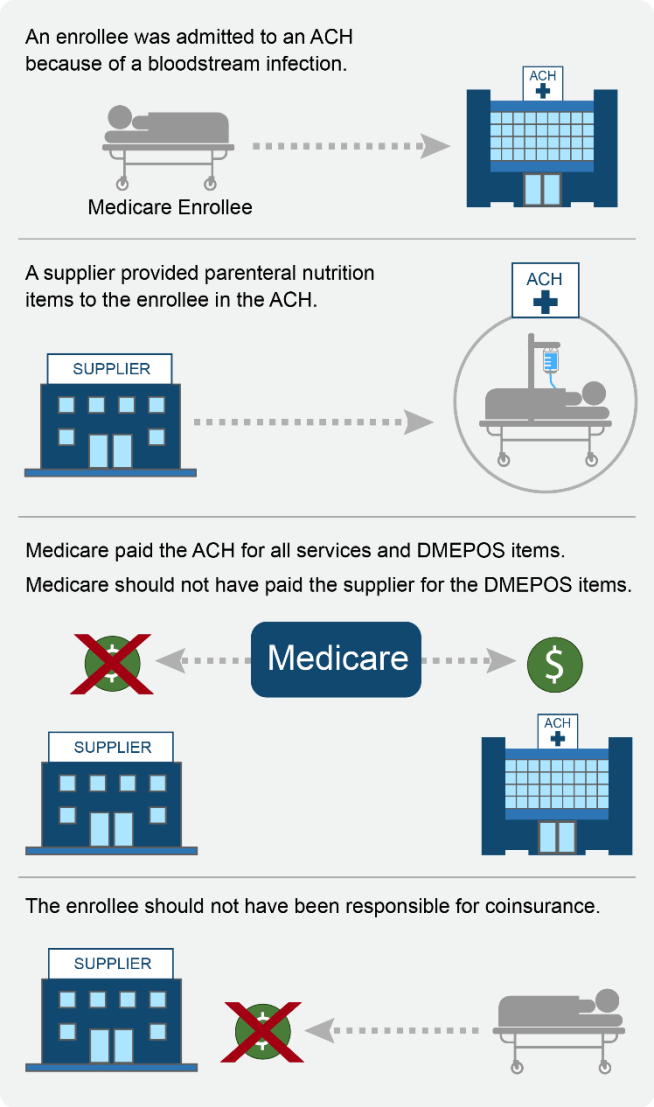
[22] Medicare laws, regulations, and guidance require providers to refund to enrollees incorrectly collected deductible and coinsurance amounts (the Act § 1866(a)(1)(C); 42 CFR §§ 489.20(b) and 489.40–489.42; and the Claims Manual, chapter 1, § 30.1.2). For requirements for suppliers to refund amounts to enrollees, see the Claims Manual, chapter 30, §§ 50.15.2 and 50.15.3.

Example: Improper Payment to a Supplier for DMEPOS Items While an Enrollee Was Still an Inpatient of an Acute-Care Hospital

A Medicare enrollee was admitted to an ACH on May 20, 2023, as an inpatient because of a bloodstream infection.

A supplier provided parenteral nutrition administration kits, supply kits, and solution to the enrollee on May 25, 2023, under arrangements with the ACH, while the enrollee was still an inpatient at the ACH.[23] Medicare Part B paid the supplier $2,939 for the DMEPOS items. The enrollee was held responsible for deductible and coinsurance amounts totaling $750 paid to the supplier for the items.

Because Medicare pays an ACH for all services and items, including DMEPOS, provided to an enrollee as part of its Part A PPS rate, Medicare should not have made a separate Part B payment to the supplier for the items, and the enrollee should not have been held responsible for the deductible and coinsurance. Instead, in this example, the supplier should have looked to the ACH for payment for the items it provided to the enrollee in the ACH.



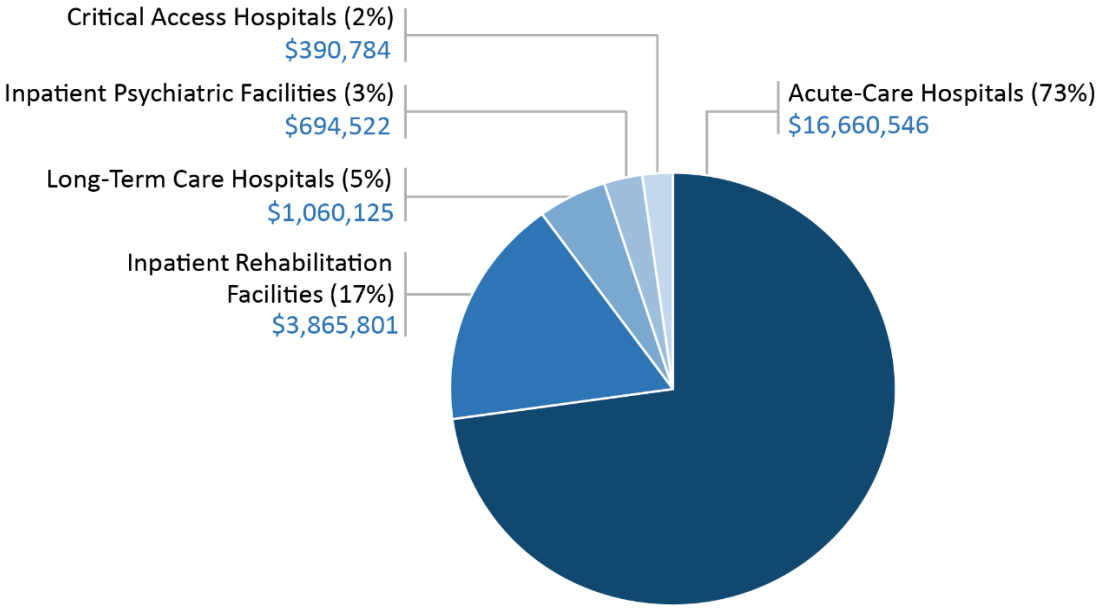
The following two sections show information on: (1) the types of facilities at which enrollees were inpatients and the improper payments that were made to suppliers for DMEPOS items and (2) the types of items that were provided.

[23] Parenteral nutrition is a form of intravenous feeding that delivers nutrients directly into a vein, bypassing the digestive system.

Seventy-Three Percent of Improper Payments Covered by This Audit Were for DMEPOS Items Provided to Enrollees in Acute-Care Hospitals

Medicare Part B improperly paid $16.7 million (73 percent of the total $22.7 million in payments) to suppliers for DMEPOS items provided to enrollees who were inpatients at ACHs. Payments for these items are included in the inpatient PPS rate for inpatient facilities. Figure 1 shows the percentage of total improper payments to suppliers for DMEPOS items provided to enrollees in each type of inpatient facility covered by this audit.

Figure 1: Percentage of Total Improper Payments to Suppliers for DMEPOS Items Provided to Enrollees in Inpatient Facilities by Type of Facility



Fifty-Five Percent of Improper Payments for DMEPOS Items Covered by This Audit Were for Artificial Limbs, Urinary Catheters, and Other Prosthetics and Orthotics

Improper payments for artificial limbs, urinary catheters, and other prosthetics and orthotics accounted for 55 percent of the total improper payments made for DMEPOS items provided to enrollees. Drugs administered through DME accounted for 15 percent of the improper payments, and DME (such as wheelchairs) accounted for 11 percent of the improper payments. The table on the following page shows the percentage of total improper payments by type of DMEPOS item.

Table: Percentage of Total Improper Payments by Type of DMEPOS Item

DMEPOS Category	Total Improper Payments	Percentage of Improper Payments
Prosthetics and Orthotics		
Artificial limbs, urinary catheters, lenses, braces, etc.	$12,329,689	55%
Feeding tubes and parenteral and enteral nutrition supply kits	1,911,945	8%
Supplies and Related Drugs		
Drugs administered through DME	$3,331,817	15%
Wound-care supplies, fillers, and other supplies	1,582,531	7%
Injections and immunosuppressive drugs	939,567	4%
Durable Medical Equipment		
Walkers, wheelchairs, hospital beds, etc.	$2,576,229	11%
Total	**$22,671,778**	**100%**

CMS'S EDITS WERE EFFECTIVE IN REDUCING IMPROPER PAYMENTS, BUT REFINEMENTS MAY BE NECESSARY

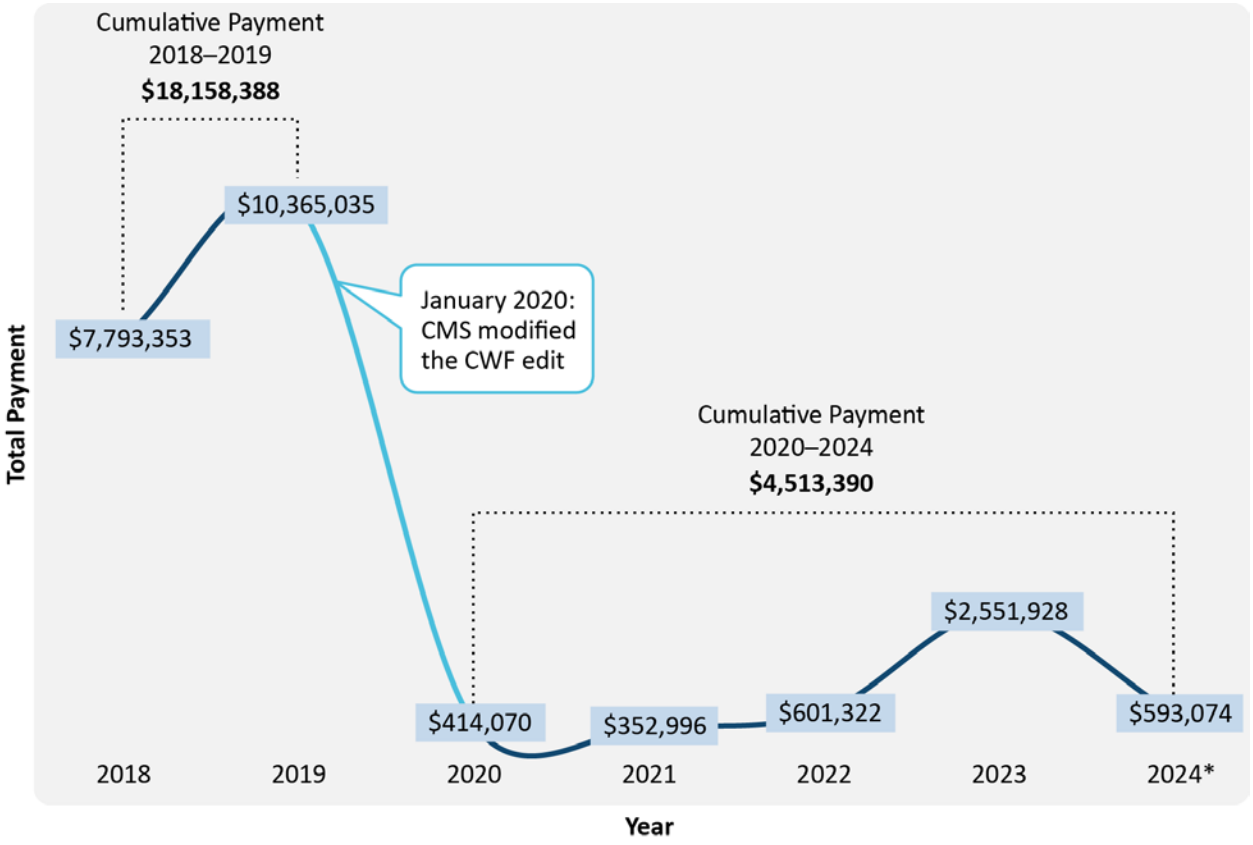
In our prior audit (A-09-17-03035), we found that CMS's CWF edits were not adequate.[24] As a result of that audit, CMS modified the edits in January 2020, to prevent or detect improper payments for DMEPOS claims billed during covered inpatient stays. For this audit, $18.2 million of the improper payments (about 80 percent of the total $22.7 million in improper payments for the entire audit period) occurred before the CWF enhancements. However, after CMS had modified the edits, improper payments to suppliers were reduced to $4.5 million (about 20 percent of the total) from January 2020 through December 2024.[25]

Figure 2 on the following page shows the changes in improper payments to suppliers for DMEPOS items during our audit period and the decrease in improper payments after CMS modified the CWF edits.

[24] See footnote 1.

[25] The improper payment amount was $4,513,390 from January 2020 through December 2024.

Figure 2: Change in Improper Payments to Suppliers for DMEPOS Items During Our Audit Period and the Decrease in Improper Payments After CMS Modified the CWF Edits



* Because of the timing of our retrieval of claims data, the payment amount for calendar year 2024 may not include all payments for DMEPOS items provided to enrollees during inpatient stays. The data obtained were the most recent data available at the start of the audit.

While CMS has significantly reduced improper payments to suppliers, improper payments still continue to be made. These improperly paid claims may be the result of the system edits not detecting some improper claims. Thus, further review of the edits is needed to determine whether refinements are necessary to identify and prevent improper payments made after our audit period.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct the DME MACs to recover from suppliers up to $22,671,778 in identified improper payments for our audit period that are within the 4-year reopening period in accordance with CMS's policies and procedures;

- direct the DME MACs to recommend that the suppliers refund to enrollees up to $5,853,922 in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf;

- instruct the DME MACs to notify, as CMS deems appropriate, suppliers that received an overpayment or overpayments to consider conducting one or more internal audits or investigations based on the risks identified by this audit to identify any similar overpayments the supplier might have received and return any identified overpayments to the Medicare program;

- identify any DMEPOS claims after our audit period for items provided to enrollees during inpatient stays and direct the DME MACs to recover any improper payments; and

- review system edits to determine whether any refinements are necessary to prevent improper payments to suppliers for DMEPOS items provided to enrollees during inpatient stays.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our first through fourth recommendations and described actions it had taken and planned to take to address the recommendations. However, CMS did not concur with our fifth recommendation. After reviewing CMS's comments, we maintain that our fifth recommendation is valid. CMS's comments are included in their entirety as Appendix C.

The following sections summarize CMS's comments and our responses.

CMS COMMENTS

- Regarding our first recommendation, CMS stated that it will direct the DME MACs to recover identified overpayments consistent with relevant laws and CMS's policies and procedures.

- Regarding our second recommendation, CMS stated that as part of the recovery process, suppliers are notified of associated deductible and coinsurance amounts so that they can refund any amounts that may have been incorrectly collected.

- Regarding our third recommendation, CMS stated that it will review OIG's data to identify which suppliers to notify of potential overpayments and will instruct the DME MACs to notify those suppliers so that they may consider conducting audits or investigations based on the risks identified by this audit to identify overpayments to the Medicare program.

- Regarding our fourth recommendation, CMS stated that in addition to the CWF edit, the Recovery Audit Contractor (RAC) has an approved automated postpayment review of unbundling of DMEPOS during an inpatient stay.[26, 27]

- Regarding our fifth recommendation, CMS stated that OIG has found the modification of the CWF edits in January 2020 significantly reduced improper payments to suppliers. CMS also stated that it reviewed a sample of claims identified by OIG and could not identify a systemic cause for the errors. Furthermore, CMS stated that the RAC has an approved automated review and at least some of the claims identified by OIG may have already been addressed by the RAC review.

OFFICE OF INSPECTOR GENERAL RESPONSE

We acknowledge the actions that CMS has taken and plans to take to address our first through fourth recommendations.

Regarding our fifth recommendation, we maintain that our recommendation is valid. We found that improper payments of $4.5 million were still made from January 2020 through December 2024, even after the CWF edits were modified. CMS initially conducted a review of sample claims we provided but could not identify a systemic cause of the errors. We subsequently provided CMS the complete list of improperly paid claims identified in our audit. CMS should conduct a review of the complete list of claims to identify whether systemic issues exist.

Furthermore, we understand that the RAC has identified some improper payments; however, the RAC did not select all claims we identified in our audit period. Consequently, the RAC recovered only a small portion of the improper payments we identified in our report, suggesting that CMS's reliance on RAC reviews may be insufficient to ensure comprehensive oversight.[28]

To strengthen program integrity and reduce financial risk to Medicare, we continue to recommend that CMS review and, if necessary, refine its system edits to better prevent improper payments to suppliers for DMEPOS items provided to enrollees during inpatient stays.

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[26] The RACs are private entities contracted by CMS to identify improper payments made to health care providers, including suppliers, under Medicare Parts A and B. The RACs conduct both complex and automated postpayment reviews. Automated postpayment reviews occur at the system level while complex reviews require a qualified individual to review the medical record. There is only one RAC dedicated to review DMEPOS claims.

[27] In the written comments, CMS provided a link to its website on *Approved RAC Topic: 0019 - Durable Medical Equipment Billed while Inpatient: Unbundling*. Accessed on Sept. 24, 2025. Since February 2017, the RAC has been approved to conduct automated reviews that identify improper payments for DMEPOS items provided to enrollees during inpatient stays. This review is referred by the RAC as unbundling of DME while inpatient.

[28] The RAC selected no more than 5 percent of the claims we identified in our audit period for review. Consequently, only 2 percent of the associated overpayments had been recovered.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $22,671,778 in Medicare Part B payments to 13,478 suppliers for 114,323 DMEPOS items provided to enrollees during inpatient stays from January 1, 2018, through December 31, 2024 (audit period). To identify these items, we first identified Medicare Part A inpatient claims from inpatient facilities with service dates during our audit period.[29]

We used enrollees' information and service dates from the inpatient claims to identify suppliers' paid Medicare Part B DMEPOS claims that overlapped with the identified inpatient claims (i.e., DMEPOS claims that had service dates between, but not including, the admission and discharge dates on the inpatient claims).[30] For the purpose of this audit, we considered all these DMEPOS items as billed during inpatient stays.

We did not verify whether the inpatient facilities paid the suppliers that provided the DMEPOS items or included those items on their Medicare Part A claims. We did not use a medical reviewer to determine whether the DMEPOS items were medically necessary.

We did not perform an overall assessment of the internal control structures of CMS. Rather, we limited our review to those internal controls (i.e., program safeguards) related to Medicare payment requirements. To assess internal controls, we interviewed CMS officials to obtain an understanding of the CWF edit process. In addition, we reviewed policies and procedures governing the processing and payment of Medicare Part B DMEPOS claims for items provided to enrollees during inpatient stays.

Our audit procedures enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the data.

We conducted our audit work from November 2024 through July 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

[29] Our audit covered ACHs, LTCHs, IRFs, IPFs, and CAHs. SNFs are also considered inpatient facilities, but we did not include them in our audit.

[30] See footnote 16.

- used CMS's NCH file to identify Medicare Part A inpatient claims from ACHs, LTCHs, IRFs, IPFs, and CAHs;

- excluded claims for enrollees who had exhausted their Medicare Part A benefits or did not have Part A benefits;

- used CMS's NCH file to identify Medicare Part B DMEPOS claims that overlapped with the identified Medicare Part A inpatient claims;

- excluded claims for DMEPOS rentals that were billed during inpatient stays;

- excluded claims for DMEPOS items related to preventative services;

- identified claims for 114,323 DMEPOS items, totaling $22,671,778 in Medicare Part B payments;

- reviewed available data from CMS's CWF for the selected DMEPOS claims to determine whether the claims had been canceled or adjusted;

- used CMS's NCH file to identify enrollee deductible and coinsurance amounts, totaling $5,853,922, related to the selected DMEPOS claims;

- interviewed CMS officials and reviewed documentation provided by them to understand how the CWF edits work;

- provided to CMS a complete list of improperly paid claims for DMEPOS items for our audit period; and

- 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: TYPES OF INPATIENT FACILITIES COVERED BY THIS AUDIT

Types of Inpatient Facilities

Acute-Care Hospital

An ACH is a facility that provides inpatient acute care that is needed for a relatively short period. An ACH is paid through the Inpatient PPS specific to ACHs.

Long-Term Care Hospital

An LTCH is a separate facility that focuses on patients with medically complex conditions or multiple conditions that require, on average, an inpatient stay of greater than 25 days. An LTCH is paid through a PPS specific to LTCHs.

Inpatient Rehabilitation Facility

An IRF is a separate facility or subunit of a hospital whose primary purpose is to provide intensive rehabilitation services (such as physical, occupational, or speech therapy) to its inpatient population. An IRF is paid through a PPS specific to an IRF.

Inpatient Psychiatric Facility

An IPF is a freestanding or specialized hospital-based unit that meets the urgent needs of those experiencing an acute mental health crisis. An IPF is paid through a per diem PPS specific to an IPF.

Critical Access Hospital

A CAH is a hospital that is accessible to enrollees in rural communities and has no more than 25 beds for inpatient care services. A CAH is not subject to a PPS and is paid on a reasonable cost basis.

APPENDIX C: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: September 24, 2025

TO: Carla J. Lewis
Acting Deputy Inspector General for Audit Services
Office of Inspector General

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

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Suppliers $22.7 Million Over 7 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Enrollees During Inpatient Stays (OAS-24-09-005)

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 recognizes the importance of providing Medicare beneficiaries with access to medically necessary services, while also 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 systems, and conducting prepayment and post-payment reviews. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

As stated in OIG's report, CMS modified the Common Working File (CWF) edits in January 2020, to prevent or detect improper payments for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims billed during covered inpatient stays. OIG has found that the modification to the edits significantly reduced improper payments to suppliers. For this audit, $18.2 million of the improper payments, approximately 80 percent of the total $22.7 million in improper payments for the entire audit period, occurred before the CWF modifications. After the CWF modifications, OIG identified approximately $4.5 million in improper payments over the course of five years.

During the audit, CMS reviewed a sample of claims identified by OIG and could not identify a systemic cause for the CWF errors. However, at least some of the claims identified by the OIG may have already been identified and addressed by the Recovery Audit Contractor's (RAC) automated review of unbundling of DMEPOS items during an inpatient stay. [1] The RAC helps identify and correct improper payments through post payment reviews.

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

[1] Additional information available at: https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/approved-rac-topics-items/0019-durable-medical-equipment-billed-while-inpatient

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services direct the DME MACs to recover from suppliers up to $22,671,778 in identified improper payments for our audit period that are within the 4-year reopening period in accordance with CMS's policies and procedures.

CMS Response
CMS concurs with this recommendation. CMS will direct the DME MACs to recover identified overpayments consistent with relevant laws and the agency's policies and procedures. CMS notes that the vast majority of the improper payments identified by the OIG are outside of the 4-year reopening period.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services direct the DME MACs to recommend that the suppliers refund to enrollees up to $5,853,922 in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

CMS Response
CMS concurs with this recommendation. As part of the recovery process, suppliers are notified of associated deductible and coinsurance amounts so that they can refund any amounts that may have been incorrectly collected.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services instruct the DME MACs to notify, as CMS deems appropriate, suppliers that received an overpayment or overpayments to consider conducting one or more internal audits or investigations based on the risks identified by this audit to identify overpayments to the Medicare program.

CMS Response
CMS concurs with this recommendation. CMS will review the OIG's data to identify which suppliers to notify of potential overpayments. CMS will then instruct the DME MACs to notify those suppliers of the OIG's audit so that they may consider conducting audits or investigations based on the risks identified by this audit to identify overpayments to the Medicare program.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services identify any DMEPOS claims after our audit period for items provided to enrollees during the inpatient stays and direct the DME MACs to recover any improper payments.

CMS Response
CMS concurs with this recommendation. In addition to the Common Working File (CWF) edit, the Recovery Audit Contractor (RAC) has an approved automated review of unbundling of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) during an inpatient stay. The RAC review is a post payment review.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services review system edits to determine whether any refinements are necessary to prevent improper payments to suppliers for DMEPOS items provided to enrollees during inpatient stays.

CMS Response

CMS does not concur with this recommendation. As noted above, CMS modified the Common Working File (CWF) edits in January 2020, to prevent or detect improper payments for DMEPOS claims billed during covered inpatient stays. OIG has found that the modification to the edits significantly reduced improper payments to suppliers. During the course of the audit, CMS reviewed a sample of claims identified by OIG and could not identify a systemic cause for the errors. As further noted above, in addition to the CWF edits, the Recovery Audit Contractor (RAC) has an approved automated review and at least some of the claims identified by the OIG may have already been addressed by the RAC review.

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