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.

Laboratory Services

FINDING: MEDICARE EPISODE

Revised 9/30/2021

Comment	Explanation	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 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)(c)2 § DHS 106.02(9)(d)(2) § DHS 106.02(9)(e)(1) § DHS 106.03(7)(b) § DHS 107.01 § DHS 108.02(9)	42 C.F.R. § 433.139	§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: TPL BILLING

Revised 9/30/2021

Comment	Explanation	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)2 § DHS 106.02(9)(d)(2) § DHS 106.02(9)(e)(1) § DHS 106.03(7)(b) § DHS 107.01 § DHS 108.02(9)	42 C.F.R. § 433.139	§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: LACK OF DOCUMENTATION

Revised 9/30/2021

Comment	Explanation	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider was unable to produce a record for the member.	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 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)	42 C.F.R. § 493.1773(c)	§ 49.45(2)(a)10 § 49.45(2)(b)4 § 49.45(3)(f)

FINDING: LACK OF M.D. ORDERS

Revised 9/30/2021

Comment	Explanation	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider was unable to produce a physician order for a service that requires a physcian order.	All diagnostic services are required to be ordered by a physician or dentist. The provider must retain a record of this order for a period of not less than five years and must submit it to DHS upon request. The provider did not submit the requested record 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 107.01 § DHS 107.02(2m) § DHS 107.25(2)(a) § DHS 108.02(9)		§ 49.46(2)(a)4e § 49.45(2)(a)10 § 49.45(3)(f)

FINDING: DUPLICATE BILLING

Revised 9/30/2021

Comment	Explanation	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider was reimbursed for the service twice when documentation submitted by the provider only supported one service.	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 106.02(9)(b) § DHS 106.02(9)(e) § DHS 106.02(9)(f) § DHS 106.02(9)(g) § DHS 106.03(2) § 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	Explanation	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.	The number of units reimbursed on the paid claim is greater than the number of units supported by documentation submitted by the provider. 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(5) § DHS 106.04(5)(a) § DHS 107.01 § DHS 108.02(9)	45 C.F.R. § 162.1000 45 C.F.R. § 162.1002(c)	§ 49.45(2)(a)10 § 49.45(3)(f) § 49.45(3)(f)2

FINDING: WRONG PROCEDURE CODE

Revised 9/30/2021

Comment	Explanation	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The wrong procedure code was used for this service.	Providers are required to use accurate and appropriate procedure codes in the submission of claims. A provider is solely responsible for the accuracy of all claims submitted, regardless of who submits them. The claim submitted was for a procedure code that did not match the procedure code described in documentation submitted by the provider. 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 106.02(9)(e) § DHS 106.03(2) § DHS 107.01 § DHS 108.02(9)	45 C.F.R. § 162.1000 45 C.F.R. § 162.1002(c)	§ 49.45(2)(a)10 § 49.45(3)(f)
The wrong level of procedure code was used for this service.	Providers are required to use accurate and appropriate procedure codes in the submission of claims. A provider is solely responsible for the accuracy of all claims submitted, regardless of who submits them. The claim submitted was for a level of service that did not match the level of service documented in documentation submitted by the provider. 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 106.02(9)(e) § DHS 106.03(2) § DHS 107.01 § DHS 108.02(9)	45 C.F.R. § 162.1000 45 C.F.R. § 162.1002(c)	§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: INCOMPLETE DOCUMENTATION

Revised 9/30/2021

Comment	Explanation	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
There are multiple records for the same service on the same date of service with differing information.	Documentation submitted by the provider includes multiple records for the same service on the same date of service with differing information. The actual services performed cannot be determined. 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 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The documentation submitted was illegible.	The claims billed could not be verified as the documentation submitted by the provider was illegible. 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 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The order was not signed by a prescriber.	Orders are required to be signed by a prescriber. Documentation submitted did not contain a prescriber's signature. 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 107.01 § DHS 107.02(2m)(b) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: NON-COVERED SERVICES

Revised 9/30/2021

Comment	Explanation	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The test was run after the claim was submitted.	A claim may not be submitted to Wisconsin Medicaid until the recipient has received the service. The claim was billed before the test was run. 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(3)(a) § DHS 107.25(2) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

The service was provided to a member who was an adult inmate of a state prison on the date of service.	Services provided to adult inmates of state prisons, as defined in § 302.01, are non-covered. The member was an inmate at one of the named institutions on the date of service. 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(13) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The service was provided to a member who was a child placed in a detention facility on the date of service.	Services provided to children placed in a detention facility are non-covered. The member was a child placed in a detention facility on the date of service. 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(14) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The test was performed as part of fertility services.	Services provided for the purpose of enhancing fertility in males or females are non-covered. Documentation submitted by the provider and/or claims data shows this service was performed as a part of fertility services. 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(19) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

The service was unbundled from another, more inclusive code that was billed.	Providers are required to use accurate and appropriate procedure codes in the submission of claims. A provider is solely responsible for the accuracy of all claims submitted, regardless of who submits them. Services described in a more inclusive procedure code are not separately reimbursable from the inclusive code unless it is a distinct procedure. Documentation submitted by the provider does not support the service being distinct. 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)(e) § DHS 106.03(2)(a) § DHS 107.01 § DHS 108.02(9)	45 C.F.R. 162.1000 45 C.F.R. 162.1002(c)	§ 49.45(2)(a)10 § 49.45(3)(f)
Specimen validity is not separately billable.	Providers are required to use accurate and appropriate procedure codes in the submission of claims. A provider is solely responsible for the accuracy of all claims submitted, regardless of who submits them. Urine drug screen codes include specimen validity testing in their definitions. These services cannot be billed separately when performed in conjunction with a urine drug screen. 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)(e) § DHS 106.03(2) § DHS 107.01 § DHS 108.02(9)	45 C.F.R. 162.1000 45 C.F.R. 162.1002(c)	§ 49.45(2)(a)10 § 49.45(3)(f)

A presumptive drug test provided the medically necessary information for treatment of this patient. The definitive drug test is not medically necessary.	Definitive drug test are not covered when a presumptive drug test is consistent with a member's self-report, presentation, medical history, and current prescriptions and when definitive drug testing is not necessary to guide further treatment. The presumptive drug test documented in the medical record was consistent with information in the medical record, and the number of drug classes described in the code billed does not meet the requirement of a definitive result being needed to guide further treatment. 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) § DHS 106.02(5) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The number of drug screens exceeds the number medically necessary during this timeframe based on the member's risk level and reason for testing.	Drug screens should not be ordered in excess of what is medically necessary for 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(96m) § DHS 106.02(5) § DHS 106.04(5)(a) § DHS 107.01 § DHS 108.02(9)		§ 49.45(3)(f) § 49.45(2)(a)10
Another provider billed the same drug test code first for the same member on the same date of service.	When testing for drugs of abuse, one unit of each code may be submitted per day, per member, regardless of the number of providers. 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) § DHS 106.02(5) § DHS 106.04(5)(a) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

More than one presumptive or definitive drug test was billed for the same member on the same date of service.	One presumptive and one definitive drug test are covered per member, per date of service. The provider billed for more than one presumptive or definitive drug test for the same member on the same date of service. 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) § DHS 106.02(5) § DHS 106.04(5)(a) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: INCORRECT MODIFIER

Revised 9/30/2021

Comment	Explanation	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The provider billed for services that were also billed by another provider for the same recipient on the same date of services	The provider billed for the complete procedure when another provider billed for either the professional or technical component. 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 107.01 § DHS 107.02(1)(a) § DHS 107.03(5) § DHS 108.02(9)	45 C.F.R. 162.1002	§ 49.45(2)(a)10 § 49.45(3)(f)

FINDING: INCOMPLETE MEDICAL ORDER

Revised 9/30/2021

Comment	Explanation	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The prescriber order was missing one or more required elements.	Diagnostic services require an order from a provider acting within the scope of their practice. This order is required to include the date of the order, the name and the address of the prescriber, the prescriber's MA provider number, the name and address of the recipient, the recipient's MA number, and an evaluation of the service to be provided. The provider submitted documentation with an order that was missing one or more of these elements. 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 107.02(2m)(b) § DHS 107.25(2) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

Generic or standing orders are not sufficiently detailed, were not executed appropriately, or were not documented effectively to verify medical necessity.	A signed and dated member-specific order for each ordered drug test that provides sufficient information to substantiate each testing panel component performed is required for drug tests. Documentation submitted by the provider shows a generic or standing order was used, but that the order was not sufficiently detailed, was not executed appropriately, or was not documented effectively, and as a result, medical necessity cannot be verified. 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) § DHS 106.02(5) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)