

HME Audits

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May 21, 2026





DME MACs

TARGETED PROBE AND EDUCATE PROGRAM



Overall Supplier Compliance Rates

J-A Provider Compliance Rate		J-B Provider Compliance Rate	
10 Claim Preview	34%	10 Claim Preview	40%
Round 1	55%	Round 1	71%
Round 2	17%	Round 2	66.7%
Round 3	0%	Round 3	81.8%
J-C Provider Compliance Rate		J-D Provider Compliance Rate	
10 Claim Preview	49.2%	10 Claim Preview	34%
Round 1	78.5%	Round 1	73%
Round 2	55.7%	Round 2	25%
Round 3	70.8%	Round 3	N/A%

Jurisdiction B Quarterly Results

Product Category	Error Rate	Product Category	Error Rate
Ankle-Foot Orthotics	25.77%	Nebulizers	36.75%
Diabetic Supplies	18%	PAP	15.92%
Enteral Nutrition	33.25%	Oxygen	13.91%
Glucose Monitor/Supplies	23.30%	Pneumatic Compression	42.29%
Hospital Beds	18.13%	Spinal Orthosis	34.71%
Knee Orthoses	40.74%	Surgical Dressings	74.81%
Lymphedema Compression	50.93%	Diabetic Shoes	41.98%
Manual Wheelchairs	32.5%	Urological Supplies	26.44%



RAC

Recovery Audit Contractor



New Federal RAC Contract

- Performant Recovery lost their contract to Cotiviti.
- Performant has ceased auditing and is finishing up reviews, rebuttals, and appeals
- Cotiviti has started auditing
- Experienced Medicaid contractor, but little Medicare and DME
- Contingency fee has not been disclosed publicly



New Federal RAC

- Visit <https://www.cotiviti.com/cms-approved-issues-cotiviti> for list of CMS approved issues for review
- Utilize the provider portal to:
 - Upload discussions and correspondence
 - Download, view and print RAC letters
 - Upload medical records
 - Check your claim review status 24/7
 - Update contact information
 - Export data



RAC

Review Topic	Review Type	Date Approved	HCPCS	Dates of Service
Immunosuppressive Drugs: Medical Necessity and Documentation Requirements	Complex	8/28/2025	J7507	Claims having a "claim paid date" that is more than 3 years prior to the ADR date will be excluded
Home Use of Oxygen: Medical Necessity and Documentation Requirements	Complex	8/27/2025	E1390, E0431	Claims having a "claim paid date" which is more than 3 years prior to the ADR date.
Durable Medical Equipment Rentals- Multiple Billing within the Same Month	Automated	8/26/2025	-	Exclude from this automated review claims having a paid claim date which is more than 3 years prior to the Informational Letter date.
Positive Airway Pressure Devices for Treatment of Obstructive Sleep Apnea: Medical Necessity and Documentation Requirements	Complex	8/26/2025	E0601, E0470	Exclude from review claims with Dates of Service prior to May 12, 2023
Ventilators: Medical Necessity and Documentation Requirements	Complex	8/26/2025	E0465 , E0466	Exclude from review claims with Dates of Service prior to May 12, 2023

SMRC

Supplemental Medical Review Contractor



SMRC



Project Title	Dates of Service Under Review	HCPCS
CGMs After the PHE	November 12, 2023, through September 22, 2025	E2103
Patient Lifts	January 1, 2023, through November 30, 2025	E0630, E0635, E0636, E1035, E1036
Office of Inspector General (OIG) Continuous Glucose Monitors and Supplies	January 1, 2024, through December 31, 2025	E2102, E2103, A4238, A4239



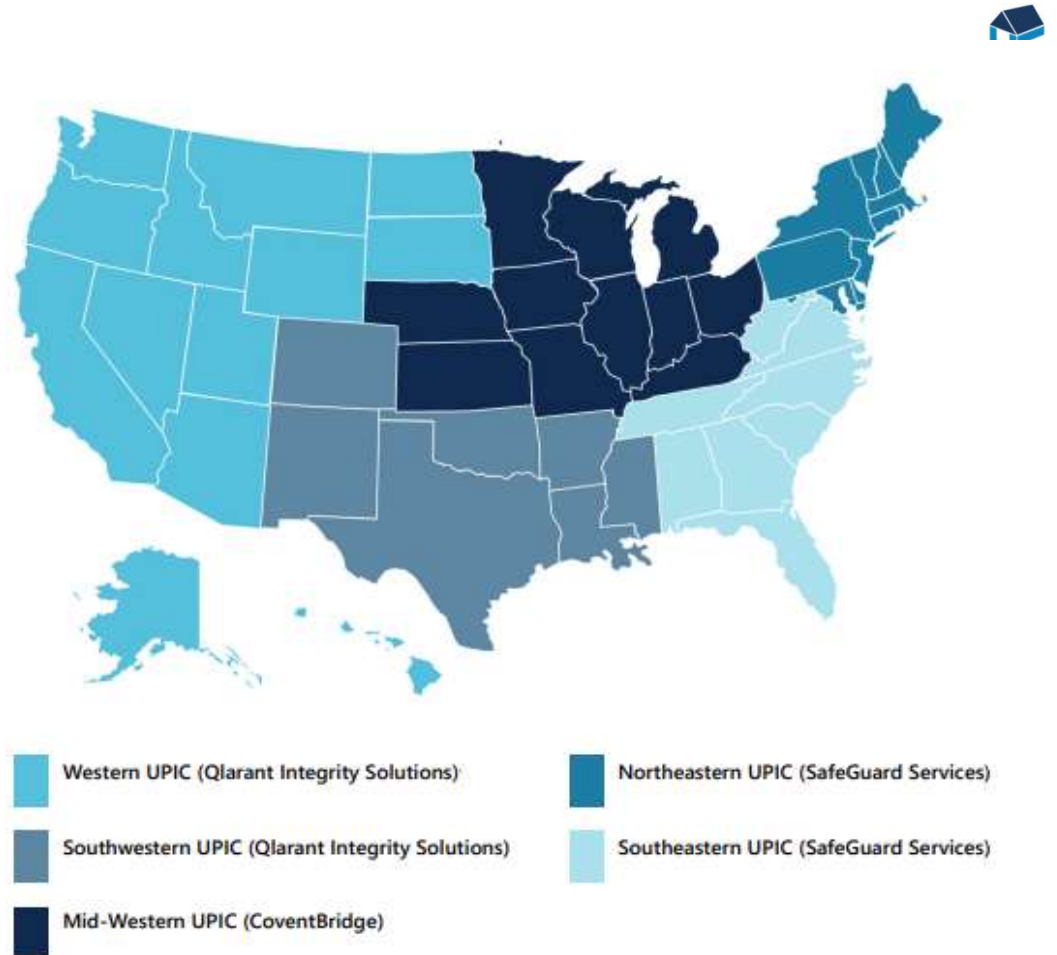
UPIC

Unified Program Integrity Contractor



UPICs

- Qlarant Western and Southwest
 - Total Funding = \$115,325,516
- CoventBridge Midwest
 - Total Funding = \$155,389,846
- Safeguard Services Southeast and Northeast
 - Total Funding = \$257,936,858



UPICs

- Popular products under review by UPICs currently
 - Ventilators
 - CGM
 - Prosthetics and Orthotics
 - Urological supplies
 - Surgical dressings
 - Wheelchair repairs
 - Respiratory products
 - Neuromuscular stimulators



UPICs – Recent OIG Report

- UPICs conducted substantially more program integrity activities for Medicare than for Medicaid
- Although most people with Medicaid are enrolled in managed care, UPICs conducted minimal activities for Managed Care
- Substantial disparities existed in the number of activities conducted across UPICs
- Strategies to improve program integrity by unifying Medicare and Medicaid data did not produce significant results



UPICs – OIG Report

- The introduction of new collaborative processes, systems, and analytical tools has laid the foundation for improvement.
- Despite challenges caused by the COVID-19 pandemic, UPICs were able to identify vulnerabilities related to the pandemic and—with some limitations—continue program integrity activities
- Overall, UPICs face challenges in conducting Medicaid program integrity activities
- **CONCLUSION – IMPLEMENT A PLAN TO INCREASE MEDICAID PROGRAM INTEGRITY ACTIVITIES, PARTICULARLY RELATED TO MANAGED CARE**



Office of Inspector General

OIG Work Plan, Office of Audit Services and Office of Evaluations and Inspections



OIG Work Plan

Project	Posted
White Paper: FWA related to DME in Medicare	8/2025
Audits of Medicare Enrollment Process for DMEPOS	7/2025
Medicare payments for Parenteral Nutrition Services	6/2025
CMS's Use of Surety Bonds with DMEPOS Overpayments	2/2025
Wheelchair Repair Services for Medicare Enrollees	10/2024
Payments to Suppliers for Oxygen and Equipment	10/2024
DME fraud in Medicare and Safeguards in Medicare	6/2024



White Paper Objective

- Each year, Medicare payments for DMEPOS top more than \$7 billion in original Medicare alone.
- Despite safeguards and other CMS efforts, recent cases demonstrate that fraudsters continue to target DMEPOS billing and have developed new schemes.
- This white paper will build on OIG's extensive expertise on DMEPOS fraud. It will provide information about the nature of DMEPOS fraud in Medicare, key program integrity vulnerabilities, and potential actions to reduce fraud, waste, and abuse.



Managed Care

Medicare and Medicaid



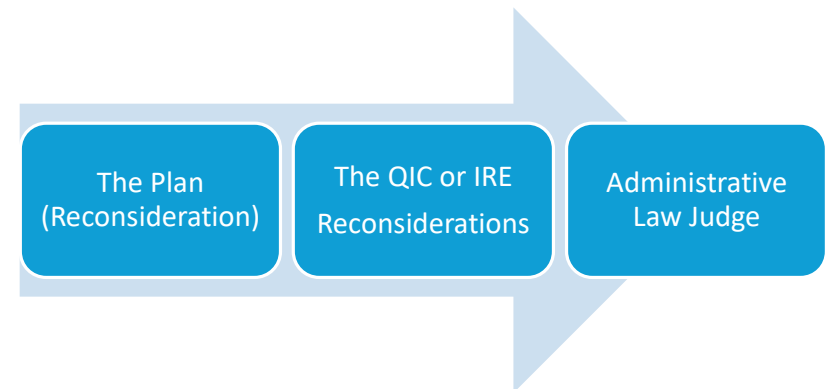
Current Landscape

- Plans more active in auditing and some using AI
- Plans are required by law to perform program integrity functions
- Pre and Postpayment reviews
- Medicaid Recovery Audit Contractors (RACs)
- Medicaid Integrity Contractors (MICs)
- Additional CMS oversight on managed care plans
- CMS applying pressure on states to increase their own program integrity functions
- OIG identified Managed Care as one of the top 6 priorities for 2024 and it remains a priority



Medicare Advantage Appeals

- In-network providers are bound to the appeal and grievance process outlined in their contract.
- The Medicare Managed Care Manual (Pub 100-16) used to outline the appeal process for out-of-network providers.
- Recent regulatory changes required updates to the Part C Appeal process and can be found here now, effective 8/3/2022:
 - <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index>



Things to consider...

- Most states have limitation on recoupment provisions which may or may not apply to MCOs.
 - Times generally range from 12 months – 3 years
 - There is a fraud or abuse clause in most, if not all, of them
- 42 CFR 422.520 discusses prompt pay requirements for managed care plans
 - Contracts with providers must include prompt pay provisions
- Many states also have prompt pay laws that may apply
- State Insurance Boards
- Can consider legal action



Arbitration

- In-network providers often have arbitration options built into their contract
- Provider generally has counsel and engages an expert to represent their interests
- Plan also has legal representation and expert
- Facts of the case are presented to a panel of judges who renders a final decision



Challenges

- Use of subcontractors that are trying to get providers to settle claims or face more intense audits.
 - In some cases, they are paid contingency fees
- Unclear and inconsistent appeal policies
- In some cases, lack of afforded appeal rights given to providers
- CMS does not like to get involved in MCO issues
- Increased use of Artificial Intelligence



Audit Strategy

- Raise concerns to management or legal counsel
- Don't just give in to their demands, as they may be denying you due process, knowingly or unknowingly
- Know your rights and the appeal process
 - In-network vs out-of-network
 - Get contracting staff involved if audit is causing issues
- Review audit and prompt pay clauses in your contracts



Audits – Looking Ahead

- Things are still uncertain under new Administration, but audit volumes are likely to increase due to focus on fraud, waste and abuse
- Implementing use of technology in audit functions
 - **WISeR** (Wasteful and Inappropriate Service Reduction) Model
- Program Integrity functions will be under some scrutiny and we may see positive changes
- Managed care plans will continue increase audit functions
- CMS scrutiny on provider enrollment functions will expand further in both Medicare and Medicaid



WISeR Goals

- Focus healthcare spending on services that will improve patient well-being
- Apply commercial payer prior authorization processes that may be faster, easier and more accurate
- Increase transparency of existing Medicare coverage policy
- De-incentivize and reduce use of medically unnecessary care
- Participants will apply their technology to help medical reviewers assess a set of services chosen by CMS that they determined:
 - May pose concerns related to patient safety if delivered inappropriately
 - Have existing publicly available coverage criteria
 - May involve prior reports of fraud, waste and abuse.



WISeR Goals

- Selected services include:
 - Skin and tissue substitutes
 - Implantable Electrical nerve stimulators
 - Knee arthroscopy for knee osteoarthritis
- Excluded services
 - Inpatient-only
 - Emergency Services
 - Services that would pose a threat if substantially delayed



WISeR Initiative

- Impact on Providers
 - Optional for providers to participate
 - If they do not participate, they are subject to post-service/prepayment medical review through the same AI tool
- Model payment
 - AI Participants will be awarded based on the effectiveness of their technology for reducing spending on medically unnecessary or non-covered services
 - Participants will receive a percentage of the reduction in savings that can be attributed to their technology



Model Performance Measures

- Process Quality
 - Number of non-affirmations and favorable appeal decisions
 - Volume of requests processed
- Provider/Supplier and Beneficiary Experience
 - Timeliness of response
 - Clarity of explanation of request determination
- Clinical quality outcomes
 - Use of alternative services
 - Evidence of ongoing urgent need to address the clinical issue



Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) RFI

- Enhanced identity proofing and ownership requirements
- Preclusion List and MAO enrollment requirements
- Reducing risks from non-participating DMEPOS suppliers in MAOs
- CMS is considering shortening claim filing deadline for high-risk items (including DMEPOS) from one year to a 90-to-180-day period.
- Beneficiary solicitation
- Beneficiary contact
- Surety Bonds



Other CRUSH Topics

- Reducing Medicare fraud related to laboratory tests, including genetic and molecular diagnostic tests
- AI in Medicare Advantage coding oversight and hospital billing
- Medicaid and CHIP
- State-specific Medicaid and CHIP questions
- Federally Facilitated Exchange (FFE) and State-Based Exchanges (SBEs)



Audit Strategy

- A provider without a compliance program is considered negligent and uncovered compliance issues could result in more severe penalties for providers without a compliance program
- Most important elements:
 - Education and Training
 - Internal Auditing
 - Risk Analysis
 - Policies and Procedures
 - Internal communication



Hot Topics



Competitive Bidding Round 2028

- **Late Spring/Early Summer 2026**
 - CMS announces specific dates for registration and bidding
 - CMS announces lead items for the DMEPOS CBP product categories and number of contracts to award for each product category
 - CMS begins bidder education program
- ***Late Summer/Early Fall 2026**
 - Bidder registration period to obtain user IDs and passwords begins
 - Bid window opens
- ***Late Summer/Early Fall 2027**
 - Contracts awarded and single payment amounts announced
 - Beneficiary education begins
- ***No Later Than January 1, 2028**
 - Start of Next Round - Contracts and single payment amounts in effect
 - Six-month transition period begins for beneficiaries to switch to contract suppliers



Competitive Bidding Round 2028

- **Round 2028 DMEPOS CBP Product Categories**
 - Class II Continuous Glucose Monitors (CGMs) and Insulin Pumps
 - Urological Supplies - will not include hydrophilic catheters
 - Ostomy Supplies
 - Hydrophilic Urinary Catheters
 - Off-the-Shelf (OTS) Back Braces
 - OTS Knee Braces
 - OTS Upper Extremity Braces



DMEPOS Supplier Enrollment

- Final Rule – Changes in Majority Ownership (CIMO)
 - Effective January 1, 2026, if a majority ownership of a DMEPOS supplier changes by sale within 36 months of the DMEPOS supplier's Medicare enrollment or prior change of majority ownership, the Medicare billing privileges will not be conveyed to the new owner.
 - The prospective provider/owner of DMEPOS supplier must instead enroll in the Medicare program as a **new DMEPOS supplier and obtain a new accreditation from a CMS-approved DMEPOS accrediting organization**, which creates significant gaps in payment for a supplier between the effective date of the transaction and when new enrollment is established.



DMEPOS Supplier Enrollment

- Final Rule - CIMO
 - The 36-Month Rule does not apply to “indirect” ownership changes
 - Change involves a party assuming a greater than 50 percent ownership interest in the DMEPOS supplier
 - Effective date of the transfer is within 36 months after the effective date of the DMEPOS supplier’s initial enrollment in Medicare or most recent change in majority ownership
 - If the effective date of the transfer does not fall within either of the aforementioned 36-month periods, the 36-Month Rule does not apply.



DMEPOS Supplier Enrollment

- Final Rule - CIMO
 - Exceptions to the 36-Month Rule
 - The DMEPOS supplier's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation;
 - The owners of an existing DMEPOS supplier are changing the DMEPOS supplier's existing business structure (for example, from a corporation to a partnership (general or limited); from an LLC to a corporation; from a partnership (general or limited) to an LLC) and the owners remain the same;
 - The individual owner of the DMEPOS supplier dies



DMEPOS Supplier Enrollment

Six Month Moratorium

- Effective February 27, 2026
- No new DMEPOS suppliers of the following seven types (as well as no new practice locations of these seven types) will be enrolled into Medicare unless the supplier's enrollment application was received by the applicable Medicare contractor prior to the effective date.
 - Medical supply company
 - Medical supply company with orthotics personnel
 - Medical supply company with pedorthic personnel
 - Medical supply company with prosthetics personnel
 - Medical supply company with prosthetic and orthotic personnel
 - Medical supply company with registered pharmacist
 - Medical supply company with respiratory therapist



DMEPOS Supplier Enrollment

Moratorium and Changes in Majority Ownership

- If a DMEPOS supplier undergoes a non-exempt change in majority ownership:
 - The supplier must enroll in Medicare as a brand-new supplier, undergo a survey, and become newly accredited.
 - The supplier's current enrollment is terminated.
 - This means that the supplier's new enrollment is an initial enrollment no less than if the supplier had never enrolled in Medicare before.
- Which means that this moratorium would prohibit the supplier from reenrolling in Medicare because, it would constitute an initial enrollment; the supplier is "new."



Accreditation

- Tighter CMS oversight of accrediting organizations (AOs) surveys remain unannounced.
- Annual resurvey & reaccreditation (moves from 36 months → 12 months).
- Sampling allowed for large chains (25+ locations), more information will be provided from CMS.
- No more 90-day temporary accreditation for new locations.
- New “36-month” rule for changes in majority ownership (may require new enrollment).



Questions and Contact Information

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