Office of the Inspector General
Post-Payment Review Comment Grids

The findings and related content detailed within the grids are not exhaustive, and the Office of the Inspector General may reference other findings and/or law or code provisions according to the individuality of the case and documentation provided during the post-payment review.

These grids may be referenced by service providers and the public as informational regarding the operational work of the OIG. Service providers are required to abide by all state and federal laws and regulations. These grids are not to be used by service providers as a checklist, legal advice, or exhaustive resource to ensure compliance with Medicaid requirements.

Ambulatory Surgery Center

FINDING: LACK OF DOCUMENTATION

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
No documentation provided for the MA claim(s).	The provider must retain records for a period of not less than five years and must submit them to the Wisconsin Department of Health Services (DHS) upon request. The provider did not submit the requested records to DHS. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 106.02(9)(a) § DHS 106.02(9)(e) § DHS 106.02(9)(f) § DHS 106.02(9)(g) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(2)(b)4 § 49.45(3)(f)

FINDING: NON-COVERED SERVICES

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The Ambulatory Surgery Center (ASC) procedure was not provided by a certified physician in a certified ASC.	Covered ASC services are provided by or under the supervision of a certified physician in a certified ASC. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 106.02(9) § DHS 107.01 § DHS 107.30(1) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

The ASC performed a non-covered sterilization procedure.	Sterilization is covered only if: (1) The individual is at least 21 years old at the time consent is obtained; (2) The individual has not been declared mentally incompetent by a federal, state or local court of competent jurisdiction to consent to sterilization; (3) The individual has voluntarily given consent in accordance with all the requirements prescribed in DHS 107.06(3)(a)4 and DHS 107.06(3)(d); and (4) At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 106.02(9) § DHS 107.01 § DHS 107.06(3)(a) § DHS 107.30(3)(a) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The ASC billed for non-covered services.	ASC services and items for which payment may be made under other provisions are not covered services. These include: (1) Physician services; (2) Laboratory services; (3) X-ray and other diagnostic procedures, except those directly related to performances of the surgical procedure; (4) Prosthetic devices; (5) Ambulance services; (6) Leg, arm, back and neck braces; (7) Artificial limbs; and (8) Durable medical equipment for use in the recipient's home. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 106.02(9) § DHS 107.01 § DHS 107.03 § DHS 107.30(3)(c)1 § DHS 107.30(4) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

The ASC was reimbursed for a non-covered ASC procedure.	Covered ASC services shall be limited to the procedures listed in DHS 107.30(1)(a) and that DHS publishes notice of in the MA provider handbook. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 106.02(9) § DHS 107.01 § DHS 107.30(1)(a) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The ASC was reimbursed for a non-covered ASC laboratory procedure.	The following laboratory procedures are (1) Complete blood count (CBC); (2) Hemoglobin; (3) Hematocrit; (4) Urinalysis; (5) Blood sugar; (6) Lee white coagulant; and (7) Bleeding time. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 106.02(9) § DHS 107.01 § DHS 107.30(1)(b) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: LACK OF PRIOR AUTHORIZATION (PA)

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The ASC performed a surgical procedure requiring a PA; however, there was no authorized PA in place.	Any surgical procedure under DHS 107.06(2) requires prior authorization. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 106.02(9) § DHS 107.01 § DHS 107.02(3)(d)5 § DHS 107.03(9) § DHS 107.06(2) § DHS 107.30(2) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: LACK OF MEDICAL NECESSITY

Revised 03/08/2022

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The procedure(s) provided are not medically necessary/appropriate for the condition of the recipient.	A medically necessary procedure means it is required to treat a recipient's illness, injury or disability and meets the following standards: 1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability. 2. Is provided consistent with the standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided. 3. Is appropriate with regard to generally accepted standards of medical practice. 4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient. 5. Is of proven medical value or usefulness and, not experimental in nature. 6. Is not duplicative with respect to other services being provided to the recipient. 7. Is not solely for the convenience of the recipient, the recipient's family or a provider. 8. With respect to prior authorization of a service and to other prospective coverage determinations made by DHS, Is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient. 9. Is the most appropriate level of service that can safely and effectively be provided to the recipient. Each provider is solely responsible for the completeness of the documentation necessary to support each claim. Claims where the provider fails to maintain records for purpose of substantiating appropriateness and necessity of services which are the subject of claims may be denied. A provider will be reimbursed only for services that are appropriate and medically necessary for the condition of the member. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 101.03(103) § DHS 101.03(96m) § DHS 106.02(5) § DHS 106.02(9)(a) § DHS 106.02(9)(b) § DHS 106.02(9)(g) § DHS 107.01 § DHS 107.03(5) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)