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

December 2025 | A-09-22-03011

Podiatrists' Claims for Routine Foot Care Services Did Not Comply With Medicare Requirements

REPORT HIGHLIGHTS

December 2025 | A-09-22-03011

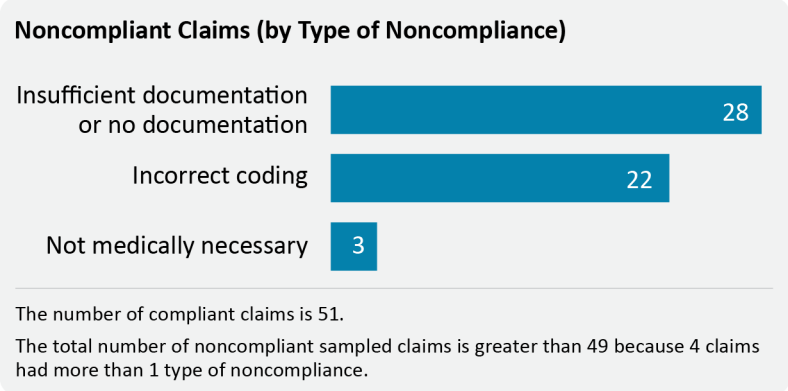
Podiatrists' Claims for Routine Foot Care Services Did Not Comply With Medicare Requirements

Why OIG Did This Audit

- Medicare does not generally cover routine foot care (RFC) services unless the enrollee has systemic medical conditions that increase the risk of infection or injury if the services are not performed by a medical nonprofessional (e.g., a podiatrist). Medicare assumes that the enrollee or a caretaker will perform these services.
- A 2002 OIG report found that Medicare inappropriately paid podiatrists for RFC services that were medically unnecessary and insufficiently documented. Because OIG has not reviewed podiatry services since that report, we conducted this audit to determine whether these compliance issues continued to exist in 2019 and 2020 (audit period).
- This audit examined whether podiatrists' claims for RFC services related to a systemic condition complied with Medicare requirements.

What OIG Found

- Of the 100 sampled claims, 49 podiatrists' claims for RFC services related to a systemic condition did not comply with Medicare requirements.
- During our audit period, CMS's oversight may not have been sufficient to prevent improper payments.
- On the basis of our sample results, we estimated that of the $18.2 million paid by Medicare for our audit period, approximately $4.4 million did not comply with Medicare requirements.



What OIG Recommends

We recommend that CMS work with the Medicare Administrative Contractors to determine whether additional oversight is necessary to prevent payments for RFC services that did not comply with Medicare requirements, which amounted to an estimated $4.4 million for our audit period.

CMS concurred with our recommendation.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

Routine foot care (RFC) services include cutting or removing corns or calluses; trimming, cutting, clipping, or debriding (reducing the thickness) of nails; and hygienic and preventative maintenance. Medicare does not generally cover RFC services unless the enrollee has systemic medical conditions that increase the risk of infection or injury if the services are not performed by a medical professional (e.g., podiatrist).[1, 2, 3] Medicare assumes that the enrollee or a caretaker will perform these services. A 2002 Office of Inspector General (OIG) report found that Medicare inappropriately paid podiatrists for certain RFC services that were medically unnecessary and insufficiently documented.[4] Because OIG has not reviewed podiatry services since 2002, we conducted this audit to determine whether the compliance issues identified in the prior report continued to exist during January 1, 2019 through December 31, 2020 (audit period).[5, 6]

OBJECTIVE

Our objective was to determine whether podiatrists' claims for RFC services related to a systemic condition complied with Medicare requirements.

BACKGROUND

Medicare Program

The Medicare program provides health insurance coverage to people aged 65 and older, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

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[1] A podiatrist is a physician who treats the foot, ankle, and related structures of the leg.

[2] Social Security Act (the Act) § 1862(a)(13)(C).

[3] Systemic medical conditions are metabolic, neurologic, or peripheral vascular diseases, such as diabetes, multiple sclerosis, and peripheral artery disease. CMS's *Medicare Benefit Policy Manual,* Pub. No. 100-02 chapter 15, § 290(C) and (D).

[4] OIG, *Medicare Payments for Nail Debridement Services* (OEI-04-99-00460), June 6, 2002.

[5] We conducted a separate audit of Medicare payments to podiatrists for evaluation and management and other services, excluding RFC services. OIG, *Medicare Improperly Paid Podiatrists for Evaluation and Management Services* (A-09-22-03012).

[6] This was the most recent data available at the start of our audit.

Medicare Part B provides supplementary medical insurance for medical and other health services, including podiatry. CMS contracts with Medicare Administrative Contractors (MACs) to process and pay Part B claims for a defined geographic area (jurisdiction).[7] MACs help CMS in its efforts to prevent and detect improper payments and promote Medicare compliance within their jurisdictions. CMS and MACs provide education and guidance to providers on Medicare requirements and billing procedures. MACs also review medical records for selected claims and develop local coverage determinations (LCDs) within their jurisdictions.[8]

Medicare Coverage of Podiatry Services

Medicare Part B covers podiatry services for certain indications, such as medically necessary treatment of injuries, diseases, or other medical conditions affecting the foot, ankle, or lower leg. Medicare generally does not cover RFC services unless an enrollee's medical condition or conditions increase the risk of infection and injury when a nonprofessional provides those services. *CMS's Medicare Benefit Policy Manual*, Pub. No. 100-02 states that Medicare will cover RFC services performed under the following conditions: in the presence of a systemic condition or conditions; as a necessary and integral part of otherwise covered services; for the treatment of warts on the foot; or for the treatment of infected toenails (chapter 15, § 290(C) and (D)).

This report focuses on RFC services related to systemic conditions (e.g., diabetes, multiple sclerosis, and peripheral artery disease).

When submitting claims for RFC services, podiatrists use Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT®) codes.[9] See Table 1 on the following page for the RFC codes and descriptions.

[7] During our audit period, the following seven MACs processed and paid Medicare Part B claims: CGS Administrators, LLC; First Coast Service Options, Inc.; National Government Services, Inc.; Noridian Healthcare Solutions, LLC; Novitas Solutions, Inc.; Palmetto GBA, LLC; and WPS Government Health Administrators.

[8] LCDs are determinations by a MAC on whether a particular item or service is reasonable and necessary and therefore covered by Medicare within the specific MAC jurisdiction.

[9] HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies. CPT codes are five-digit numeric or alphanumeric codes that are used for reporting and billing medical services and procedures or performance measurement.

Table 1: CPT and HCPCS Codes for Routine Foot Care Services

CPT or HCPCS Code	Description
11055	Paring or cutting skin lesion (e.g., corn or callus)[10, 11]
11056	Paring or cutting 2 to 4 skin lesions
11057	Paring or cutting more than 4 skin lesions
11719	Trimming of non-dystrophic nails, any number
11720	Debridement of 1 to 5 nail(s) by any method(s)
11721	Debridement of 6 or more nails by any method(s)
G0127	Trimming of dystrophic nails (e.g., deformed, thickened, discolored, brittle), any number

In addition, Medicare covers evaluation and management (E/M) services provided by a podiatrist if there is an underlying systemic condition or symptoms warranting the need for an E/M service.[12] E/M services are performed by physicians and other health care professionals to assess and manage enrollees' health. Medicare does not cover E/M services when they are billed for the same date of service as an RFC service unless the E/M service is a significant and separately identifiable service (*2019 AMA CPT Manual, Evaluation and Management Services Guidelines*). CMS's *Medicare Claims Processing Manual,* Pub. No. 100-04, states that documentation should support the level of E/M service billed (chapter 12 § 30.6.1(A)). A podiatrist uses modifier 25 to indicate that an E/M service was significant and separately identifiable from another podiatry procedure or service performed on the same day.[13] For a claim to be paid, a podiatrist must furnish information necessary to determine the amounts due.[14]

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[10] *CPT copyright 2019 and 2020 American Medical Association. All rights reserved.*

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT is a registered trademark of the American Medical Association.

[11] **U.S. Government End Users.** CPT is commercial technical data, which was developed exclusively at private expense by the American Medical Association (AMA), 330 North Wabash Avenue, Chicago, Illinois 60611. Use of CPT in connection with this product shall not be construed to grant the Federal Government a direct license to use CPT based on FAR 52.227-14 (Data Rights - General) and DFARS 252.227-7015 (Technical Data - Commercial Items).

[12] The Act § 1862(a)(1)(A) and LCD L35138.

[13] A modifier is a two-character code reported with an HCPCS code or CPT code and is used to give Medicare additional information needed to process a claim (NCCI Manual, chapter I, § E).

[14] The Act § 1833(e).

HOW WE CONDUCTED THIS AUDIT

Our nationwide audit covered 155,811 podiatrists' claims that included a RFC service with a payment of $8 or greater and had a date of service during our audit period, for which Medicare paid approximately $18.2 million.[15] Of the total payments, $8.2 million was for RFC services, $8.8 million was for E/M services, and $1.2 million was for other services (e.g., x-rays, injections, and ultrasounds). We stratified the claims into two groups: (1) enrollees who did not have a history of a systemic condition and (2) enrollees with a history of a systemic condition whose claims included a paid E/M service.[16] We selected a stratified random sample of 100 claims, totaling $11,169, and reviewed all services on the selected claims.

We requested supporting documentation from podiatrists who submitted the claims in our sample. That documentation included medical records, which we provided to an independent medical review contractor to determine whether all the services on the claims met Medicare requirements.[17]

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 contains our sample results and estimates.

FINDINGS

Some podiatrists' claims for RFC services related to a systemic condition did not comply with Medicare requirements.[18] Of the 100 sampled claims, 51 complied with Medicare requirements. However, the remaining 49 sampled claims did not comply with the requirements because services, totaling $2,902, were: insufficiently documented or no

[15] We selected claims for the following places of service: office, home, assisted living facility, group home, skilled nursing facility, nursing facility, custodial care facility, and intermediate care facility.

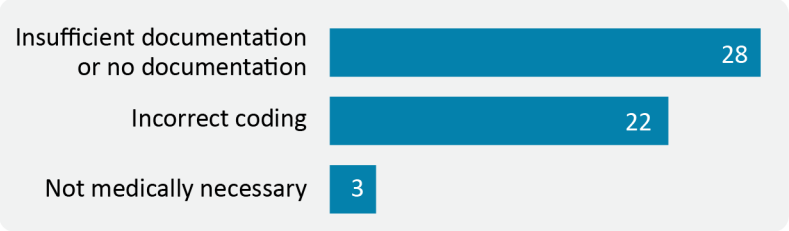
[16] CMS's *Medicare Benefit Policy Manual,* Pub. No. 100-02 chapter 15, § 290(D), and MAC LCDs included the most common systemic conditions that might justify coverage for RFC services.

[17] We did not request supporting documentation for one claim because the podiatrist was part of another ongoing OIG review.

[18] The claims included other services, which we reviewed as part of this audit.

documentation was provided; incorrectly coded; or not medically necessary. The figure below shows the number of noncompliant claims by type of noncompliance.[19]

Figure: Noncompliant Claims by Type



During our audit period, CMS's oversight of podiatrists' billing for RFC services may not have been sufficient to prevent improper payments. In addition, podiatrists may not have understood Medicare coding and documentation requirements.

On the basis of our sample results, we estimated that of the $18.2 million in payments for RFC services paid by Medicare for our audit period, approximately $4.4 million[20] did not comply with Medicare requirements.[21]

CLAIMS FOR ROUTINE FOOT CARE SERVICES DID NOT COMPLY WITH MEDICARE REQUIREMENTS

For 49 sampled claims, Medicare incorrectly paid for RFC services that were insufficiently documented, or documentation was not provided (28 claims), were incorrectly coded (22 claims), or were not medically necessary (3 claims).

Services Were Insufficiently Documented, or Documentation Was Not Provided

Payment must not be made to a podiatrist for an item or service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (Social Security Act (the Act) § 1833(e)). The provider must document in the medical

[19] The total number of noncompliant sampled claims is greater than 49 because 4 claims had more than 1 type of noncompliance.

[20] The estimated improper Medicare payment amount was $4,425,822.

[21] We determined the improper payment for the noncompliant sample claims by calculating the difference between the amount paid for the services and the amount that should have been paid based on the independent medical review determinations.

record the appropriate signs and symptoms along with the complicating condition(s) (LCD L33941).

For 28 sampled claims, services were either insufficiently documented or documentation was not provided.

Specifically, for 22 of the 28 sampled claims, services were insufficiently documented. The independent medical review contractor determined that information in enrollees' medical records did not support the services billed by the podiatrists.

EXAMPLE

Insufficiently Documented Services

According to the medical records, an 82-year-old enrollee was seen by the podiatrist for elongated and painful toenails. The podiatrist billed CPT code 11721 for the RFC service of debridement of six or more nails and CPT code 99213 for an E/M service, for which Medicare paid a total of $102. However, the medical record was incomplete, and the podiatrist's notes did not include information on any procedures performed at the visit and were not signed or dated. Therefore, Medicare should not have paid for the claim, resulting in an overpayment of $102.

For the remaining six sampled claims, podiatrists did not provide any documentation. Without the documentation, the independent medical review contractor could not determine whether the services on the claims complied with Medicare requirements. Therefore, we considered all six sampled claims noncompliant.

Services Were Incorrectly Coded

Payment must not be made to a podiatrist for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (the Act § 1833(e)). Providers are required to use CPT codes and HCPCS codes when billing Medicare for physician services (45 CFR §§ 162.1000(a), 162.1002(c)(1) and (a)(5)).

All documentation must be maintained in the enrollee's medical record and available to the contractor upon request. The submitted medical record should support the use of the selected code(s). The submitted CPT/HCPCS code should describe the service performed (LCD L35138 and *2019 AMA CPT Codebook (Surgery Codes)*).

EXAMPLE

Incorrectly Coded Service

According to the medical records, a 70-year-old enrollee was seen by the podiatrist for complaints of painful feet and was treated for skin lesions. The podiatrist billed CPT code 11057 for the RFC service of paring or cutting more than four skin lesions, for which Medicare paid $65. However, the medical records supported that the podiatrist treated only three skin lesions and therefore should have billed CPT code 11056 for pairing or cutting two to four skin lesions; and Medicare should have paid $59 for the claim, resulting in an overpayment of $6.

For 22 sampled claims, services were incorrectly coded. Specifically, the independent medical review contractor determined that the information in the enrollees' medical records did not support the services billed by the podiatrists.

Services Were Medically Unnecessary

To be paid by Medicare, an item or a service must be reasonable and necessary for the diagnosis or treatment of illness or injury, or for improving the functioning of a malformed body member (the Act § 1862(a)(1)(A)).

Medicare payment may be made for RFC when the enrollee has a systemic disease—such as metabolic, neurologic, or peripheral vascular disease—of sufficient severity that performance of such services by a nonprofessional person would put the enrollee at risk (e.g., a systemic condition that has resulted in severe circulatory embarrassment or areas of desensitization in the enrollee's legs or feet) (LCD L33636).

EXAMPLE

Medically Unnecessary Service

According to the medical records, an 84-year-old enrollee was seen in the podiatrist's office for complaints of a lesion on the right second toe and painful, thickened, ingrown nails on both feet. The podiatrist billed four services: two RFC services (HCPCS code G0127 for trimming dystrophic nails and CPT code 11056 for paring or cutting two to four skin lesions); x-rays of both feet (CPT code 73620); and an E/M service for a new patient (CPT code 99203), for which Medicare paid a total of $221. The medical records did not support that the RFC services and x-rays were medically necessary. Rather, the medical records supported only the E/M service. Medicare should have paid only $97 for the claim, resulting in an overpayment of $124.

The enrollee's medical record must contain documentation that fully supports the medical necessity for services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity, such as physical and/or clinical findings consistent with the diagnosis and severity of the condition must be maintained in the enrollee record. Physical findings and services must be precise and specific (e.g., left great toe, or fourth digit.). Documentation of co-existing systemic illness should be maintained. There must be adequate medical documentation to demonstrate the need for RFC services as outlined in this determination. This documentation may be office records, physician notes or diagnoses characterizing the enrollee's physical status as being of such severity to meet the criteria for exceptions to the Medicare RFC exclusion (LCD L33636).[22]

For three sampled claims, services were not medically necessary. Specifically, the independent medical review contractor determined that the information in the enrollees' medical records did not support the medical necessity of the services billed.

[22] This criteria was removed from the LCD on Dec. 26, 2019, and added to the billing and coding article A57759. Thus, beginning on Dec. 12, 2019, this language is considered guidance.

CMS OVERSIGHT MAY NOT HAVE BEEN SUFFICIENT TO PREVENT IMPROPER PAYMENTS

During our audit period, CMS's education of podiatrists and MACs' medical reviews of RFC services may not have been sufficient to prevent improper payments. CMS's last podiatry-specific education for our audit period was guidance issued in September 2018.[23] In addition, according to the MACs, they were not routinely conducting reviews of RFC services during our audit period and not all providers took advantage of the information and training available to them. MACs stated concerns that podiatrists may not have fully understood Medicare coding and documentation requirements (e.g., having adequate documentation to support the medical necessity of an RFC service or billing an E/M service for the same date of service as an RFC service). The MACs also expressed the need for additional provider education. CMS provided additional guidance and education to providers on coverage, billing, and coding of podiatry services after our audit period. In addition, some MACs conducted reviews of podiatrists' billing of select RFC services. Because of our substantial findings (i.e., 49 of the 100 sampled claims did not comply with Medicare requirements) and the MACs' concerns about podiatrists' lack of understanding of Medicare billing requirements, we believe additional oversight may improve compliance with the requirements.

RECOMMENDATION

We recommend that the Centers for Medicare & Medicaid Services work with the MACs to analyze RFC care claims related to systemic conditions billed by podiatrists—specifically claims billed with E/M services—to determine whether additional oversight (e.g., guidance, education, medical reviews, and/or provider internal audits) is necessary to prevent improper payments, which amounted to an estimated $4,425,822 for our audit period.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendation and described actions it has taken and planned to take to address it. Specifically, CMS stated that it instructed the MACs to target their efforts to services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. CMS also stated that it will notify the MACs of this audit so they may take our findings and recommendation into consideration as they prioritize services and items for additional oversight. In addition, CMS stated that it works with the MACs to continuously educate physicians on Medicare requirements, including maintaining Medicare Learning Network booklets and other educational materials that include information about coverage, billing, and coding for podiatry and E/M services. CMS also provided separate technical comments, which we addressed as appropriate.

CMS's comments, excluding technical comments, are included in their entirety as Appendix D.

[23] CMS Medicare Learning Network Matters article, *Medicare Podiatry Services: Information for Medicare Fee-for-Service Health Care Professionals*, September 2018. No longer available online.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our nationwide audit covered 155,811 podiatrists' claims that included a RFC service with a payment of $8 or greater and had a date of service during our audit period, for which Medicare Part B paid $18,166,801.[24] Of the total payment amount, $8,224,930 was for RFC services, $8,755,151 was for E/M services, and $1,186,720 was for other services (e.g., x-rays, injections, and ultrasounds). We stratified the claims into two groups: (1) enrollees who did not have a history of a systemic condition, and (2) enrollees with a history of a systemic condition whose claims included a paid E/M service.[25] We selected a stratified random sample of 100 claims and an independent medical review contractor reviewed all services on the selected claims for which we obtained documentation from podiatrists.

We obtained an understanding of CMS's oversight activities related to RFC services that were relevant to our objective. Specifically, we interviewed CMS and MAC officials to gain an understanding of the following: (1) Medicare requirements for RFC services; (2) education and guidance provided to podiatrists; and (3) claims processing procedures for RFC services.

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 from April 2022 through September 2025.

METHODOLOGY

To accomplish our objective, we took the following steps:

- reviewed applicable Federal laws, regulations, and CMS and MAC guidance;
- interviewed CMS and MAC officials to gain an understanding of Medicare procedures for payments and claims processing related to RFC and E/M services;
- obtained paid claims data from CMS's NCH file;
- created a sampling frame of 155,811 paid claims (Appendix B);

[24] We selected claims for the following places of service: office, home, assisted living facility, group home, skilled nursing facility, nursing facility, custodial care facility, and intermediate care facility.

[25] CMS's *Medicare Benefit Policy Manual,* Pub. No. 100-02 chapter 15, § 290(D), and MAC LCDs included the most common systemic conditions that might justify coverage for RFC services.

- selected a stratified random sample of 100 paid claims and performed the following steps:

    - reviewed data from CMS's Common Working File to determine whether the claims had been canceled or adjusted,

    - requested supporting documentation from podiatrists,[26]

    - provided supporting documentation to an independent medical review contractor to determine whether the services on the claims complied with Medicare requirements,

    - reviewed and summarized the independent medical review contractor's results, and

    - calculated the improper payment amount for the sampled claims;

- estimated the amount of the Medicare payments in the sampling frame that did not comply with Medicare requirements (Appendix C); 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.

[26] We did not request supporting documentation for one claim because the podiatrist was part of another ongoing OIG review. We treated this claim as a non-error.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 155,811 Medicare Part B claims paid to podiatrists nationwide, totaling $18,166,801, with dates of service during our audit period. Each claim included an RFC service with a payment of $8 or greater and a systemic condition diagnosis. We stratified the claims into two groups: (1) enrollees who did not have a history of a systemic condition, and (2) enrollees with a history of a systemic condition whose claims included a paid E/M service.

SAMPLE UNIT

The sample unit was a claim.

SAMPLE DESIGN AND SAMPLE SIZE

We selected a stratified random sample of 100 sample items (Table 2).

Table 2: Strata

Stratum	Description	No. of Claims	Frame Dollar Value	Sample Size
1	Claims for enrollees without a history of a systemic condition	7,621	$694,173	10
2	Claims for enrollees with a history of a systemic condition that included a paid E/M service	148,190	17,472,628	90
	Total	**155,811**	**$18,166,801**	**100**

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS) statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the sample units in each stratum by the CMS Integrated Data Repository record link number and then consecutively numbered the items in each stratum. After generating the random numbers for each stratum, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the total amount of the Medicare payments in the sampling frame that did not comply with Medicare requirements. We used this software to calculate the point estimate and the corresponding lower and upper limits of the two-sided 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Details and Results

Stratum	Number of Claims in Sampling Frame	Value of Frame	Sample Size	Value of Sample	Number of Noncompliant Sampled Claims	Value of Noncompliant Sampled Claims
1	7,621	$694,173	10	$900	6	$399
2	148,190	17,472,628	90	10,269	43	2,503
Total	**155,811**	**$18,166,801**	**100**	**$11,169**	**49**	**$2,902**

Table 4: Estimated Value of Payments in the Sampling Frame That Did Not Comply With Medicare Requirements (*Limits Calculated for a 90-Percent Confidence Interval*)

Point estimate	$4,425,822
Lower limit	3,277,962
Upper limit	5,763,097

APPENDIX D: CMS Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: October 23, 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: Podiatrists' Claims for Routine Foot Care Services Did Not Comply With Medicare Requirements (A-09-22-03011)

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.

OIG's audit covered podiatrists' claims that included a routine foot care service with dates of service in 2019 and 2020. The audit included routine footcare services, evaluation and management services, and other services (e.g., x-rays, injections, and ultrasounds). Since the OIG's audit period, CMS has taken additional action to reduce and prevent Medicare improper payments to podiatrists for evaluation and management services. For example, in 2022, CMS issued Comparative Billing Reports (CBRs) on Medicare Part B claims for podiatry nail debridement and evaluation and management services. CBRs provide data on Medicare billing trends, allowing a health care provider to compare their billing practices to peers in the same state and across the nation. A CBR educates providers about Medicare's coverage, coding, and billing rules and acts as a self-audit tool for providers.

Additionally, CMS has taken action to educate health care providers on the proper billing of Medicare services more broadly. For example, CMS has published a Medicare Learning Network (MLN) educational tool with Medicare provider compliance tips. This web page includes information about common denial reasons and how to prevent denials.[1] Additionally, CMS maintains a MLN booklet for evaluation and management services that includes information about the principles of documentation and choosing the code that characterizes the service (including the level of service).[2] CMS also maintains a booklet for global surgery that

[1] MLN Educational Tool – Medicare Provider Compliance Tips – Podiatry Care. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html#OtherErrors

[2] MLN Booklet – Evaluation and Management Services. Available at: https://www.cms.gov/files/document/mln006764-evaluation-management-services.pdf

includes information about billing a separately identifiable evaluation and management service on the same day as a procedure, including appropriate use of modifier 25.[3] CMS has also published a booklet that includes information about items and services that are not covered under Medicare, including information about foot care services and supportive devices.[4]

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

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services work with the MACs to analyze RFC claims related to systemic conditions billed by podiatrists – specifically claims billed with E/M services – to determine whether additional oversight (e.g., guidance, education, medical reviews, and/or provider internal audits) is necessary to prevent improper payments, which amounted to an estimated $4,425,822 for our audit period.

CMS Response

CMS concurs with this recommendation. The Medicare Administrative Contractors (MACs) have been instructed to target their efforts to those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. CMS notes that OIG estimated that improper payments associated with this issue were approximately $4.4 million nationwide over a two-year period. CMS will notify the MACs of this audit so they may take the OIG's findings and this recommendation into consideration as they prioritize services and items for additional oversight.

It should also be noted that CMS and the MACs are continuously educating physicians on Medicare requirements. As stated above, CMS maintains Medicare Learning Network (MLN) booklets, along with other educational materials, that include information about coverage, billing, and coding for podiatry and evaluation and management services.

[3] MLN Booklet: Global Surgery. Available at: https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf

[4] MLN Booklet – Items & Services Not Covered Under Medicare. Available at: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/items-and-services-not-covered-under-medicare-booklet-icn906765.pdf

Report Fraud, Waste, and Abuse

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Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov