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

December 2025 | A-09-22-03012

Podiatrists' Claims for Evaluation and Management Services Did Not Comply With Medicare Requirements

REPORT HIGHLIGHTS

December 2025 | A-09-22-03012

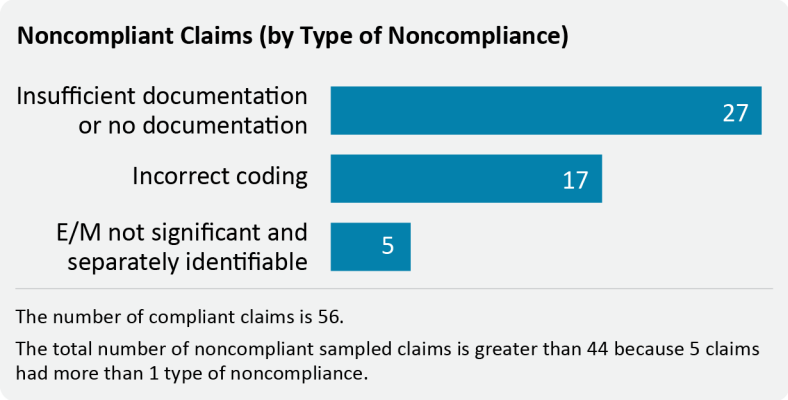
Podiatrists' Claims for Evaluation and Management Services Did Not Comply With Medicare Requirements

Why OIG Did This Audit

- Medicare covers evaluation and management (E/M) services when the service is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- A 2010 OIG report found that Medicare inappropriately paid $6.7 billion for E/M claims that were incorrectly coded or were insufficiently documented. We conducted this audit to determine whether these compliance issues existed for payments to podiatrists for E/M services performed from January 1 through December 31, 2019 (audit period).
- This audit examined whether podiatrists' claims for E/M services billed with modifier 25—which indicates that an E/M service was significant and separately identifiable from another procedure or service performed on the same day—complied with Medicare requirements.

What OIG Found

- Of the 100 sampled claims, 44 podiatrists' claims for E/M services 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 $222.5 million paid by Medicare for our audit period, approximately $39.6 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 improper payments associated with podiatrists' billing of E/M services with modifier 25, which amounted to an estimated $39.6 million for our audit period.

CMS concurred with our recommendation.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare covers evaluation and management (E/M) services for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, when the service is reasonable and necessary.[1] E/M services are performed by physicians, including podiatrists and other health care professionals, to assess and manage enrollees' health.[2] A 2010 Office of Inspector General (OIG) report found that Medicare inappropriately paid $6.7 billion for E/M claims that were incorrectly coded or were insufficiently documented.[3] Because OIG has not reviewed podiatry services since 2002, we conducted this audit to determine whether the compliance issues identified in the prior report existed for payments to podiatrists for E/M services performed from January 1 through December 31, 2019 (audit period).[4, 5, 6] See Appendix B for a list of related OIG reports.

OBJECTIVE

Our objective was to determine whether podiatrists' claims for E/M services 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.

Medicare Part B provides supplementary medical insurance for medical and other health services, including podiatry. CMS contracts with Medicare Administrative Contractors (MACs) to

[1] The Social Security Act (the Act) § 1862(a)(1)(A).

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

[3] OIG, *Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010* (OEI-04-10-00181), May 28, 2014.

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

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

[6] We conducted a separate audit of Medicare payments to podiatrists for routine foot care services. OIG, *Podiatrists' Claims for Routine Foot Care Services Did Not Comply With Medicare Requirements* (A-09-22-03011).

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.

Medicare Coverage of Evaluation and Management Services Provided by Podiatrists

Medicare Part B generally covers E/M services provided by podiatrists. However, an E/M service provided on the same day as another podiatry service is not covered unless the E/M service is significant and separately identifiable.[8]

When submitting claims for E/M services, podiatrists use Current Procedural Terminology (CPT®) codes to define the medical procedures performed.[9, 10] For a claim to be paid, a podiatrist must furnish information necessary to determine the amounts due.[11] A podiatrist uses modifier 25 to indicate that an E/M service was significant and separately identifiable from another procedure or service performed on the same day.[12, 13]

The medical record documents the care of the enrollee chronologically and is an important element contributing to high-quality care. The *CMS Medicare Claims Processing Manual,* Pub. No. 100-04, states that documentation should support the level of E/M service reported

[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] The Act § 1862(a)(1)(A); 42 CFR § 411.15(k)(1); *National Correct Coding Initiative Policy Manual* (NCCI Manual), chapter I, § E(b).

[9] CPT codes are five-digit numeric or alphanumeric codes that are used for reporting and billing medical services and procedures for performance measurement.

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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.

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[11] The Act § 1833(e) and 42 CFR § 424.5(a)(6).

[12] A modifier is a two-character code reported with a Healthcare Common Procedure Coding System (HCPCS) code or CPT code and is used to give Medicare additional information needed to process a claim (NCCI Manual, chapter I, § E(b)).

[13] **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).

(chapter 12, § 30.6.1(A)).[14] In addition, CMS has issued guidelines for providers, including podiatrists, to use when documenting and determining the level of E/M services.[15] Within these guidelines, CMS states that medical record documentation is required to record pertinent facts, findings, and observations about an enrollee's health history, including past and present illnesses, examinations, tests, treatments, and outcomes.

HOW WE CONDUCTED THIS AUDIT

Our nationwide audit covered 1.4 million podiatrists' claims for E/M services billed with modifier 25 that included another paid podiatry service on each claim and had dates of service during our audit period, for which Medicare paid approximately $222.5 million. Of the total payment amount, $88.3 million was for E/M services billed with modifier 25, and $134.2 million was for podiatry and other services (e.g., x-rays, ultrasounds, and vaccinations). We selected a simple random sample of 100 claims, totaling $16,434, and reviewed all services on the selected claims.

We requested supporting documentation from the podiatrists who submitted the claims in our sample and provided the records to an independent medical review contractor, who then determined whether all services on the claims met Medicare requirements.[16]

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 C describes our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

Some podiatrists' claims for E/M services did not comply with Medicare requirements.[17] Of the 100 sampled claims, 56 complied with Medicare requirements; however, the remaining 44 sampled claims did not comply with the requirements because services, totaling $2,881, were:

[14] *The responsibility for the content of any "National Correct Coding Policy" included in this product is with the Centers for Medicare and Medicaid Services and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, nonuse or interpretation of information contained in this product.*

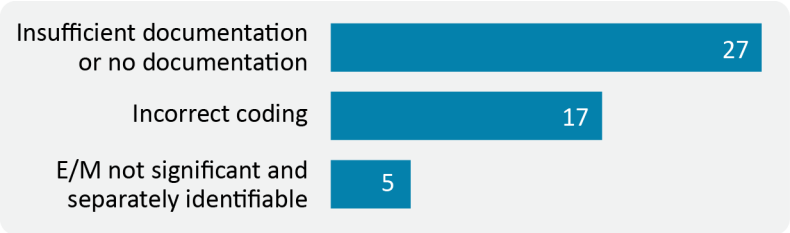
[15] CMS's *1997 Documentation Guidelines for Evaluation and Management Services*.

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

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

insufficiently documented or no documentation was provided; incorrectly coded; or not significant and separately identifiable. The figure below shows the number of noncompliant claims by type of noncompliance.[18]

Figure: Noncompliant Claims by Type



During our audit period, CMS's oversight of podiatrists' billing for E/M services may not have been sufficient for podiatrists to fully understand Medicare coding and documentation requirements to prevent improper payments.

On the basis of our sample results, we estimated that of the $222.5 million in payments for E/M services paid by Medicare for our audit period, approximately $39.6 million did not comply with Medicare requirements.[19, 20]

CLAIMS FOR EVALUATION AND MANAGEMENT SERVICES DID NOT COMPLY WITH MEDICARE REQUIREMENTS

For 44 sampled claims, Medicare incorrectly paid for E/M services that were insufficiently documented, or documentation was not provided (27 claims); were incorrectly coded (17 claims); or were not significant and separately identifiable (5 claims).

Services Were Insufficiently Documented, or Documentation Was Not Provided

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 for such provider" (Social Security Act (the Act) § 1833(e)).

According to the *2019 AMA CPT Codebook, Evaluation and Management Services Guidelines*, certain key components are required to support the level of E/M service provided including

[18] The total number of noncompliant sampled claims is greater than 44 because 5 claims had more than 1 type of noncompliance.

[19] The estimated improper Medicare payment amount was $39,583,052.

[20] 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 paid based on the independent medical review determinations.

history, examination, and medical decision making.

For 27 sampled claims, services were insufficiently documented, or documentation was not provided.

Specifically, for 22 of the 27 sampled claims, services were insufficiently documented. The independent medical review contractor determined that information in the enrollees' medical records did not support the services billed by the podiatrists.

For the remaining five 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 met Medicare requirements. Therefore, we considered the five 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 physician services (45 CFR §§ 162.1000(a), 162.1002(c)(1) and (a)(5)). The *2019 AMA CPT Codebook, Evaluation and Management Services Guidelines*, instructs providers on how to select the appropriate CPT code to bill based on the level of E/M service provided.

For 17 sampled claims, services were incorrectly coded. Specifically, the independent medical review contractor

EXAMPLE

Insufficiently Documented Services

A podiatrist billed CPT code 99213 for an E/M service provided to an enrollee, and CPT code 11730 for a surgical nail removal, for which Medicare paid a total of $118. The independent medical review contractor determined that, in addition to not being legible, the documentation did not support the required key components of the E/M service and did not support the surgical nail removal. Because there was not sufficient information to determine the amounts due to the podiatrist, Medicare should not have paid for the claim, resulting in an overpayment of $118.

EXAMPLE

Incorrectly Coded E/M Service

According to the medical records, an 84-year-old enrollee was seen by a podiatrist for pain beneath the foot, and a physical exam was conducted. The podiatrist billed CPT code 99204 for a new patient E/M service and CPT code 17110 for the removal of a wart, for which Medicare paid $265. The independent medical review contractor determined that the physical exam was not comprehensive enough to justify the level of E/M service billed. Rather, the medical records supported a lower-level E/M service. Therefore, the podiatrist should have billed CPT code 99203, and Medicare should have paid $214 for the claim, resulting in an overpayment of $51.

determined that the information in the enrollees' medical records did not support the CPT codes billed by the podiatrists.

Services Were Not Significant and Separately Identifiable

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)). An E/M service provided on the same day as another service is not covered unless the E/M service is significant and separately identifiable (The *2019 AMA CPT Codebook, Evaluation and Management Services Guidelines*). Modifier 25 indicates that a significant, separately identifiable E/M service was performed by the same physician or other qualified health care professional on the same day of the procedure or other service (National Correct Coding Initiative Policy Manual, chapter 1, § (E)(b)).

For five sampled claims billed with modifier 25, the E/M services were not significant and separately identifiable. Specifically, the independent medical review contractor determined that the information in each enrollee's medical records did not support that the E/M service billed was not related to other podiatry services performed on the same day.

EXAMPLE

E/M Service That Was Not Significant and Separately Identifiable

According to the medical records, a 71-year-old enrollee was seen by the podiatrist for follow-up wound care to a previous debridement (reducing the thickness) of a diabetic ulcer on the left foot. During the visit, the podiatrist examined the wound and further debrided the ulcer. The podiatrist billed CPT code 99213 with modifier 25 for the E/M service and CPT code 97597 for the ulcer debridement, for which Medicare paid a total of $139. The independent medical review contractor determined that although the podiatrist debrided the ulcer again, the E/M service was not significant and separately identifiable because it was a follow up to the previous debridement. Therefore, the podiatrist should have billed only CPT code 97597, and Medicare should have paid $77 for the claim, resulting in an overpayment of $62.

CMS OVERSIGHT MAY NOT HAVE BEEN SUFFICIENT TO PREVENT IMPROPER PAYMENTS

During our audit period, CMS's education and MACs' medical reviews of E/M services billed by podiatrists may not have been sufficient to prevent improper payments. In 2018, CMS provided guidance to all providers on billing for E/M services, including E/M services billed with modifier 25. [21] At the time of our audit, CMS stated that it was aware of risks associated with podiatrists' use of modifier 25 to bill for unnecessary E/M services with foot care services, but it had no plans for additional provider education specifically for podiatrists. In addition, according to the MACs, they were not routinely conducting reviews of E/M services during our audit period, and not all podiatrists took advantage of the information and training available to them.

[21] CMS, *Global Surgery Booklet*, August 2018. This edition is no longer available online because the *Global Surgery Booklet* is continuously updated.

MACs stated concerns about providers' overuse of modifier 25, excessive billing for E/M services with podiatry services, and insufficient documentation (e.g., podiatrists using checklists that did not include enough information to determine the services provided). The MACs expressed the need for additional provider education. CMS provided additional guidance and education to all providers on coverage, billing, and coding of podiatry services after our audit period. In addition, some MACs conducted reviews of podiatrists' billing of E/M services with modifier 25. Because of our substantial findings (i.e., 44 of the 100 sampled claims did not comply with Medicare requirements) and the MACs' concerns about podiatrists' billing of E/M services with modifier 25, we believe additional oversight may improve compliance with Medicare requirements.

RECOMMENDATION

We recommend that the Centers for Medicare & Medicaid Services work with MACs to determine whether additional oversight (e.g., guidance, education, medical reviews, and/or provider internal audits) is necessary to prevent improper payments associated with podiatrists' billing of E/M services with modifier 25, which amounted to an estimated $39,583,052 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 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 it works with the MACs to continuously educate physicians of Medicare requirements, including billing E/M services with modifier 25. CMS also provided separate technical comments, which we addressed as appropriate.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our nationwide audit covered 1,373,934 podiatrists' claims for E/M services billed with modifier 25 that included another paid podiatry service on each claim and had a date of service during our audit period, for which Medicare Part B paid $222,502,582.[22] Of the total payment amount, $88,284,089 were for E/M services billed with modifier 25 and $134,218,493 were for podiatry and other services (e.g., x-rays, ultrasounds, and vaccinations). We selected a simple 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 related to E/M 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 E/M services; (2) education and guidance provided to podiatrists; and (3) claims processing procedures for E/M 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 objectives, 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 E/M services;
- obtained paid claims data from CMS's NCH file;
- created a sampling frame of 1,373,934 paid claims (Appendix C);
- selected a simple random sample of 100 paid claims and performed the following steps:
    - reviewed data from CMS's Common Working File to determine whether claims had been canceled or adjusted,

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- requested supporting documentation from podiatrists,[23]
- 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 D); 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.

[23] 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: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Payments for Evaluation and Management Services Provided on the Same Day as Eye Injections Were at Risk for Noncompliance With Medicare Requirements	A-09-23-03014	5/27/2025
Medicare Generally Paid for Evaluation and Management Services Provided via Telehealth During the First 9 Months of the COVID-19 Public Health Emergency That Met Medicare Requirements	A-01-21-00501	2/13/2024
Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010	OEI-04-10-00181	5/28/2014
Coding Trends of Medicare Evaluation and Management Services	OEI-04-10-00180	5/8/2012
Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005	A-05-07-00077	4/20/2009
Review of Cataract Global Surgeries and Related Evaluation and Management Services, Wisconsin Physicians Service Insurance Corporation Calendar Year 2003	A-05-06-00040	3/5/2007
Use of Modifier 25	OEI-07-03-00470	11/28/2005
Medicare Payments for Nail Debridement Services	OEI-04-99-00460	6/6/2002

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 1,373,934 Medicare Part B claims paid to podiatrists nationwide, totaling $222,502,582, with dates of service during our audit period. Each claim included a paid E/M service billed with modifier 25 and at least one other paid podiatry service on the same claim.[24]

SAMPLE UNIT

The sample unit was a claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a simple random sample and selected 100 sample units.

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 items by the CMS Integrated Data Repository record link number and then consecutively numbered the items in the sampling frame. After generating the random numbers according to our sample design, 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.

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APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Details and Results

Number of Claims in Sampling Frame	Value of Frame	Sample Size	Value of Sample	Number of Noncompliant Sampled Claims	Value of Noncompliant Sampled Claims
1,373,934	$222,502,582	100	$16,434	44	$2,881

Table 2: 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	$39,583,052
Lower limit	29,589,998
Upper limit	51,299,154

APPENDIX E: 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 Evaluation and Management Services Did Not Comply With Medicare Requirements (A-09-22-03012)

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 period covered payments to podiatrists for evaluation and management services with dates of service in 2019. 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 includes information about billing a separately identifiable evaluation and management service

[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

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 determine whether additional oversight (e.g., guidance, education, medical reviews, and/or provider internal audits) is necessary to prevent improper payments associated with podiatrists' billing of E/M services with modifier 25, which amounted to an estimated $39,583,052 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 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 the principles of documentation for evaluation and management services, choosing the code that characterizes the service (including the level of service), and proper use of modifier 25 when billing evaluation and management services performed on the same day as a minor surgical procedure.

[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

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Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov