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July 2026 | A-07-24-04138

Wisconsin Physicians Service Insurance Corporation Made Incorrect Medicare Payments to Providers for Outpatient Services

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Why OIG Did This Audit

- A series of previous OIG audits of Medicare Part B services examined whether payments for outpatient services that Medicare administrative contractors made to providers in excess of the providers' billed charges were correct. Those audits found that some providers that billed charges in excess of the amounts that Medicare paid received incorrect payments.
- This audit, a followup to that previous series of OIG audits, assessed whether certain Medicare Part B payments that Wisconsin Physicians Service Insurance Corporation (WPS) made to providers that were in excess of billed charges were correct.

What OIG Found

- Of the 801 selected claim lines for which WPS paid providers during January 1, 2022, through December 31, 2023 (audit period), 138 claim lines were incorrect and resulted in overpayments totaling at least $140,182 that WPS made to providers.
- In addition, we identified 31 claim lines totaling $76,640 for which providers received Part B payments; however, there was no supporting documentation.
- Providers attributed the overpayments we identified to clerical errors and issues with their billing systems. In addition, WPS had system edits in place, but those edits, and WPS's review of payments flagged by those edits, did not always identify the claim lines that were in error, which resulted in the overpayments.

What OIG Recommends

We made five recommendations to WPS, including that it confirm the recovery of the $140,182 in overpayments. We also made procedural recommendations regarding the need to locate additional medical record documentation related to claim lines totaling $76,640 and recover any identified overpayments, the enhancement of existing system edits, and the enhancement of WPS's provider education activities. The full recommendations are in the report.

WPS concurred with all of our recommendations and described steps it had taken and planned to take to address them.

TABLE OF CONTENTS

APPENDICES

INTRODUCTION

WHY WE DID THIS AUDIT

Medicare uses an outpatient prospective payment system (OPPS) to pay providers for certain types of services, such as designated hospital outpatient services and certain Medicare Part B (Part B) services furnished to hospital inpatients who do not have Medicare Part A (Part A) coverage. For this reimbursement, the Medicare payment is based, not on the amount that the provider charges, but on a rate-per-service basis determined by the assigned ambulatory payment classification (APC) groups.

A series of previous Office of Inspector General (OIG) audits of Part B services examined whether payments that Medicare administrative contractors (MACs) made to providers in excess of the providers' billed charges were correct.[1, 2] Those audits found that some providers received incorrect Medicare payments for outpatient services that were in excess of the billed charges. In those previous audit reports, we recommended that, among other things, MACs work with the Centers for Medicare & Medicaid Services (CMS) to implement system edits to identify cases of improper payments that exceed billed charges.

This audit of one MAC, Wisconsin Physicians Service Insurance Corporation (WPS), is a followup to that previous series of OIG audits.

OBJECTIVE

Our objective was to determine whether certain Medicare Part B payments that WPS made to providers that were in excess of billed charges were correct.

BACKGROUND

Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Part A provides inpatient hospital insurance benefits and coverage for extended care services for patients after discharge, and Part B provides supplementary medical insurance for medical and other health services, including coverage of therapy services. CMS administers the Medicare program. CMS contracts with MACs to, among other things, process and pay claims submitted by health care providers, including Part B claims submitted by providers of outpatient services. There are 12 A/B MAC jurisdictions.

[1] MACs' responsibilities include determining reimbursement amounts, conducting reviews and audits, safeguarding against fraud and abuse, and maintaining adequate internal controls. The MACs evaluate, process, and pay Medicare claims submitted by providers.

[2] Previous OIG audits of payments in excess of billed charges are published on the OIG website.

Medicare Administrative Contractors' Responsibilities and Implemented System Edits

To process providers' outpatient claims, the MACs use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF verifies the enrollee's eligibility for Medicare, deductible status, available benefits, and claims history. The CWF can detect certain incorrect payments during prepayment validation.

In 2012, CMS implemented a "verification edit" (i.e., a system edit) for claims with OPPS payments in which the payments to providers exceeded the billed charges. CMS guidance (in the *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 1, § 140.3) instructs MACs to suspend those claims that the verification edit identifies and to contact providers to resolve billing errors. If the MAC then determines that the claim was billed incorrectly, the MAC should return the claim to the provider. If the MAC determines that the claim was billed correctly, the MAC should override the edit and pay the claim.

Claims for Outpatient Services

CMS implemented an OPPS, which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. The OPPS payment methodology uses Healthcare Common Procedure Coding System (HCPCS) codes to map clinically and financially related codes into an APC payment group. HCPCS codes include the American Medical Association's Current Procedural Terminology (CPT®) codes for physician services and CMS-developed codes for products, supplies, and services not included in the CPT codes. To receive payment under OPPS, providers submit claims with HCPCS codes for outpatient services provided to Medicare enrollees. MACs map the reported HCPCS codes to one or more APCs, and, together with the HCPCS codes' payment status indicators, determine the payment amount due to providers.[3] Providers must report charges for each HCPCS code on the claim, regardless of whether the code is paid separately or packaged into the APC payment.

The Social Security Act (the Act), Federal regulations, and CMS guidance require providers to submit accurate claims for services. The Manual also directs providers to use the appropriate HCPCS codes and to report units of service as the number of times that a service or procedure was performed. If the HCPCS code is associated with a prescription drug, the number of billable units administered—as defined by the HCPCS code description—should be reported.

CMS considers an overpayment as a Medicare payment that a provider has received in excess of amounts due and payable under statute and regulations. Some types of overpayments involve services billed with incorrect modifiers, services that lack supporting documentation, services

[3] Under the OPPS, each HCPCS code is assigned a payment status indicator, which specifies whether payment for that code is made separately or packaged into the APC payment. Status indicators can also provide other information such as indicating that the code is paid under another payment system.

that are unallowable for Medicare payment, and services billed with incorrect units of service.[4] In cases when an overpayment to a provider has been identified, the relevant MAC is responsible for collecting that amount and refunding it to the Federal Government.

Wisconsin Physicians Service Insurance Corporation

WPS administers Part A and Part B operations for enrollees in A/B MAC Jurisdiction 5, which includes the States of Iowa, Kansas, Missouri, and Nebraska.[5]

HOW WE CONDUCTED THIS AUDIT

Of the approximately 399 million claim lines for outpatient services that WPS processed during January 1, 2022, through December 31, 2023 (audit period), 801 claim lines from A/B MAC Jurisdiction 5 had: (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service.[6, 7, 8] The 801 claim lines we reviewed were associated with 50 providers in Jurisdiction 5 that received the selected Medicare payments. We contacted the providers that received the Medicare payments associated with the 801 claim lines and relied on the providers' determinations as to whether the Medicare payments for the selected claim lines were correct and, if not, why the payments were incorrect.

We obtained an understanding of WPS's organizational structure, policies and procedures regarding the processing and payment of Medicare claims, and protocols for communications with providers. In addition, our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data we obtained, but we did not assess the completeness of the data. We relied on the providers' determinations of the correctness of the claim lines that they had submitted for Medicare payment and did not use medical review to determine the allowability of the claim lines.

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[4] Modifiers are two-digit identifiers that are reported with HCPCS codes (as well as other procedure codes that are not relevant to this audit) to provide additional information about how an item, procedure, or service is provided, and to improve the accuracy of coding. Providers may use any applicable modifier where appropriate. For Medicare purposes, modifiers are used either as pricing or as informational and tracking indicators.

[5] WPS also administers Part A and Part B operations for enrollees in A/B MAC Jurisdiction 8, which includes the States of Indiana and Michigan. We did not review claim lines from Jurisdiction 8 for this audit.

[6] A single Medicare claim from a provider typically includes more than one claim line. In this audit, we did not review entire claims; rather, we reviewed specific claim lines that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charge amount" hereafter in this report.

[7] From the 817 claim lines that we had initially identified, we removed 15 claim lines associated with a provider that was under review and 1 claim line associated with a provider that was not located in Jurisdiction 5. Therefore, we reviewed 801 claim lines.

[8] We used the most recent data available at the start of the audit.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology.

FINDINGS

WPS made Medicare Part B payments in excess of charges to providers for outpatient services that were not correct. Specifically, of the 801 selected claim lines for which WPS paid providers during our audit period, 632 claim lines were correct. Of the remaining 169 claim lines, 138 claim lines were incorrect, resulting in overpayments totaling at least $140,182 that WPS made to providers. In addition, we identified 31 claim lines totaling $76,640 in payments for outpatient services for which WPS made Part B payments to providers, but for which the providers did not furnish supporting documentation.

Of the 138 incorrect claim lines for outpatient services for which WPS made Part B payments to providers, WPS had not processed corrected claims for 15 claim lines as of the end of our audit work. We therefore could not determine the associated overpayment amounts. The 15 claim lines had the following types of errors: incorrect modifiers (6 claim lines), unallowable services (6 claim lines), and incorrect number of units of service (3 claim lines).

Of these 138 incorrect claim lines for outpatient services, we identified the following types of errors made by providers.

- Providers incorrectly billed Medicare for 54 claim lines with incorrect modifiers, resulting in overpayments totaling at least $77,556. During our audit, the providers in question corrected all of these claim lines to address the overpayments, but as of the end of our audit work WPS had not processed six claim lines.

- Providers incorrectly billed Medicare for 14 claim lines for which the services were not allowable for Medicare payment, resulting in overpayments totaling at least $34,379. During our audit, the providers in question corrected all of these claim lines to address the overpayments, but as of the end of our audit work WPS had not processed six claim lines.

- Providers billed Medicare for 16 claim lines that had an incorrect number of units of service, resulting in overpayments totaling at least $28,247. During our audit, the providers in question corrected all of these claim lines to address the overpayments, but as of the end of our audit work WPS had not processed three claim lines.

- In addition, providers incorrectly billed Medicare for 54 claim lines that had incorrect charges. Because WPS paid the providers for these services under the OPPS payment methodology, these incorrect charges did not have any financial impacts on the payments that WPS made to these providers.

The table below summarizes our findings for the 169 claim lines.

Table: Types of Errors in Claim Lines for Outpatient Services

Type of Error	Number of Claim Lines	Overpayment Amount (at Least)	Unsupported Amount
Incorrect Modifiers	54	$77,556	
Unallowable Services	14	34,379	
Incorrect Number of Units of Service	16	28,247	
Incorrect Charges	54	0*	
Lack of Supporting Documentation	31		$76,640
Totals	**169**	**$140,182**	**$76,640**

***** WPS paid providers for these services under the OPPS payment methodology; therefore, these incorrect charges did not result in any overpayments.

According to providers, the errors we identified were the result of clerical errors, billing systems that could not prevent or detect the incorrect billing of units of service, and other types of billing errors. In addition, the providers associated with the 31 claim lines that lacked supporting documentation were no longer in business or did not have valid contact information on file with WPS. Because some providers acknowledged that their billing staffs had committed clerical errors, including the incorrect charges we identified, enhanced provider education can improve the accuracy of submitted Part B claims.

WPS had system edits in place to identify claim lines in which payments exceeded charges, but these edits, and WPS's review of the payments flagged by these edits, did not identify all of the claim lines that were in error, which resulted in the overpayments.

FEDERAL REQUIREMENTS AND GUIDANCE

The following requirements establish the Medicare billing standards that providers must follow to help ensure that claims are accurate, complete, and supported by sufficient documentation. Taken together, these requirements formed the basis of our assessments as to whether the providers' claims complied with Medicare requirements.

Section 1833(e) of the Act states: "No payment shall be made to any provider of services . . . unless there has been furnished such information as may be necessary in order to determine

the amounts due such provider . . . for the period with respect to which the amounts are being paid . . . ."

Federal regulations state: "The provider, supplier, or [enrollee], as appropriate, must furnish to the [MAC] sufficient information to determine whether payment is due and the amount of payment" (42 CFR § 424.5(a)(6)).

Federal regulations state: "A claim must be filed with the appropriate [MAC] on a form prescribed by CMS in accordance with CMS instructions" (42 CFR § 424.32(a)(1)).

Federal regulations exclude from coverage "[d]ental services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth" (42 CFR § 411.15(i)(1)).

The Manual, chapter 1, section 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately."

The Manual, chapter 17, section 90.2, states: "Hospitals should report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient."

If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, "[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 . . . ."

The *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, section 150, states: "As indicated under the general exclusions from coverage . . . items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered."

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION PAID PROVIDERS FOR CLAIM LINES THAT WERE INCORRECT

Of the 801 selected claim lines for which WPS paid providers during our audit period, providers billed Part B for 138 claim lines that were incorrect, resulting in overpayments totaling at least $140,182 that WPS made to providers.

Providers Incorrectly Billed Medicare for Claim Lines With Incorrect Modifiers

Of the 50 providers we reviewed in A/B MAC Jurisdiction 5 that received Part B payments, 7 providers incorrectly billed Part B for a total of 54 claim lines with incorrect modifiers. For 48 of the 54 claim lines, we obtained what the corrected payment amounts should be from the providers, verified that WPS had processed the corrected claims, and determined that the associated overpayments totaled $77,556. The providers in question refunded all of these overpayments during our audit. For the other six claim lines, WPS had not processed a corrected claim as of the end of our audit work, and we therefore could not determine the associated overpayment amounts.

For example, for one claim line with a date of service of December 18, 2023, the provider originally billed for 5 units of service for a procedure to remove premalignant lesions that may have been caused by sun-damaged skin or other skin conditions. The provider billed these units of service using CPT code 17003 with modifier 59.[9, 10, 11] During our audit, the provider stated that its use of this modifier and the resulting increased payment were incorrect because the documentation in the medical records did not reflect that the procedure met the requirements for use of modifier 59. The provider therefore determined that it should *not* have used modifier 59 on the claim line for this service and *should* have billed 5 units of CPT code 17003 without modifier 59. The provider said that as a result, it was "providing education" to staff to eliminate

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[11] CPT 17003 is an add-on code to the primary procedure (i.e., destruction of the first lesion) that is used to describe the destruction of 2nd to 14th premalignant lesions. Providers typically use this code when they remove these lesions using methods such as cryotherapy, laser therapy, or other techniques. According to the CMS's *National Correct Coding Initiative Policy Manual for Medicare Services*, chapter 1, section E.d., modifier 59 is used to identify procedures and services, other than Evaluation and Management services, that are not normally reported together but are appropriate under the circumstances. Documentation of these services must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same provider. See also footnote 4.

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these types of errors. WPS had originally paid the provider $1,012 for this claim line. The provider corrected this claim line by removing modifier 59, after which WPS processed the claim and its claim processing system adjusted the payment for this claim line to $0.[12]

Providers Incorrectly Billed Medicare for Claim Lines for Which the Services Were Not Allowable for Payment

Five providers incorrectly billed Part B for a total of 14 claim lines for services that were not allowable for Medicare payment. For eight of the claim lines in error, we obtained what the corrected payment amounts should be from the providers, verified that WPS had processed the corrected claims, and determined that the associated overpayments totaled $34,379. The providers in question refunded all of these overpayments during our audit. For the other six claim lines, WPS had not processed a corrected claim as of the end of our audit work, and we therefore could not determine the associated overpayment amounts.

For example, one provider incorrectly billed Part B for a claim line involving an outpatient dental procedure (repair of a tooth socket) that was unallowable for Medicare payment. The provider billed the units of service on this claim line using CPT code 41874.[13, 14] During our audit, the provider submitted a corrected claim (which removed the units of service for this procedure) to WPS, and WPS confirmed to us that this procedure was not allowable for Medicare payment and that WPS had processed the corrected claim. Because WPS had originally paid the provider $2,004 for this claim line and subsequently processed a corrected claim that paid $0, the entire amount of the $2,004 constituted (before the corrective actions) an overpayment.

Providers Billed Medicare for Claim Lines That Had Incorrect Numbers of Units of Service

Nine providers incorrectly billed Part B for a total of 16 claim lines, each of which had an incorrect number of units of service. For 13 of the claim lines in error, we obtained what the corrected payment amounts should be from the providers, verified that WPS had processed the corrected claims, and determined that the associated overpayments totaled $28,247. The providers in question refunded all of these overpayments during our audit. For the other three claim lines, WPS had not processed a corrected claim as of the end of our audit work, and we therefore could not determine the associated overpayment amounts.

For example, one provider incorrectly billed Part B for an incorrect number of units of service on one claim line for the administration of a medication used to treat rheumatoid arthritis. The

[12] This same provider reported (in response to our query about claim lines during our audit period) that it had incorrectly billed Medicare for nine claim lines (outside of our audit period) with an incorrect modifier (modifier 59). This provider submitted corrected claims totaling $7,096 in overpayments to WPS.

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[14] CPT code 41874 is for alveoloplasty, a surgical procedure performed to reshape the alveolar bone in preparation for dental implants or prostheses.

provider billed these units of service using HCPCS code J3262.[15] Because the provider incorrectly calculated the units of service, it billed for 400 units of this medication but should have billed for 200 units. During our audit, this provider submitted a corrected claim (reflecting 200 units of service) to WPS, and we verified that WPS had processed the corrected claim. Because WPS had originally paid the provider $1,933 for this claim line and subsequently processed a corrected claim that paid $966, the difference of $967 constituted (before the corrective actions) an overpayment.

Providers Incorrectly Billed Medicare for Claim Lines That Had Incorrect Charges

Thirteen providers incorrectly billed Part B for a total of 54 claim lines that had incorrect charges. Under the OPPS, these incorrect charges did not have any financial impact on the payments that WPS made to these providers.[16] However, Medicare regulations require providers to submit accurate claims for all services billed to Medicare. When these claims have errors, as in the case of incorrect charges (as well as the other types of errors discussed above), they could be indicative of weaknesses in the education that WPS (and other MACs) delivers to providers and their billing staffs.

For example, one provider submitted an incorrect charge on a claim line for the intravenous administration of a proteinase inhibitor. The provider billed the units of service on this claim line using HCPCS code J0256.[17] During our audit, the provider identified this error and stated that its pricing system had incorrectly reported the charge for this service. Because the incorrect charge had no impact on the APC payment made to the provider for this service, no financial adjustment was necessary. Therefore, the provider did not submit a corrected claim to WPS, nor was it required to do so.

PROVIDERS BILLED MEDICARE FOR CLAIM LINES THAT LACKED SUPPORTING DOCUMENTATION

Two providers billed Part B for a total of 31 claim lines totaling $76,640 in payments for outpatient services for which WPS made payments to providers; however, there was no supporting documentation. During our audit, we attempted to contact these two providers several times through various means, to no avail. In this regard, the contact information that WPS had on file for these providers was invalid. The two providers associated with the 31 claim lines either never responded to our correspondence or were no longer in business. Accordingly,

[15] HCPCS code J3262 is for the injection, Tocilizumab, 1mg, that is used for the treatment of certain inflammatory conditions. It is typically used to manage autoimmune disorders, most notably rheumatoid arthritis and cytokine release syndrome (a condition that occurs when the immune system is highly activated, leading to the rapid and excessive release of cytokines (proteins) into the bloodstream).

[16] See "Claims for Outpatient Services" earlier in this report.

[17] HCPCS code J0256 is for the Injection, alpha 1 proteinase inhibitor, 10mg. Proteinase inhibitors treat certain viral infections by preventing the virus from making more copies of itself.

because neither we nor WPS was able to contact these providers, we were unable to obtain medical record documentation that would support whether or not these 31 claim lines were correctly billed to Medicare.

CLERICAL ERRORS AND BILLING SYSTEM ISSUES, AS WELL AS SYSTEM EDITS THAT WERE NOT ALWAYS ADEQUATE, LED TO INCORRECT MEDICARE PAYMENTS

Providers attributed the overpayments we identified to clerical errors, to billing systems that could not prevent or detect the incorrect billing of units of service, and to other types of billing errors. The total number of errors we identified was relatively small in relation to all of the claim lines for outpatient services that providers submitted to WPS during our audit period.

Because some providers acknowledged that their billing staffs had committed clerical errors, including the incorrect charges we identified, enhanced provider education can improve the accuracy of submitted Part B claims. For example, one provider responded to our query about errors we found by explaining that it was "taking steps to improve our internal workflows and have provided re-education of staff . . . ."

In addition, although WPS had system edits in place to identify claim lines in which payments exceeded charges, these edits, and WPS's review of the payments flagged by these edits, could be improved because they were not always able to identify incorrect payments. The Manual instructs MACs to suspend payments for claims for which Medicare payments exceeded the billed charges. Moreover, if a MAC determines that the billing was accurate, the MAC can override the system edit and pay the provider for the claimed services. However, WPS's edits, and WPS's review of the payments flagged by these edits, did not identify all of the claim lines that were in error. Therefore, appropriate steps were not taken to ensure that these claim lines were not incorrectly paid.

RECOMMENDATIONS

- We recommend that WPS confirm to OIG that the $140,182 in overpayments associated with the 123 incorrect claim lines—for which WPS has already processed a corrected claim—has been fully recovered.

- We recommend that WPS locate the medical record documentation associated with the 31 claim lines totaling $76,640 in which WPS paid the 2 providers that we were not able to contact, determine whether those claim lines were supported and correctly paid, and recover any identified overpayments.

- We recommend that WPS work with the providers associated with the 15 incorrect claim lines for which WPS had not processed the corrected claims as of the end of our audit work and recover any identified overpayments.

- We recommend that WPS work with CMS to enhance existing system edits that identify line-item payments that exceed billed charges and that WPS enhance its processes for review of payments flagged by the enhanced system edits.

- We recommend that WPS use the results of this audit to enhance its provider education activities.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, WPS concurred with all of our recommendations and described corrective actions that it had taken or planned to take to address them.

For our first recommendation, WPS stated that it would verify the overpayment collections in its accounting system. For our second recommendation, WPS stated that it would attempt to locate documentation for the two providers that we were unable to contact, determine whether those claim lines were supported and correctly paid, and recover any identified overpayments. Regarding our third recommendation, WPS stated that it would work with providers associated with the 15 incorrect claim lines to identify and recover overpayments. WPS added that providers had already adjusted some claims. For our fourth recommendation, WPS described its current process for adjudicating claims when payments exceed charges and added that it would work to enhance any editing currently in place. Lastly, for our fifth recommendation, WPS stated that it would specifically address the appropriateness of coding of modifier 59, non-covered Medicare procedures such as outpatient dental procedures, correct units-of-service billing, and submission of accurate claims for payment. WPS added that it would also address the importance of having current contact information on file.

We commend WPS for the actions it has taken and plans to take to address our recommendations.

WPS's comments appear in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Of the approximately 399 million claim lines for outpatient services that WPS processed during our audit period, 817 claim lines from A/B MAC Jurisdiction 5 had: (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service (footnote 6).

From the 817 claim lines that we had initially identified, we removed 15 claim lines associated with a provider that was under review and 1 claim line associated with a provider that was not located in Jurisdiction 5. Therefore, we reviewed 801 claim lines (footnote 7).

We limited our review of WPS's internal controls to those that were applicable to the payments associated with the claim lines we reviewed, because our objective did not require an understanding of all internal controls over the submission and processing of claims. Specifically, we obtained an understanding of WPS's organizational structure, policies and procedures regarding the processing and payment of Medicare claims, and protocols for communications with providers. In addition, our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data we obtained, but we did not assess the completeness of the data. We relied on the providers' determinations of the correctness of the claim lines that they had submitted for Medicare payment and did not use medical review to determine the allowability of the claim lines.

We performed our audit work from August 2024 through May 2026.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and guidance
- Interviewed staff at WPS to obtain an understanding of WPS's policies and procedures regarding the processing and payment of Medicare claims
- Used the OIG, Division of Data Analytics, to identify claim lines for outpatient services that WPS processed during our audit period that had: (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service
- Identified (after removing 16 claim lines as discussed above) 801 claim lines, totaling approximately $2.7 million that Medicare paid to 50 providers, for review

- Contacted the 50 providers in Jurisdiction 5 that received the Medicare payments associated with the selected claim lines and relied on the providers' determinations as to whether or not the Medicare payments for the selected claim lines were correct and, if not, why the payments were incorrect

- Reviewed medical record documentation and billing information that the providers furnished to determine whether or not we agreed with the providers' determinations that each selected claim line had been billed correctly

- Reviewed, for claim lines that (according to the providers' determinations) had been incorrectly billed, the updated claim and billing information to determine whether the providers had corrected the claim line payments

- Obtained the corrected payment amounts, and the updated claim and billing information, from the providers, and used this information to determine the overpayments that WPS had processed and paid during our audit period

- Provided the results of our audit to WPS officials, discussed the results with those officials, and gave them detailed data on the 31 claim lines associated with the 2 providers that we were not able to contact

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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June 17, 2026
Mr. James I. Korn
Office of Audit Services, Region VII
1201 Walnut Street, Suite 1309
Kansas City, MO 64106

RE: Office of Inspector General (OIG) Draft Report- A-07-24-04138

Dear Mr. Korn,

This letter is in response to the OIG draft report titled *Wisconsin Physicians Service Insurance Corporation Made Incorrect Medicare Payments to Providers for Outpatient Services.*

The OIG objective was to determine whether certain Medicare Part B payments WPS made to providers in excess of billed charges were correct.

The OIG concluded that WPS made incorrect Medicare Part B payments in excess of charges to providers for outpatient services. Specifically, of the 801 selected claim lines for which WPS paid providers during the audit period, 632 claim lines were correct. Of the remaining 169 claim lines, 138 claims lines were incorrect, resulting in overpayment totaling at least $140,182 that WPS made to providers. In addition, the OIG identified 31 claim lines totaling $76,640 in payments for outpatient services for which WPS made Part B payments to providers, but providers did not furnish supporting documentation. WPS is committed to improving our processes in accordance with OIG's recommendations.

OIG Recommendations and WPS responses:

- We recommend that WPS confirm to the OIG that the $140,182 in overpayments associated with the 123 incorrect claim lines – for which WPS has already processed a corrected claim – has been fully recovered.

  WPS Response: WPS concurs with the OIG's recommendation. We will verify the overpayment collections in Health Integrated General Ledger Accounting System (HIGLAS).

- We recommend that WPS locate the medical record documentation associated with the 31 claim lines totaling in $76,640 in which WPS paid the 2 providers that we were not able to contact, determine whether those claim lines were supported and correctly paid, and recover any identified overpayments.

  WPS Response: WPS concurs with the OIG's recommendation. We will attempt to locate documentation for the two providers the OIG was unable to contact, determine whether those claim lines were supported and correctly paid, and recover any identified overpayments.

- We recommend that WPS work with the providers associated with the 15 incorrect claim lines for which WPS had not processed the corrected claims as of the end of our audit work and recover any identified overpayments.

WPS Response: WPS concurs with the OIG's recommendation. We will work with providers associated with the 15 incorrect claim lines to identify and recover overpayments. Some claims have already been adjusted by providers, therefore WPS will not need to contact all providers.

- We recommend that WPS work with CMS to enhance existing system edits that identify line-item payments that exceed billed charges and that WPS enhance its processes for review of payments flagged by the enhanced system edits.

  WPS Response: WPS concurs with the OIG's recommendation. We currently have reason code 39132 set up to adjudicate these claims through an Expert Claims Processing System (ECPS) event that was created in May 2012 with Change Request (CR) 7771 *New Fiscal Intermediary Shared System (FISS) Edit to Review Medicare Outpatient Prospective Payment System (OPPS) Payments Exceeding Charges*. We will work with the Shared System Maintainer to enhance any editing currently in place through the ECPS event.

- We recommend that WPS use the results of this audit to enhance its provider education activities.

  WPS Response: WPS concurs with the OIG's recommendation to enhance provider education activities, as they relate to this report's findings. Specifically, WPS will address the appropriateness of coding modifier 59, non-covered Medicare procedures (such as outpatient dental), correct units of service billing, submitting accurate claims for payment, and the importance of having current contact information on file.

If you have any questions or need additional information, please contact me at (608)977-5470.

Sincerely,

/s/ Angela Mitchell

Angela Mitchell
Executive Vice President

cc:

Phillip Smith, CMS
Christopher Kerr, CMS
Christopher Holder, OIG

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