Department of Health and Human Services
Office of Inspector General
Office of Audit Services

July 2025 | A-06-24-04001

Wisconsin Physicians Service Government Health Administrators Reopened and Corrected Cost Report Final Settlements for Desk Reviews Only With Obvious Errors To Correct Payments Made to Medicare Providers

REPORT HIGHLIGHTS

July 2025 | A-06-24-04001

Wisconsin Physicians Service Government Health Administrators Reopened and Corrected Cost Report Final Settlements for Desk Reviews Only With Obvious Errors To Correct Payments Made to Medicare Providers

Why OIG Did This Audit

- Medicare providers are required to submit annual cost reports to their Medicare administrative contractors (MACs). These financial documents convey the providers' costs associated with providing services to Medicare enrollees. MACs use the reports in determining the final amount owed providers for their cost reporting periods (the final settlements of the cost reports).
- MACs perform a mandatory desk review to determine the accuracy and reasonableness of the data contained in a provider's cost report. This process does not include detailed verification and is designed to identify issues that may warrant additional review in the form of an audit by the MAC.
- This audit assessed cost reports that one MAC, Wisconsin Physicians Service Government Health Administrators (WPS), reopened to correct final settlements. We performed this audit to determine whether any of the cost reports that WPS settled with a desk review only and then reopened to correct the final settlements contained obvious errors or were inconsistent with Medicare requirements.

What OIG Found

- Of the 15 cost reports that WPS settled with a desk review only and that WPS reopened to correct the final settlements, all of the associated desk reviews contained obvious errors or were inconsistent with Medicare requirements.
- WPS reported to us that errors in the 15 final settled cost reports were caused by a lack of effective controls and effective auditor training and by inadequate supervisory review.
- The 15 cost report reopenings resulted in corrected final settlements to providers totaling $1.2 million in net overpayments.

What OIG Recommends

We recommend that WPS develop and provide additional education to desk reviewers and supervisors on applicable criteria and review requirements; and that WPS develop and implement enhanced procedures so that supervisors are better qualified to detect incorrect adjustments.

WPS agreed with both of our recommendations and described the corrective actions it had taken to address them.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare-certified institutional providers, including hospitals, skilled nursing facilities, and home health agencies, among others, are required to submit an annual cost report to their Medicare administrative contractor (MAC).[1] Cost reports are financial documents that convey the provider's costs associated with providing services to people enrolled in Medicare and are used by MACs to determine the final amount of Medicare program reimbursement due providers for their cost reporting period (i.e., accounting year).

After performing a desk review of the cost report, the MAC issues a Notice of Program Reimbursement (NPR) to the provider. As the final settlement document, the NPR shows whether payment is owed to the provider or to Medicare. If there is an error made in the final settlement, the cost report final settlement can be reopened and adjusted to correct for the error.[2]

Some cost reports that have been desk reviewed and settled are later reopened to correct the final settlement. The MACs maintain supporting documents for the cost reports that they reopen, which include the reasons for the reopenings. These supporting documents include information related to the monetary adjustments to correct the final settlements. MACs submit cost report-related information to the Centers for Medicare & Medicaid Services (CMS).

We performed this audit to determine whether Wisconsin Physicians Service Government Health Administrators (WPS), which has multiple MAC jurisdictions (Jurisdictions 5 and 8) covering six States, reopened and corrected cost report final settlements because of desk review errors.[3, 4]

OBJECTIVE

Our objective was to determine whether, for the cost reports with a desk review only and that WPS reopened to correct the final settlements, any of the desk reviews contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by WPS**.**

[1] Social Security Act (the Act) § 1815(a); 42 CFR § 405.1801(b)(1); 42 CFR § 413.24(f).

[2] We refer to the reopening of cost report final settlements as the "reopening of cost reports" throughout the remainder of the report.

[3] MAC Jurisdiction 5 consists of the States of Iowa, Kansas, Missouri, and Nebraska. MAC Jurisdiction 8 consists of the States of Indiana and Michigan.

[4] See Appendix B for a list of related Office of Inspector General reports.

BACKGROUND

Medicare Program

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

Medicare Cost Reports

Certain institutional providers, such as hospitals, skilled nursing facilities, home health agencies, renal dialysis centers, hospices, rural health clinics, community mental health centers, federally qualified health centers, and organ procurement organizations, are required to submit annual cost reports to their MAC. CMS uses the financial and statistical data reported in the cost reports to set Medicare payment rates and calculate reimbursements for provider spending on medical education, uncompensated care, low-income patients, and high-cost Medicare cases. The cost report contains a series of worksheets with information on facility characteristics, health care utilization, employee salary and wage data, facility costs and charges, and Medicare settlement data.

Providers attest to the accuracy of the data when submitting their cost reports. After acceptance of each cost report, the MAC performs a tentative settlement, then performs a desk review of the cost report and conducts an audit, as appropriate, before final settlement.[5]

Medicare Administrative Contractor Cost Report Reviews

MACs serve as the primary operational contact between the Medicare fee-for-service program and the health care providers enrolled in the program. MACs perform many administrative activities, including desk reviews and audits of cost reports.

MACs must conduct desk reviews of cost reports for all providers that file a Medicare cost report. Exceptions are made for cost reports for hospices and for providers that have low or no Medicare utilization. A desk review is an analysis of the provider's cost report to evaluate its adequacy and completeness and determine the accuracy and reasonableness of the data contained in the cost report. This process does not include detailed verification and is designed to identify issues that may warrant additional review. The purpose of the desk review is to determine whether the cost report can be settled without an audit or whether an audit is

[5] 42 CFR § 413.64(f)(2); *Provider Reimbursement Manual*, CMS Pub. No. 15-1, part 1, § 2408.2; *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 20.

necessary.[6] All work performed by the MAC's staff during the desk review is subject to appropriate supervision, which includes instructing staff members, reviewing the work performed (supervisory review), and providing effective on-the-job training to ensure audit quality.[7] In contrast to the desk review, an audit is an examination of financial transactions that test the provider's compliance with the laws, regulations, and Medicare manual instructions.

At the conclusion of the desk review and a subsequent decision not to perform an audit, the MAC issues an NPR to the provider. As the final settlement document, the NPR shows whether payment is owed to the provider or to the Medicare program.

Cost Report Reopenings

A cost report final settlement may be reopened at the request of the provider or on the MAC's own initiative within 3 years of the date of the NPR to re-examine and adjust the final determination of the amount of total reimbursement due the provider (42 CFR § 405.1885).[8] The MAC's decision to reopen a settled cost report generally depends on whether new and material evidence has been submitted by the provider, an error was made during the final settlement process, or the settled cost report is found to be inconsistent with the law, regulations, and manual instructions (*Provider Reimbursement Manual*, part I, § 2931.2).

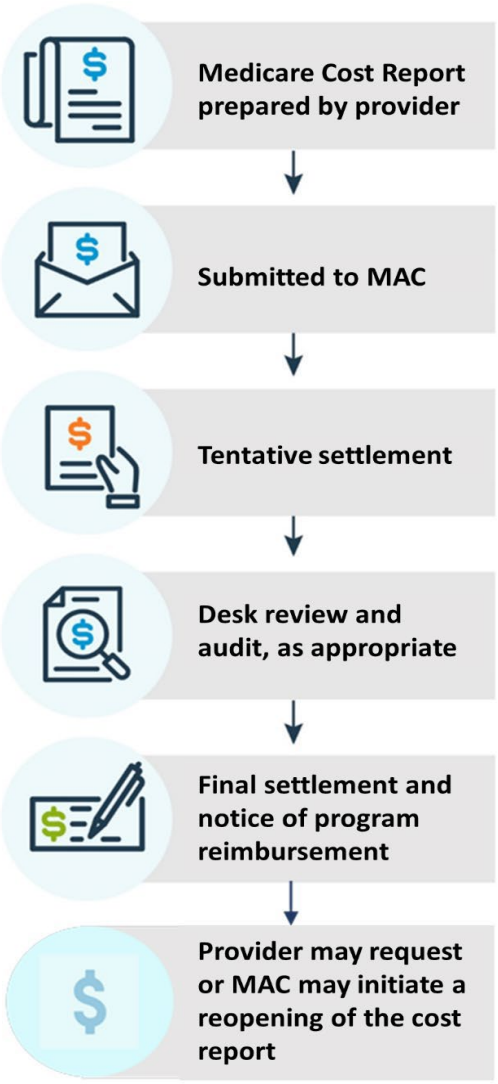
The figure on the following page depicts the Medicare cost report submission, review, settlement (tentative and final), and reopening process.

[6] *Medicare Financial Management Manual,* CMS Pub. No. 100-06, chapter 8, § 20.1**.**

[7] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, §§ 20.3 and 60.13.

[8] A MAC may reopen and revise a final settlement at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision.

Figure: Medicare Cost Report Process



HOW WE CONDUCTED THIS AUDIT

For both WPS MAC jurisdictions, we obtained information regarding 15 final settled cost reports for fiscal years (FYs) ending in 2016 and 2017 and for which WPS performed a desk review only,[9] and which had been reopened because of 1 or more errors on WPS's part. For these 15 cost report reopenings, we obtained workpapers, adjustments, and final settlement summaries to identify: whether the provider requested the reopening or WPS initiated the reopening, the reasons for the reopening, and the effect of the corrected final settlement.

[9] We audited reopened cost reports for fiscal years ending (FYE) in 2016 and 2017 because there can be a significant delay, more than 3 years, between the cost report FYE and the reopened and revised final settlement to correct any errors associated with the MAC's desk review. The figure on this page of this report depicts the Medicare cost report submission, review, settlement (tentative and final), and reopening process.

When applicable, WPS officials furnished, and we reviewed, a description of the reasons the cost reports with a desk review only were reopened to correct final settlements that contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions.

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 the details of our audit scope and methodology.

FINDING

FIFTEEN REOPENED COST REPORTS INVOLVED OBVIOUS ERRORS BY WISCONSIN PHYSICIANS SERVICE GOVERNMENT HEALTH ADMINISTRATORS

We determined that of the 15 cost reports that WPS settled with a desk review only and that WPS reopened to correct the final settlements, all of the associated desk reviews contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by WPS. These errors involved omitting, misclassifying, misreporting, miscalculating, or duplicating adjustments.

Below are examples of the reopening adjustments for obvious errors in 2 of the 15 cost reports' final settlements.

According to WPS, it reopened one of the final settled cost reports because its desk review had misclassified the provider as a low-volume provider. WPS added that during its desk review, it did not apply the correct effective date for the provider's low-volume payment adjustment; WPS therefore reopened this cost report to reflect the actual low-volume effective date. Adjustments in the reopening of the final settlement corrected the previous overpayment of $215,427 to this provider.

According to WPS, for another cost report, it reopened the final settled cost report on its own initiative because its desk review had duplicated charges for drugs charged to patients. Reopening adjustments of the final settlement corrected an underpayment of $20,608 to this provider.

WPS officials reported that the errors in the 15 final settled cost reports were caused by a lack of effective controls or auditor training and by inadequate supervisory review.

The 15 cost report reopenings resulted in corrected final settlements to providers totaling $1,155,040 in net overpayments (which consisted of $1,212,608 in overpayments and $57,568 in underpayments). Moreover, although an analysis of time delays was not part of our

methodology for this audit, the risk exists that delays in the finalization of desk-reviewed cost reports could prevent some Medicare funds from being expended in the most efficient and effective ways.

Appendix C provides the details about the desk review errors, including descriptions of the errors and why they occurred, information on specific Medicare requirements, identification of which entity detected the errors, and the incorrect payment amounts.

RECOMMENDATIONS

We recommend that Wisconsin Physicians Service Government Health Administrators:

- develop and deliver additional education regarding applicable criteria and review requirements to auditors who perform desk reviews and supervisors who oversee the process, and

- develop and implement enhanced procedures so that supervisors are better qualified to detect incorrect adjustments.

WISCONSIN PHYSICIANS SERVICE GOVERNMENT HEALTH ADMINISTRATORS COMMENTS

In written comments on our draft report, WPS concurred with both of our recommendations and described the corrective actions it had taken to address them. These actions include implementing enhancements to its processes, including educational awareness activities, and periodically updating its supervisory review program.

Specifically, for our first recommendation WPS stated that since FYs 2016 and 2017, it had "consistently reviewed its audit and desk review work processes for continuous process improvement." According to WPS, these measures included both internal quality control reviews and various annual external audits. WPS added that it had implemented several educational awareness activities, including an internal informational newsletter, a supplemental desk review checklist, and a "phased approach" whereby a newly hired auditor "must demonstrate proficiency at one task before moving on to a more difficult task."

For our second recommendation, WPS stated that it had periodically updated its supervisory review program to incorporate feedback from internal and external quality control reviews and to use a checklist to evaluate the "procedural quality" of its desk reviews. WPS also said that in 2018, it adopted a quality review process to incorporate a tertiary level of review, completed by a different supervisor from the one who had performed the original supervisory review, for "certain complex desk reviews and audits before the final settlement is issued."

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For both WPS MAC jurisdictions, we obtained information regarding 15 final settled cost reports for FYs ending in 2016 and 2017 and for which WPS performed a desk review only (footnote 9), and which had been reopened because of 1 or more errors on WPS's part. For these 15 cost report reopenings, we obtained workpapers, adjustments, and final settlement summaries to identify: whether the provider requested the reopening or WPS initiated the reopening, the reasons for the reopening, and the effect of the corrected final settlement.

We assessed internal controls necessary to satisfy the audit objective. In particular, we gained an understanding of and reviewed WPS's policies and procedures regarding supervisory review before the final settlement of cost reports. On the basis of these audit steps, we assessed WPS's ability to detect errors in the desk reviewed-only cost reports.

We performed audit work from April 2024 through April 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and Medicare manual instructions;
- obtained and reviewed workpapers, adjustments, and final settlement summaries from WPS that were related to cost reports with a desk review only that were subsequently reopened for FYs 2016 and 2017;
- obtained and reviewed, for the 15 cost report reopenings, the reopening documentation, including the reasons for the reopening, the root causes of the errors that WPS identified, and the impacts of the reopened final settlements;
- obtained and reviewed WPS's policies and procedures for its desk reviews, its reopening process, and its process for supervisory review;
- assessed the adequacy of WPS's supervisory review to detect errors in cost reports for which WPS performed a desk review only; and
- discussed the results of our audit with WPS officials.

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 B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
National Government Services, Inc. Reopened and Corrected Cost Report Final Settlements With Obvious Errors to Collect Overpayments Made to Medicare Providers	A-06-24-05000	10/28/2024
Novitas Solutions, Inc., Reopened and Corrected Cost Report Final Settlements With Obvious Errors To Collect Overpayments Made to Medicare Providers	A-06-23-05001	9/11/2024
Noridian Healthcare Solutions Reopened and Corrected Cost Report Final Settlements To Collect $11 Million in Net Overpayments That Had Been Made to Medicare Providers	A-06-22-05000	11/1/2023

APPENDIX C: DESK REVIEW ERROR DETAILS

Reopened Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by WPS on the Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
1	WPS misreported level payment amounts.	Inadequate supervisory review did not detect this mistake.	Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare enrollee by a hospital will equal the sum of the appropriate prospective payment rates for operating costs, capital-related costs, and additional costs and payments as applicable (42 CFR § 412.110). The provider must furnish such information to the MAC as may be necessary to— (i) Assure proper payment by the program; (ii) Receive program payments; and (iii) Satisfy program overpayment determinations (42 CFR § 413.20). After reviewing a cost report and any audit findings pertaining to it, the MAC determines the total allowable cost for the period of provider operations covered by the cost report and the total reasonable cost reimbursement due the	WPS	($18,000)

Reopened Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by WPS on the Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			provider for the services furnished during this period. When these determinations have been made, a final retroactive adjustment, if required, is made by the MAC. In making a final adjustment, the MAC reduces the payment by any monies owed the program by the provider (CMS Pub. 15-1, § 2408.4).		
2	WPS misreported pass-through payment amounts.	Inadequate supervisory review did not detect this mistake.	Providers of services paid on the basis of the reasonable cost of services furnished to enrollees will receive interim payments approximating the actual costs of the provider. These payments will be made not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of a reporting period (42 CFR § 413.64).	WPS	(13,983)
3	WPS miscalculated the final Supplemental Security Income (SSI) adjustment.	Inadequate supervisory review did not detect this mistake.	A hospital's disproportionate share percentage is calculated, in part, by: (1) determining the number of patient days for patients entitled to both Medicare Part A and	WPS	0

Reopened Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by WPS on the Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			SSI for the Federal FY and (2) dividing that number by discharge days for Medicare Part A patients (42 CFR § 412.106(b)(2)). A hospital can change from Federal FY to its cost reporting period in calculating patient days (42 CFR § 412.106(b)(3)). For hospitals with at least 100 beds located in an urban area and serving low-income patients, a disproportionate share adjustment factor is applied that reflects the higher costs attributable to furnishing services to indigent patients (42 CFR § 412.312).		
4	WPS misreported interim payment amounts.	Inadequate supervisory review did not detect this mistake.	Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare enrollee by a hospital will equal the sum of the appropriate prospective payment rates for operating costs, capital-related costs, and additional costs and payments as applicable (42 CFR § 412.110). The provider must furnish such information to the	WPS	171,236

Reopened Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by WPS on the Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			MAC as may be necessary to— (i) Assure proper payment by the program; (ii) Receive program payments; and (iii) Satisfy program overpayment determinations (42 CFR § 413.20). After reviewing a cost report and any audit findings pertaining to it, the MAC determines the total allowable cost for the period of provider operations covered by the cost report and the total reasonable cost reimbursement due the provider for the services furnished during this period. When these determinations have been made, a final retroactive adjustment, if required, is made by the MAC. In making a final adjustment, the MAC reduces the payment by any monies owed the program by the provider (CMS Pub. 15-1, § 2408.4).		
5	WPS omitted full-time equivalent (FTE) reduction	Inadequate supervisory review did not	Use Worksheet E-Part A to calculate allowable FTEs (CMS Pub. 15-2, § 4030.1). Use	WPS	16,459

Reopened Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by WPS on the Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
	for displaced residents.	detect this mistake.	Worksheet E-4 to calculate direct graduate medical education costs related to certain approved hospital teaching programs (CMS Pub. 15-2, § 4034).		
6	WPS duplicated patient drug charges.	Lack of auditor training.	To assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare enrollees, the MAC, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs (CMS Pub 15-1, § 2203).	WPS	(20,608)
7	WPS misreported an adjustment related to medical devices.	Inadequate supervisory review did not detect this mistake.	If the expenses for chargeable implantable devices are accumulated together with non-chargeable implantable devices in the "Central Services" general ledger account and are reported in that cost center (line 14 on Worksheet A), do not include the high-cost chargeable implantable devices expenses on Worksheet A, line 72. Rather, allocate the costs	Provider	(3,540)

Reopened Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by WPS on the Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			in column 14 of Worksheet B to line 72 (and other lines) using the recommended "costed requisitions" statistics (CMS Pub. 15-2, § 4013).		
8	WPS misclassified provider as low volume.	Lack of effective controls and auditor training.	CMS provides an additional payment to a qualifying hospital for the higher incremental costs associated with a low volume of discharges (42 CFR § 412.101).	WPS	215,427
9	WPS misreported housekeeping square footage.	Inadequate supervisory review did not detect this mistake.	Providers receiving payment on the basis of reimbursable cost must provide adequate cost data (42 CFR § 413.24).	WPS	(1,437)
10	WPS misreported the final settlement for this provider.	Inadequate supervisory review did not detect this mistake.	After reviewing a cost report and any audit findings pertaining to it, the MAC determines the total allowable cost for the period of provider operations covered by the cost report and the total reasonable cost reimbursement due the provider for the services furnished during this period. When these determinations have been made, a final retroactive adjustment, if required, is made by the MAC. In making a final	WPS	256,225

Reopened Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by WPS on the Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			adjustment, the MAC reduces the payment by any monies owed the program by the provider (CMS Pub. 15-1, § 2408.4).		
11	WPS misclassified a rural health clinic (RHC) as eligible for an exception to the per-visit limit.	Lack of auditor training.	Prior to April 1, 2021, a provider-based RHC that is an integral and subordinate part of a hospital could receive an exception to the per-visit payment limit if: the hospital had fewer than 50 beds; or the hospital's average daily patient census count of those beds did not exceed 40; and the hospital meets both of the following conditions: it was a sole community hospital or an essential access community hospital, and it was located in a level 9 or level 10 Rural-Urban Commuting Area. The exception to the payment limit applied only during the time that the RHC met the requirements for the exception (42 CFR § 412.105(b); CMS Pub. 100-2, chapter 13, § 70.2).	WPS	189,952

Reopened Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by WPS on the Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
12	WPS misreported the final settlement for this provider.	Inadequate supervisory review did not detect this mistake.	Providers of services paid on the basis of the reasonable cost of services furnished to enrollees will receive interim payments approximating the actual costs of the provider. These payments will be made not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of a reporting period (42 CFR § 413.64).	WPS	0
13	WPS omitted some paid dates and interim payment amounts.	Inadequate supervisory review did not detect this mistake.	Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare enrollee by a hospital will equal the sum of the appropriate prospective payment rates for operating costs, capital-related costs, and additional costs and payments as applicable (42 CFR § 412.110). The provider must furnish such information to the MAC as may be necessary to— (i) Assure proper payment by the program; (ii) Receive program payments; and (iii) Satisfy	WPS	76,450

Reopened Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by WPS on the Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			program overpayment determinations (42 CFR § 413.20). After reviewing a cost report and any audit findings pertaining to it, the MAC determines the total allowable cost for the period of provider operations covered by the cost report and the total reasonable cost reimbursement due the provider for the services furnished during this period. When these determinations have been made, a final retroactive adjustment, if required, is made by the MAC. In making a final adjustment, the MAC reduces the payment by any monies owed the program by the provider (CMS Pub. 15-1, § 2408.4).		
14	WPS miscalculated FTE counts for the short-period cost report.	Inadequate supervisory review did not detect this mistake.	If the hospital's unweighted and weighted number of FTE residents exceeds the limit, the respective primary care and obstetrics and gynecology weighted FTE and other weighted FTE counts are adjusted to make the total weighted	WPS	168,244

Reopened Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by WPS on the Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			FTE count equal the limit. If the number of weighted FTE residents does not exceed that limit, then the allowable weighted FTE count is the actual weighted FTE count (42 CFR § 413.79 (c)(2)(iii)).		
15	WPS misclassified provider as low volume.	Lack of auditor training.	CMS provides an additional payment to a qualifying hospital for the higher incremental costs associated with a low volume of discharges (42 CFR § 412.101).	WPS	118,615

* As reported by WPS.

† If the provider detected the error, the provider requested that WPS reopen the cost report final settlement. If WPS detected the error, WPS initiated the reopening of the cost report final settlement.

‡ WPS corrected overpayments/underpayments during the reopening of the final settlement.

APPENDIX D: WISCONSIN PHYSICIANS SERVICE GOVERNMENT HEALTH ADMINISTRATORS COMMENTS

Wisconsin Physicians Service Insurance Corporation
A CMS Medicare Contractor
1717 W. Broadway | P.O. Box 1787 | Madison, WI 53708-1787

June 10, 2025

Patricia Wheeler
Regional Inspector General for Audit Services
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: Report Number: A-06-24-04001

Dear Ms. Wheeler:

Wisconsin Physicians Service Insurance Corporation (WPS) appreciates the opportunity to review and address the facts and recommendations presented by the Department of Health and Human services, Office of Inspector General (OIG) in its draft report A-06-24-04001. In the introduction to the draft report, the OIG states "[i]f there is an error made in the final settlement, the cost report final settlement can be reopened and adjusted to correct for the error. Some cost reports that have been desk reviewed and settled are later reopened to correct the final settlement. The MACs maintain supporting documents for the cost reports that they reopen, which include the reasons for the reopenings." While following this CMS-approved process, WPS believes it is important to note that, throughout the two fiscal years audited (FY2016 and FY2017), WPS completed 6,688 desk reviews for both the J5 and J8 jurisdictions, and self-identified 14 of the cost reports which required reopening (one reopening was done at provider request). The 15 reopened reports represent 0.22% of the total population of desk reviews completed. WPS detected the errors in 14 of the cost reports identified in the audit through its Internal Quality Control (IQC) review processes. Those cost reports (including the single provider-requested cost report) were reopened, and any under- or overpayment in final settlements were corrected by WPS.

OIG recommended the following in the draft report:

1.) WPS "develop and provide additional education to desk reviewers and supervisors on applicable criteria and review requirements."

WPS Response: WPS concurs with this recommendation. Since FYs 2016 and 2017, WPS has consistently reviewed its audit and desk review work processes for continuous process improvement. As a result, WPS has been able to quickly address areas identified through its own Internal Quality Control (IQC) review process to enhance controls and internal oversight procedures. Additionally, WPS has had consistent agency oversight through various annual external audits (e.g., Quality Audit Surveillance Plan (QASP), Statement on Standards for Attestation Engagements (SSAE) 16 (superseded by SSAE 18 in 2017). WPS has implemented a multitude of enhancements to its processes, including educational awareness activities with several examples detailed below:

A. WPS regularly publishes an internal newsletter called the *Audit Advisor*, which is informational and provides guidance and education/training material to WPS audit staff on relevant issues. It is reviewed in detail with all audit staff and communicates important topics to continuously improve the overall quality of desk review and audit work.

B. WPS utilizes a supplemental desk review checklist to identify areas above and beyond what the CMS uniform desk review program requires. This was built out of experience in understanding various complexities of the audit process and the desire to exceed the government's standard review practices.

C. In 2021, WPS established a new process for the audit and supervisory staff to report opportunities for improvement of existing forms, procedures, and training. These enhancements are then made by experts on the various topics from WPS' Audit Advisement area.

D. WPS' new-hire training program utilizes effective learning and skill development principles with a phased approach where the auditor must demonstrate proficiency at one task before moving on to a more difficult task. This establishes a strong foundation and ensures readiness for new team members in tackling complex audit issues. An experienced team member is also assigned as a mentor to help guide the new auditor as they begin their initial work assignments.

2.) WPS "develop and implement enhanced procedures so that supervisors are better qualified to detect incorrect adjustments."

WPS Response: WPS concurs with this recommendation. Since FYs 2016 and 2017, WPS has had in place an Internal Quality Control (IQC) process to review desk reviews and audits, and the results of these reviews are shared quarterly with supervisors and managers. This helps identify areas of improvement and opportunity in our training, forms, processes, and other factors.

A. The WPS supervisory review program has been periodically updated to incorporate feedback from external QASP and IQC reviews. A checklist that includes a scoring mechanism that evaluates desk review procedural quality is employed. In addition, there is a step that traces adjustments to the adjusted cost to ensure the proper application of adjustments and flow through to the cost report.

B. In 2018, WPS adopted a Field Quality review process to incorporate a tertiary level of review on certain complex desk reviews and audits before the final settlement is issued. This is completed by a different supervisor from the one performing the original supervisor review and provides an independent assessment of the cost report.

In conclusion, WPS acknowledges and concurs with the recommendations provided in the report and, as it has done over the years since the audited work was completed, will continue to develop and deliver additional education and enhance procedures to reduce and strive to eradicate the errors that can result in inaccurate payments as they are identified. Thank you for the opportunity to comment on this draft report and the provided recommendations.

Sincerely,

Angela Mitchell
Sr. Vice President – Government Services

cc: James Wilkerson, CMS
Phillip Smith, CMS
Robert Bernal, CMS
Matthew Odom, OIG

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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