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 Office of the Inspector General. 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.

Chiropractic Services

FINDING: LACK OF DOCUMENTATION

Revised 9/30/2021

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider did not submit any documentation for the claim	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 required 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: MEDICARE EPISODE

Revised 9/30/2021

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider did not show the claim was billed to and denied by Medicare before billing Wisconsin Medicaid.	Wisconsin Medicaid is the payer of last resort. The provider is required to bill other insurance, including Medicare, prior to billing Medicaid. The provider must retain records showing proof of denial and submit them to 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)(c)2 § DHS 106.02(9)(d)2 § DHS 106.02(9)(e)1 § DHS 106.03(7) § DHS 106.03(6) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f) § 49.46(2)(c)

FINDING: TPL BILLING

Revised 9/30/2021

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider did not show the claim was billed to and denied by the member's other insurance before billing Wisconsin Medicaid.	Wisconsin Medicaid is the payer of last resort. The provider is required to bill other insurance prior to billing Medicaid. The provider must retain records showing proof of denial and submit them to 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)(c) § DHS 106.02(9)(d) § DHS 106.02(9)(e) § DHS 106.03(7) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: DUPLICATE BILLING

Revised 9/30/2021

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider was reimbursed for the service twice.	Two claims were paid for the same member on the same date of service with the same procedure code, modifiers, and quantity. Documentation submitted by the provider only supports paying one claim. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 106.04(5)(a) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: BILLING IN EXCESS OF SERVICES PROVIDED

Revised 9/30/2021

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider was reimbursed for more units of service than the documentation submitted by the provider supports.	A provider is required to use the applicable medical data code sets valid at the time the health care is furnished. The actual provision of service that was reimbursed cannot be verified from the provider's records. 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 106.04(5)(a) § DHS 107.01 § DHS 108.02(9)	45 C.F.R. § 162.1000 45 C.F.R. § 162.1002	§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: LACK OF PRIOR AUTHORIZATION Revised 9/30/2021				
Comment	**Description**	**Wisconsin Administrative Code**	**Code of Federal Regulations**	**Wisconsin State Statutes**
The provider billed for services beyond the initial 20 spinal manipulations without a prior authoriztion.	Prior authorization is required for service reimbursement beyond the initial 20 spinal manipulations per spell of illness. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.01 § DHS 107.15(3)(a)1 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
There was no prior authorization obtained beyond the initial spell of illness (SOI) justifying why the condition is chronic and why it warrants the scope of service being requested.	Prior authorization is required for service reimbursement beyond the initial 20 spinal manipulations per spell of illness. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.01 § DHS 107.15(3)(a)1 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
There was no prior authorization obtained for a spinal support priced over $75.	A prior authorization is required for spinal supports prescribed by a physician or a chiropractor if the purchase or rental price is over $75. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.01 § DHS 107.15(3)(a)2 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: NONCOVERED SERVICES Revised 9/30/2021				
Comment	**Description**	**Wisconsin Administrative Code**	**Code of Federal Regulations**	**Wisconsin State Statutes**
The provider performing the service does not have a valid license.	A provider must maintain MA certification requirements. The provider license is not valid. The service is non-covered. 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(4) § DHS 106.02(5) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f) § 448.12

The performing provider is not an MA certified provider.	Non-Emergency Services by a provider who is not MA certified are not reimbursable. The provider who performed the service is not MA certified. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 105.03 § DHS 106.02(4) § DHS 107.01 § DHS 107.15(2) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The x-ray or set of x-rays is not covered.	An x-ray or set of x-rays is only covered if it is performed either in the course of diagnosing a spinal subluxation or in the course of verifying symptoms of other medical conditions beyond the scope of chiropractic for an initial visit. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.01 § DHS 107.15(4)(a) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The diagnostic urinalysis (U/A) is not covered.	A diagnostic U/A is covered only for an initial office visit when related to the diagnosis of a spinal subluxation or when verifying a symptomatic condition beyond the scope of chiropractic. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.01 § DHS 107.15(4)(b) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The spell of illness (SOI) is not documented in the plan of care.	The services are non-covered if the SOI is not documented in the plan of care. 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)(b) § DHS 107.01 § DHS 107.15(1) § DHS 107.15(2) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The provider billed for consultation with another provider.	Diagnosis or treatment consultations between providers is not covered. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.01 § DHS 107.15(5) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

Treatment days covered by Medicare or other third party insurance were not included in computing the 20 spinal manipulations per SOI.	Treatment days covered by Medicare or other third-party insurance shall be included in computing the 20 spinal manipulations per spell of illness total. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.01 § DHS 107.15(3)(f) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
Unused treatment days from one SOI were carried over into a new SOI.	Unused treatment days carried over from one SOI to another SOI are non-covered. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.01 § DHS 107.15(3)(e) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The initial office visit procedures are not clearly described.	Reimbursable billing for an initial office visit shall clearly describe all procedures performed. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.01 § DHS 107.15(4)(c) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The services provided were not manual manipulations of the spine used to treat a subluxation.	Services are not reimbursable unless manual spine manipulations are used to treat subluxations defined as, alterations of the normal dynamics, anatomical or physical relationships of contiguous articular surfaces. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.01 § DHS 107.15(1) § DHS 107.15(2) § DHS 108.02(9)	42 C.F.R. § 440.60 (b)(2)	§ 49.45(2)(a)10 § 49.45(3)(f)

The treated condition does not justify a new spell of illness designation.	The following conditions may justify designation of a new spell of illness: an acute onset of a new spinal subluxation; an acute onset of an aggravation of pre-existing spinal subluxation by injury; or an acute onset of a change in pre-existing spinal subluxation based on objective findings. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.01 § DHS 107.03(5) § DHS 107.15(3)(b)1 § DHS 107.15(3)(b)2 § DHS 107.15(3)(b)3 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING:INCORRECT MODIFIER

Revised 9/30/2021

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The modifier used with this procedure code is incorrect.	A provider is required to use the applicable medical data code sets valid at the time the health care is furnished. The documentation does not support the use of the modifier with the procedure code. The modifier [xx] is used incorrectly. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 106.03(2)(a) § DHS 107.01 § DHS 108.02(9)	45 C.F.R. § 162.1000 45 C.F.R. § 162.1002	§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: INCOMPLETE DOCUMENTATION

Revised 9/30/2021

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider did not submit one or more documents required for the claim.	The provider must retain records for a period of not less than five years and must submit them to DHS upon request. The provider did not submit the required 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: WRONG PROCEDURE CODE				
				Revised 9/30/2021
Comment	**Description**	**Wisconsin Administrative Code**	**Code of Federal Regulations**	**Wisconsin State Statutes**
The procedure code submitted for reimbursement is not supported by the documentation submitted by the provider.	A provider is required to use the applicable medical data code sets valid at the time the health care is furnished. The provider was reimbursed for code [xx]. The documentation reflects the service performed is procedure code [xx]. 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(96m)(b) § DHS 106.03(2)(a) § DHS 107.01 § DHS 108.02(9)	45 C.F.R. § 162.1000 45 C.F.R. § 162.1002	§ 49.45(2)(a)10 § 49.45(3)(f)
The Evaluation and Management level procedure code submitted for reimbursement is not supported by the documentation submitted by the provider.	A provider is required to use the applicable medical data code sets valid at the time the health care is furnished. The provider was reimbursed for a level [xx] [new/established] patient Evaluation and Management service. The documentation reflects the level of the [new/established] patient Evaluation and Management service performed is [xx]. The reimbursement is adjusted to reflect the level of service documented. 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(96m)(b) § DHS 106.03(2)(a) § DHS 107.01 § DHS 108.02(9)	45 C.F.R. § 162.1000 45 C.F.R. § 162.1002	§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: PROVIDER IS NOT THE PERFORMING PROVIDER Revised 9/30/2021				
Comment	**Description**	**Wisconsin Administrative Code**	**Code of Federal Regulations**	**Wisconsin State Statutes**
The individual performing the service is required to be identified as the rendering provider on claims submitted for reimbursement.	Any claim submitted by an employer or facility so authorized shall identify the provider number of the individual provider who actually provided the service or item that is the subject of the claim.The documentation reflects the requirements are not met. DHS was unable to verify the actual provision of Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 106.03(5)(b) § DHS 107.01 § DHS 108.02(9)	45 C.F.R. § 455.440	§ 49.45(2)(a)10 § 49.45(3)(f)