FRAUD DEFENSE OPERATIONS CENTER | **CMS.GOV/FRAUD**

Fast Facts

The Fraud Defense Operations Center

CMS took decisive action to **combat suspected fraud and improper payments** by implementing key program integrity initiatives through the end of 2025. These initiatives **saved taxpayers billions while protecting beneficiary care**.

In March 2025, CMS launched the Fraud Defense Operations Center (FDOC), also known as the **Fraud War Room**, which integrates cross-functional expertise through a specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement. The FDOC **safeguards policyholders and protects taxpayer resources by leveraging rigorous data-driven analysis** to proactively detect, address, and prevent fraud, waste, and abuse in real time. Using this approach, the team coordinates timely interventions to ensure that **improper payments are halted before financial loss is incurred by Medicare**.

The FDOC Continues to Halt Financial Loss

In 2025, FDOC efforts resulted in over $1.8 billion in payments suspended*

- **Investigated 347 providers**, over five per business day
- **Suspended payment to 249 providers** due to suspected fraud
- This included over **$1.5 billion** for suspect **durable medical equipment** billing
- This included over **$170 million** to suspect providers billing for **skin substitutes**
- This included over **$100 million to suspect laboratories**

Examples of egregious behavior caught by the FDOC

A laboratory began billing Medicare for genetic tests to identify epilepsy and Parkinson's disease.

The beneficiaries identified in the claims had neither condition, and after investigation, **no services were ever performed**. The laboratory's offices were empty with **no staff or equipment**, suggesting its sole purpose was to fabricate high-value claims. The scheme targeted **$1.6 million in payments**. FDOC's swift actions ensured the lab **never received a single dollar**.

A sham clinic in south Florida tried to bill Medicare for costly skin substitutes.

The clinic had **no location, no patients, and no staff**. Its sole purpose seems to have been to use stolen beneficiary information to generate false claims. Using advanced analytics, the FDOC identified this phantom provider and CMS cut off claims payments before the scheme could succeed. Immediate payment suspension blocked 90% of attempted payouts (**$1.4 million**), forcing the suspected fraudsters to abandon their billing.

*Numbers are cumulative of the pilot dates (March 31 - May 1, 2025) and the FDOC (July 22 - December 31, 2025).

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