Indiana Health Coverage Programs

Desk Aid

Intermittent Urinary Catheters: Compliance Strategies, Trends, and FWA Risk

Executive Summary

Intermittent urinary catheter billing has become a major focus of national and state program integrity efforts due to a sharp rise in fraud, waste, and abuse (FWA) within the durable medical equipment (DME) sector. Between 2021 and 2025, improper Medicare and Medicaid payments tied to catheter schemes grew to billions of dollars, prompting federal and state regulators, including Centers for Medicare and Medicaid Services (CMS), Office of Inspector General (OIG), Department of Justice (DOJ), and Indiana Medicaid to implement heightened oversight, targeted audits, and rapid policy updates.

Indiana Healthcare Coverage Program (IHCP) providers now operate in an environment of increased scrutiny driven by historic spikes in catheter spending, evolving documentation expectations, and strengthened audit methodologies. This desk aid distills national and IHCP-specific trends, common scheme patterns, and practical compliance strategies to help IHCP-enrolled providers reduce FWA risk and improve billing accuracy for intermittent urinary catheter claims.

The analysis draws on federal and state audit findings, investigative reporting, regulatory guidance, legal cases, whistleblower reports, and data trends from 2021–2025. These sources highlight recurring red flags such as sudden claim volume increases, unusual code usage, or billing after a member's death and translate them into actionable documentation and compliance practices to support provider readiness and program integrity.

Topics

Intermittent Urinary Catheters: National & Indiana Fraud Trends

Nationally, fraudulent claims for intermittent urinary catheters have reached historic highs, with Medicare and Medicaid programs targeted by sophisticated schemes.

The period spanning 2021 to 2025 has been marked by a dramatic escalation in intermittent urinary catheter-related FWA, particularly in DME billing (see Figure 1).

Magnitude of Dollar Increase

- Medicare spending on intermittent urinary catheters **increased** from **$153 million in 2021** to over **$2 billion in 2023**, representing a tenfold increase in claims. CMS addresses unusual catheter spending | Becker's
- Estimated **losses** reached **$2–$3 billion annually in 2023**, with projections of up to **$10.6 billion** across all DME claims in 2025. DOJ Workgroup Yields Results | Medtrade

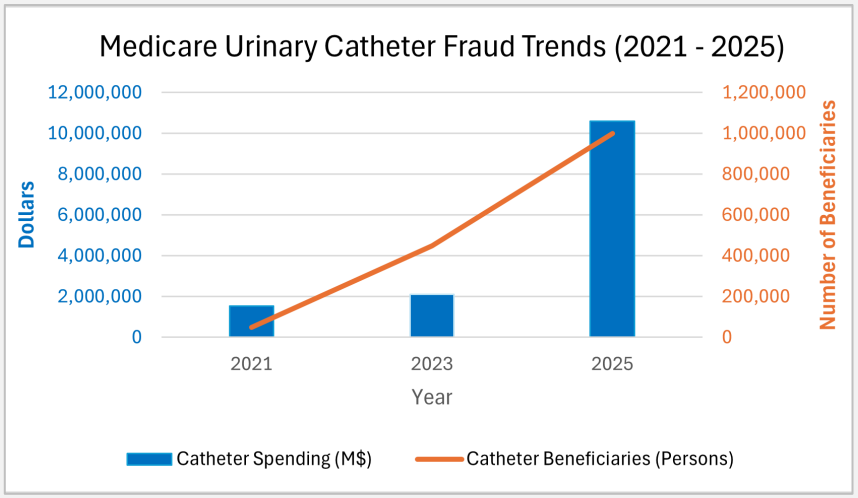
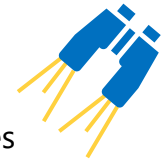


Figure 1: IHCP State Directed Payments

Improper Payments: State-Level Risks, National Fraud Patterns

Recent Indiana Medicaid reviews have identified hundreds of millions of dollars in potential improper payments—including duplicate claims and post-death billing—closely mirroring broader national fraud trends. This analysis underscores that state-level risks are tightly linked to federal fraud patterns, reinforcing the need for local oversight aligned with national enforcement standards.

Areas of Suspected Fraud



- Overutilization of catheter supplies
- Upcoding to higher reimbursed catheter types (e.g., hydrophilic or coude tip) without medical necessity
- Improper supplier practices, including billing for supplies not ordered or delivered
- Misrepresentation or lack of documented medical necessity
- Duplicate billing and claims submitted for deceased or ineligible members

Common Fraud Schemes

- Exploitation of new or revised billing codes following reimbursement policy changes, resulting in sudden spikes in claims
- A relatively small number of suppliers driving a disproportionate share of fraudulent billing activity
- Telemarketing operations using member data to submit claims for catheters that were never ordered or delivered
- Use of stolen identities and fabricated or complicit provider authorizations

Indiana Medicaid Oversight Shifts: Audit Readiness

Indiana Medicaid is responding with stronger oversight, tighter documentation requirements, and expanded use of analytics. At the same time, recent FWA schemes involving intermittent urinary catheters appear larger in scale, more sophisticated, and more coordinated than in prior years. Together, these trends raise the bar for audit readiness and have significant implications for program integrity, provider accountability, and—most importantly—patient safety.

Oversight and Compliance Training

How Providers Can Prepare

To protect against scrutiny from the IHCP:

- **Prioritize Education:** Stay current with annual training on documentation, FWA, and medical necessity requirements
- **Stay "Audit-Ready":** Maintain documentation and charts in real-time, as required
- **Accuracy is Key:** Proper documentation reduces unintentional errors that trigger red flags

In addition, Indiana has implemented focused audits, particularly in high-risk categories such as DME services billed during an inpatient or long-term care stay and CPAP unbundling., with detailed examination of paid claims, medical necessity, and documentation compliance.

To reinforce controls for high-risks behaviors, IHCP recommends annual compliance training focused on documentation standards, "red flag" recognition, and evolving clinical best practices for catheter technology. Provider commitment to ongoing education and maintaining audit-ready files can reduce unintentional errors and strengthen their defenses against the heightened scrutiny of state and federal audits and investigations.

Technology & Data Analytics

Indiana Medicaid leverages advanced data analytics to detect FWA with high precision. By cross-referencing real-time service documentation against clinical records and beneficiary eligibility files, these automated systems can immediately flag discrepancies, gaps in logging, (e.g., missing, incomplete, inconsistent, time stamp issues) or abnormal billing spikes.

Analytics can help identify anomalies that inform targeted education, improving staff understanding of clinical and administrative compliance responsibilities. This reduces errors and strengthens overall program integrity. Utilizing these tools, Indiana can more easily detect FWA during desk or onsite audits.

The Integrity Engine

- **Automated Claim Review Systems:** Matches claims against member death files, review usage frequencies against median benchmarks, and flag spikes associated with specific provider IDs or sudden volume growth
- **Integrated Analytics:** Facilitates matching supply orders against documented face-to-face assessments and prescription orders to confirm that only eligible living members are included in claims

Why It Matters

To support the fiscally responsible stewardship of federal and state Medicaid funds, we must verify provider enrollment accuracy, billing integrity, and compliance with applicable Medicaid requirements to protect program resources and members.

State of IN Executive Order [25-60]

Billing Best Practices: Do This, Document That

IHCP policy focuses on the common correct Healthcare Common Procedure Coding System (HCPCS) codes and denial drivers. Here are some practical "what to do/ what to document" examples for intermittent urinary catheter billing.

1 Do This

Bill the DME/HME Codes (match what was supplied)

- **A4351:** Intermittent urinary catheter; **straight tip**, with or without coating (teflon, silicone, or silicone elastomer, etc.), each
- **A4352:** Intermittent urinary catheter; **coude (curved) tip**, with or without coating (teflon, silicone, or silicone elastomer, etc.), each
- **A4353:** Intermittent urinary catheter, with **insertion supplies**

Best Practices

Employ certified coders and/or coding guidelines to perform documentation quality checks that accurately and clearly distinguish A4351 vs A4352 vs A4353 kits to prevent miscoding

2 Do This

Use IHCP's "source of truth" documents (keep policy current)

- IHCP Provider Reference Modules (PRMs) are the primary consolidated guidance; policy changes are often announced in IHCP bulletins and later incorporated into PRMs (including the Durable and Home Medical Equipment and Supplies PRM)

Best Practices

Assign an owner to review IHCP bulletins monthly and update your internal job aids, edits, and templates

3 Do This

Stay within IHCP quantity limits (most frequent denial)

- Effective May 1, 2024, IHCP increased the service limit to 200 units per month per code for A4351, A4352, A4353

Best Practices

Limit orders to clinically necessary quantities supported by appropriate code to prevent excess quantities

4 Document That

Prior authorization (PA): IHCP vs managed care nuance

- As of May 1, 2024, PA is not required for A4351–A4353 under IHCP FFS policy, excluding limitations
- For members in a managed care program, confirm requirements with the member's Managed Care Entity (MCE)

Best Practices

At intake/eligibility, capture program type (FFS vs MCE) and route the order through the correct ruleset before shipping

5 Document That

Documentation essentials (e.g., medical necessity that must support the code)

A4352 (coude tip)

- IHCP expects medical necessity clearly documented; For example: "member cannot catheterize with a straight tip catheter"

A4353 (kit) – Document qualifying clinical rationale

- Coverage is supported when specific criteria are met, such as nursing facility residence, immunosuppression, paralysis requiring intermittent catheterization, documented vesicoureteral reflux, or recurrent UTIs despite sterile technique

Best Practices

- Require a prescriber note/order field such as "failed/contraindicated straight tip" (and keep it in the record)
- Use a simple Attestation Checklist (For example: yes/no with supporting note location) before billing the kit code

IHCP Provider Compliance: Supplier & Staff Best Practices

Best Practice:

To remain in good standing, IHCP suppliers must keep their enrollment profile up-to-date. For example, Providers should timely report (within 10 business days) any ownership changes to avoid disqualification.

Indiana has intensified oversight through frequent revalidations, data-driven fraud detection, and onsite and desk inspections, particularly targeting high-risk areas like third-party marketing and delivery documentation. Importantly, providers should foster a culture of compliance through continuous training and proactive internal oversight. These actions will strengthen accountability, reduce risk, and adherence to regulatory requirements.

Reminders:

- **Annual Training:** Consider providing all staff members to complete IHCP policy training and sign adherence attestations every year
- **Conduct Internal Audits:** Routinely perform reviews of DME inventory and shipping records to confirm delivery accuracy and documentation meets IHCP standards
- **Report Changes:** Notify IHCP within 10 business-days of any shifts in business ownership or structure to avoid program disqualification as per IHCP Provider Enrollment Profile Updates

Key FWA Risks in Intermittent Urinary Catheter Claims

Intermittent urinary catheter claims present elevated FWA risk. Common red flags can include sudden billing spikes, use of high-cost codes without medical necessity, and claims for deceased or ineligible members.

For example, the supplier submitted claims for catheter kits that were never delivered to the beneficiary. When questioned, the file contained no valid proof of delivery—such as a signed delivery receipt with required details—yet the items were still billed as if fulfilled. The activity suggests intent to obtain reimbursement for non-provided supplies through falsified or unsupported documentation.

Figure 2 summarizes the potential consequences when these risks are not addressed. If intent or knowledge is established under Indiana Code (IC) 5-11-5.7 (Indiana Medicaid False Claims), providers may face significant damages and inflation-adjusted civil penalties per claim. As of 2025, penalties range from approximately $11,242 to $22,483 per claim and are subject to annual adjustment. In addition to financial penalties, providers may face administrative actions—including recoupment, payment suspension, termination, or exclusion from Medicaid and other health care programs—which can be effectively business-ending.

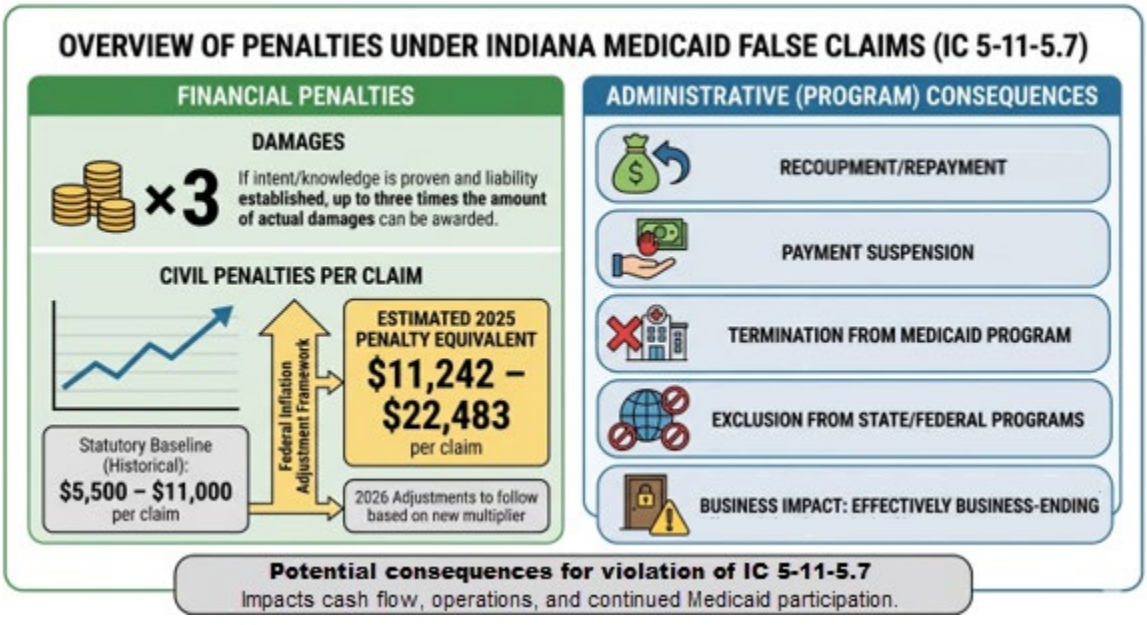


Figure 2: Overview of Penalties under Indiana Medicaid False Claims

FWA Risks in Intermittent Urinary Catheter Claims (cont.)

Managing FWA in intermittent urinary catheter claims requires a proactive approach to identifying and addressing key risk indicators. Providers must remain vigilant for red flags—such as sudden spikes in claim volumes, use of high-cost specialty codes without medical justification, or billing for deceased or ineligible members—which may signal potential fraud, waste, or abuse. To maintain billing integrity and stay audit-ready, providers should implement targeted mitigation strategies, including maintaining patient-specific documentation, verifying member eligibility, and conducting regular internal audits to detect duplicate or false claims. Early identification of FWA indicators and organized records help reduce exposure while supporting compliant, high-quality patient care.

FWA Risk Indicators and Mitigation Strategies

Risk	Definition	Mitigation
Overutilization	Billing for more catheters or supplies than a patient **actually needs.** This includes routinely sending excessive quantities or failing to adjust amounts when a patient's condition changes.	Evaluate individual patient quantities and medical needs; especially for re-fill and auto-deliveries
Upcoding	Using **higher-reimbursing catheter codes** (e.g., hydrophilic or coude-tip) without documented medical necessity increases the risk of improper coding, denials, and recoupments. Audits have identified significant growth in specialty catheter billing patterns that are inconsistent with typical clinical need, highlighting the importance of aligning code selection to the prescriber's order and supporting documentation.	Document diagnosis specific medical necessity
Misrepresent Medical Necessity	Submitting claims for patients who don't meet coverage criteria or lack proper documentation. Warning signs include vague diagnoses, missing urology notes, or identical justifications used across many patients.	Document diagnosis specific medical necessity (signed physician order and original documentation)
Improper Supplier Practices	Billing for items **never delivered, using stolen identities, or submitting claims** for deceased or ineligible members. Some cases involved large numbers of claims with no orders, no delivery proof, or billing long after a patient's death.	Verify eligibility and retain proof of delivery
Duplicate Billing	**Charging twice** for the same supplies or service—such as splitting one service into multiple codes, double billing monthly supplies, or re submitting denied claims without fixing errors.	Centralize charge capture and provide staff training
Kickbacks and Inducements	Offering or receiving money or incentives in **exchange for referrals or unnecessary DME orders**, which violates anti kickback laws.	Enforce anti kickback policies and staff training
False Documentation	Creating or altering records to justify claims, including **backdated notes, copied assessments, or generic documentation** used across multiple patients.	Original documentation requirement for billing

Figure 3: FWA Indicators and Mitigation Strategies Table

Why It Matter

Identifying FWA risk indicators early allows providers to correct issues before they escalate into audits, recoupments, or enforcement actions.

FWA Desk Aid

Issue #2 – March 2026

Key Takeaways

Intermittent urinary catheter billing is a high-risk focus area for FWA enforcement. Rapid growth in spending, evolving billing codes, and recurring scheme patterns have made catheter claims a priority for both state and federal oversight.

Indiana Medicaid fraud trends closely mirror national patterns. Investigations have identified large-scale improper payments driven by overutilization, upcoding, duplicate claims, and billing for deceased or ineligible members.

Advanced data analytics are accelerating fraud detection. Indiana Medicaid and CMS now use real-time analytics to flag abnormal billing spikes, documentation gaps, and eligibility mismatches—often before claims are paid.

Documentation quality is the strongest defense against audits. Patient-specific medical necessity, accurate HCPCS coding, eligibility verification, and proof of delivery are critical to reducing denials and enforcement risk.

Small billing errors can escalate into major enforcement actions. Unchecked red flags may lead to audits, recoupments, civil penalties, payment suspension, termination, or exclusion from Medicaid and other health care programs.

Proactive compliance protects both providers and program integrity. Ongoing training, internal audits, and audit-ready practices help providers remain compliant, operational, and eligible to continue serving Medicaid members.

Call to Action

Suspected FWA should be reported to:

IHCP Provider and Member Concerns Line
800-457-4515

IHCP Program Integrity
Programintegrity.FSSA@fssa.in.gov

Medicaid Fraud Control Unit
Medicaid Fraud Complaints

Note: Billing and office staff who have concerns of potential FWA or compliance violations can/should reach out - even anonymously to report.

References

- Durable and Home Medical Equipment and Supplies
- DME/HME Codes
- Indiana Medicaid: Providers: Electronic Visit Verification
- Indiana Medicaid: Providers: Prior Authorization
- Attorney General: Medicaid Fraud & Patient Abuse

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION