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.

Metastar's Post-Payment Reviews

FINDING: NOT APPLICABLE

Revised 9/30/2021

Comment	Description	Wisconsin Administrative Code	Code of Federal Regulations	Wisconsin State Statutes
The physician certification of need for service lacks one or more required element.	Physicians must certify that ambulatory care resources do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will be needed in reduced amount or intensity or no longer be needed. The Wisconsin Department of Health 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 106.02(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.13(1)(b)3 § DHS 107.13(1)(b)7.a § DHS 108.02(9)	42 C.F.R. § 441.152(a) 42 C.F.R. § 441.152(a)(1) 42 C.F.R. § 441.152(a)(2) 42 C.F.R. § 441.152(a)(3) 42 C.F.R. § 441.152(b) 42 C.F.R. § 441.153 42 C.F.R. § 456.160	§ 49.45(2)(a)10 § 49.45(3)(f)
The certification was not made by an independent team that included a physician.	Certification of the need for services shall be made for a recipient when the person is admitted to a facility or program by an independent team that includes a physician. 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 107.01 § DHS 107.13(1)(b)3.b § DHS 108.02(9)	42 C.F.R. § 441.152(a) 42 C.F.R. § 441.153	§ 49.45(2)(a)10 § 49.45(3)(f)

The physician did not certify the need for services within the required time frame.	Certification of the need for services shall be made at the time of admission or, if an individual applies for assistance while in a psychiatric hospital, before the agency authorizes payment. 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 107.01 § DHS 107.13(1)(b)7.b § DHS 108.02(9)	42 C.F.R. § 441.152(a) 42 C.F.R. § 456.160(a) 42 C.F.R. § 456.160(a)(1) 42 C.F.R. § 456.160(a)(2)	§ 49.45(2)(a)10 § 49.45(3)(f)
The physician did not certify the need for emergency inpatient hospital services within the required time frame.	A Physician must certify the need for emergency inpatient hospital admissions within 14 days. 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.01 § DHS 107.13(1)(b)3.d § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
The physician did not recertify the need for services within the required time frame.	Recertification shall be made at least every 60 days after certification. 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.01 § DHS 107.13(1)(b)7.c § DHS 108.02(9)	42 C.F.R. § 456.160(b)(1) 42 C.F.R. § 456.160(b)(2)	§ 49.45(2)(a)10 § 49.45(3)(f)
There was no psychiatric evaluation in the member's medical file.	Before a recipient is admitted to a psychiatric hospital or before payment is authorized for a patient who applies for MA, the physician shall make a medical evaluation of each recipient's need for care in the hospital and professional personnel shall make a psychiatric and social evaluation of the recipient's need for 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.01 § DHS 107.13(1)(b)6.a § DHS 107.13(1)(b)9 § DHS 108.02(9)	42 C.F.R. § 441.155(b)(1)	§ 49.45(2)(a)10 § 49.45(3)(f)

A psychiatric evaluation is documented in the member's record, but it is missing one or more required elements.	Each medical evaluation shall include a diagnosis, a summary of present medical findings, medical history, the mental and physical status and functional capacity, a prognosis, and a recommendation by a physician concerning admission to the psychiatric hospital or concerning continued care in the psychiatric hospital for an individual who applies for MA while in the hospital. 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.01 § DHS 107.13(1)(b)6.b § DHS 108.02(9)	42 C.F.R. § 441.155(b)(1)	§ 49.45(2)(a)10 § 49.45(3)(f)
The member's medical record does not contain an individual plan of care.	An individual plan of care shall be developed by an interdisciplinary team and implemented no later than 14 days after admission. 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.01 § DHS 107.13(1)(b)4 § DHS 107.13(1)(b)5 § DHS 108.02(9)	42 C.F.R. § 441.153 42 C.F.R. § 441.154 42 C.F.R. § 441.155	§ 49.45(2)(a)10 § 49.45(3)(f)
The individual plan of care was not developed within required time frame.	An individual plan of care shall be developed & implemented no later than 14 days after admission, & shall be designed to meet the members discharge from inpatient status at the earliest possible 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.01 § DHS 107.13(1)(b)4 § DHS 108.02(9)	42 C.F.R. § 456.180(a)	§ 49.45(2)(a)10 § 49.45(3)(f)
The team that developed the individual plan of care lacked personnel from one or more of the required disciplines.	There are very specific, minimum requirements regarding the make up of the interdisciplinary team of providers who must participate in creating the treatment plan. 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.01 § DHS 107.13(1)(b)5.b § DHS 108.02(9)	42 C.F.R. § 441.156(a) 42 C.F.R. § 441.156(b) 42 C.F.R. § 441.156(c) 42 C.F.R. § 441.156(d)	§ 49.45(2)(a)10 § 49.45(3)(f)

The physician did not develop an initial plan of care before admission or before payment was authorized.	The physician must establish a written plan of care for the member, before admission or before payment is authorized. 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.01 § DHS 107.13(1)(b)8.a § DHS 107.13(1)(b)9 § DHS 108.02(9)	42 C.F.R. § 456.180(a) 42 C.F.R. § 456.180(b)	§ 49.45(2)(a)10 § 49.45(3)(f)
The physician plan of care is missing one or more required elements.	The physician's plan of care shall include diagnosis, symptoms, complaints and complications indicating the need for admission; a description of the functional level of the individual; objectives; any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet or special procedures recommended for the health and safety of the patient; plans for continuing care, including review and modification to the plan of care; and plans for discharge. 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.01 § DHS 107.13(1)(b)8.a § DHS 108.02(9)	42 C.F.R. § 456.180(b)	§ 49.45(2)(a)10 § 49.45(3)(f)
Documentation does not demonstrate that active treatment was provided.	Inpatient psychiatric services must involve “active treatment,” which requires implementation of a professionally developed & supervised individual 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 101.03(2) § DHS 106.02(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.01 § DHS 107.13(1)(b)4 § DHS 108.02(9)	42 C.F.R. § 441.154 42 C.F.R. § 441.155	§ 49.45(2)(a)10 § 49.45(3)(f)
The physician plan of care was not reviewed within the required time frame.	The attending or staff physician and other personnel involved in the recipient's care shall review each plan of care at least every 30 days. 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(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 107.01 § DHS 107.13(1)(b)8.b § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

Documentation provided does not demonstrate an accurate claim. The Diagnosis Related Group (DRG) code billed by the provider is not supported by the documentation.	Claims must be accurate and complete using diagnosis, place of service, type of service, procedure codes and other information specified by DHS under s. DHS 108.02(4) for identifying services billed on the claim. Unnecessary or inappropriate inpatient admissions or portions of a stay; are non-covered hospital 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 106.02(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.02(9) § DHS 106.03(2) § DHS 106.03(a) § DHS 107.01 § DHS 107.08(4)(a)1 § DHS 108.02(4) § 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)
Provider submitted claims for services billed as inpatient hospital services, when the documentation does not support the level of care billed.	Claims submitted must be accurate and complete using diagnosis, place of service, type of service, procedure codes and other information specified by DHS under s. DHS 108.02 (4) for identifying services billed on the 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 101.03(2) § DHS 101.03(96m) § DHS 106.02(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 106.03(2) § DHS 106.03(a) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
Provider submitted claim for inpatient services when the member did not meet the appropriate inpatient criteria.	A member is considered either an inpatient or outpatient but cannot be both. A member is considered an inpatient when the member is admitted to the hospital as an inpatient and meets one of the following criteria: (1) is counted in the midnight census (2) is a same day admission and discharge patient (3) who dies before the midnight census. If an event results in the member not meeting one of the criteria, the inpatient service is non-covered. DHS was unable to verify the actual provision of the Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.08(3)(c)3 § DHS 101.03(2) § DHS 101.03(96m) § DHS 106.02(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 107.01 § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)

Provider submitted claim for inpatient hospital institution for mental disease (IMD) services when the member did not meet the appropriate inpatient criteria.	A member is considered either an inpatient or outpatient but cannot be both. A member is considered an inpatient when the member is admitted to the hospital IMD as an inpatient and meets one of the following criteria: (1) is counted in the midnight census (2) is a same day admission and discharge patient (3) who dies before the midnight census. If an event results in the member not meeting one of the criteria, the inpatient service is non-covered. DHS was unable to verify the actual provision of the Medicaid-covered services, the appropriateness of the services, or the accuracy of the claim.	§ DHS 107.08(3)(c)3 § DHS 101.03(2) § DHS 101.03(96m) § DHS 106.02(2) § DHS 106.02(4) § DHS 106.02(5) § DHS 107.01 § DHS 107.13(1)(f)(4) § DHS 107.13(1)(f)(8) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)
Provider submitted a claim(s) for an IMD resident member aged 21 to 64 without a qualifying exception	WI Medicaid does not reimburse expenditures for any service to a person aged 21 to 64 who is a resident of an IMD, unless one of the following exceptions are met: ● The member was a resident of the IMD immediately prior to turning 21, and continues as a resident up to their 22nd birthday. ● The member was on convalescent leave from an IMD. 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(2) § DHS 101.03(96m) § DHS 106.02(2) § DHS 106.02(9) § DHS 107.13 § DHS 107.13(1)(f)(8) § DHS 108.02(9)		§ 49.45(2)(a)10 § 49.45(3)(f)