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Client Alert: 2025 Podiatry Audit: What Physicians and Compliance Leaders Need to Know

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Executive Summary

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) reviewed Medicare Part B payments to podiatrists for "routine foot care" (RFC) associated with systemic conditions during 2019–2020. Nearly half of sampled claims did not meet Medicare requirements, driven primarily by insufficient documentation and incorrect coding, with some services deemed not medically necessary. OIG recommended that Centers for Medicare and Medicaid Services (CMS), working with Medicare Administrative Contractors (MACs), strengthen oversight and provider education. CMS concurred and stated that it would forward the recommendations.

What the Audit Covered

The audit assessed whether claims for RFC services related to systemic conditions complied with Medicare requirements. RFC includes the paring/cutting of corns or calluses, trimming or debridement of nails, and hygienic or preventive maintenance. Medicare generally excludes RFC but covers it when an enrollee's systemic disease (e.g., diabetes, peripheral artery disease, neurologic conditions) makes nonprofessional performance unsafe, when RFC is integral to a covered service, or for specified exceptions (e.g., infected toenails, warts). The audit also examined evaluation and management (E/M) services submitted on the same date as RFC, which are only payable when significant and separately identifiable.

The nationwide sampling frame comprised 155,811 claims with RFC billed in contexts involving systemic conditions, across office and facility settings, totaling $18.2 million in Medicare payments. The sample included 100 claims (stratified by enrollee systemic history and presence of a paid E/M service) for detailed medical record review by an independent contractor.

Key Findings and Patterns of Noncompliance

OIG found that 49 of 100 sampled claims were noncompliant. Extrapolated, an estimated $4,425,822 in payments did not meet Medicare requirements.

The dominant reasons were:

- **Insufficient or missing documentation.** Twenty-eight claims lacked sufficient medical record support for the billed service level, or providers failed to submit any documentation when requested. Typical deficiencies included incomplete or absent procedure notes, lack of signatures or dates, failure to document the required complicating systemic condition, and inadequate detail to substantiate the number of lesions or nails treated.
- **Incorrect coding.** Twenty-two claims used Current Procedural Terminology (CPT)/Health Care Common Procedure Coding System (HCPCS) codes that were not supported by the record. A common pattern was upcoding lesion counts (e.g., billing for "more than four" when only three lesions were documented) or selecting nail debridement codes inconsistent with the number or type of nails treated. Documentation often failed to align with the descriptor requirements of codes 11055–11057, 11719–11721, and G0127.
- **Lack of medical necessity.** Three claims did not meet Medicare's "reasonable and necessary" standard. Records failed to demonstrate that systemic disease severity made nonprofessional RFC unsafe or that ancillary services (such as imaging) were warranted. Physical findings lacked the precision CMS and MACs expect (e.g., specific digit/side, circulatory or neurologic compromise, infection).
- **E/M services billed with RFC.** While not quantified as a separate error category, OIG and MAC interviews highlighted recurrent issues with E/M billed on the same date as RFC without adequate support for a significant, separately identifiable service. Documentation often did not justify modifier 25.

OIG also concluded that CMS and MAC oversight during the period (e.g., provider education and targeted medical review) may have been insufficient to prevent improper payments. MACs reported concerns that many podiatrists did not fully understand Medicare documentation and coding requirements for RFC and related E/M services.

Regulatory and Guidance Touchpoints

- Medicare covers RFC in limited circumstances tied to systemic disease risk, when integral to another covered service, or for defined exceptions.
- Documentation must include relevant medical history, precise physical findings (e.g., side and digit), and clear evidence of systemic disease severity necessitating professional RFC. Providers must maintain records supporting CPT/HCPCS selection and medical necessity.
- E/M on the same date as RFC is payable only if significant and separately identifiable, supported by the record; modifier 25 should be used appropriately.
- MAC Local Coverage Determinations (LCDs) and related billing/coding articles govern jurisdiction-specific expectations and documentation elements for RFC and podiatry E/M services.

OIG's Recommendation and CMS Response

OIG recommended that CMS work with MACs to analyze RFC claims—especially those accompanied by E/M services—to determine whether additional oversight, medical review, education, and/or provider internal audits are necessary. CMS concurred and indicated it would notify MACs to prioritize oversight where program risk is highest and continue education through Medicare Learning Network materials and other channels.

Practical Implications for Physicians and Compliance Officers

The audit underscores persistent, high-impact risks in podiatry RFC billing—chiefly documentation sufficiency, code selection precision, and substantiation of medical necessity tied to systemic disease. Given potential MAC focus following this report, practices should anticipate increased pre- and post-payment

reviews, especially where RFC is paired with E/M services. Appropriate documentation, coding discipline, and proactive compliance controls will be critical to protect revenue and reduce recoupment exposure.

Action Steps for Medical Practices

- Strengthen documentation of medical necessity. Ensure the chart clearly ties the RFC service to a qualifying systemic condition with sufficient severity to make nonprofessional care unsafe. Document specific vascular, neurologic, or metabolic findings; precise anatomic details (e.g., left great toe, right second digit); and any infection or complicating factors. Include relevant history, exams, and any diagnostic data supporting the need for professional RFC.
- Align procedure notes with code descriptors. For lesion paring (11055–11057), explicitly document the number of lesions treated and their locations. For nail services (11719, 11720, 11721, G0127), specify the number and type of nails (dystrophic vs non-dystrophic), the method (e.g., debridement), and clinical indications (e.g., pain, infection risk). Sign and date all notes.
- Apply E/M and modifier 25 conservatively. Only bill an E/M service on the same date as RFC when there is a significant, separately identifiable evaluation beyond the pre- and post-procedural work inherent to the RFC code. The documentation should clearly support the E/M level and the distinct nature of the service.
- Calibrate coding with MAC guidance. Review the applicable LCDs and billing/coding articles for your MAC jurisdiction regarding RFC and podiatry E/M. Confirm that diagnosis coding reflects the systemic condition and that documentation meets MAC-specific expectations for coverage.
- Implement targeted pre-bill reviews. Prioritize pre-bill checks for encounters that combine RFC with E/M services, high lesion counts, or higher-intensity nail debridement codes. Verify that documentation supports the billed code and medical necessity before submission.
- Conduct periodic internal audits. Sample RFC claims regularly to test for documentation completeness, accurate code selection, and appropriate use of modifier 25. Trend error types and provide targeted feedback and education to clinicians and coding staff.
- Standardize with templates and checklists. Use structured note templates that prompt documentation of systemic disease severity, physical findings, counts of nails/lesions, anatomic specificity, and signatures/dates. Embed coding tips that align with CPT/HCPCS descriptors.
- Provide and supplement focused staff education. Train clinicians and coders on the limited coverage rules for RFC, the distinction between dystrophic and non-dystrophic nails, precise lesion counting, and E/M criteria on the same date as procedures. Reinforce the need for documentation to match code selection exactly. Provide clinicians with supplemental information like this article to educate and inform.
- Monitor denials and payer signals. Track payer edits and MAC probes related to RFC and same-day E/M. Use denial data to refine documentation standards and pre-bill controls.
- Maintain records and responsiveness. Ensure timely, complete responses to medical record requests, given OIG's finding that lack of documentation converted otherwise reviewable claims into overpayments.

By reinforcing these controls, practices can reduce compliance risk in a high-scrutiny service line, support defensible billing, and be better positioned for heightened MAC oversight following the OIG's 2025 findings.

If you have questions or would like more information, please feel free to contact Grant Dearborn, Mara Rendina, or Daphne Kackloudis.

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