Office of the Inspector General (OIG) Fact Sheet

Established in October 2011, OIG consolidates all program integrity, audit, and fraud investigation activities into one office. Since its beginning, it has saved taxpayers millions of dollars. Staff works closely with other state and local partners to identify misuses of public assistance funds, and where appropriate, forwards fraud cases to federal, state, and local officials for prosecution.

Fraud

Fraud is any intentional act or omission designed to deceive others in order to get undeserved money or other items of value. Examples of fraud include:

- Accepting kickbacks for referring Medicaid patients to a particular provider
- Billing a long-term care program for services that were not provided
- Billing for services for a recipient or provider who is incarcerated or deceased
- Billing inflated hours to an agency providing home healthcare
- Failing to accurately report on applications who and how many people make up a household
- Forging or altering documentation
- Overstating needs on the Personal Care Screening Tool or Long Term Care Functional Screen
- Receiving benefits in more than one state at a time

Abuse

Abuse is behaving improperly or unreasonably, or misusing your position or authority. Examples of abuse include:

- Intentionally using the wrong billing code resulting in a higher payment
- Performing and billing for medically unnecessary services

Waste

Waste is squandering money or resources, even if it's not actually illegal or intentional. It could be getting more of something due to a clerical error. Examples of waste include:

- Prescription is written for 30 days but the pharmacy fills for 90 days
- Indicating a prescription as brand name medically necessary when the generic equivalent could have safely and effectively been used

Programs and Services within OIG

Monitor and Audit Providers

The Medical and Program Audit Review sections focus on preventing, detecting, and investigating provider fraud, waste, and abuse in Wisconsin's Medicaid program.

Track Retailer/Recipient Fraud
The Fraud Investigation, Recovery, and Enforcement section investigates possible recipient fraud in DHS programs like BadgerCare Plus, Medicaid, and FoodShare, as well as retailer fraud in the WIC program.

Perform Internal Audits
Internal auditors objectively investigate and evaluate DHS programs and processes to improve operations, reduce risk, increase efficiency, and provide oversight.

Analyze Data
The Data Analytics section collects and analyzes data used by OIG in audits and investigations, and reports monthly statistical results.

Support Partners
OIG staffers work closely with our partners, helping with verifications, collections, and overpayments. They also provide technical auditing and accounting guidance to providers.

Provide Accountability
OIG issues information and reports detailing the success of its efforts to fight fraud, taxpayer savings, and audit results.

Report Public Assistance Fraud
The OIG investigates fraud tips for any type of abuses of public resources. If the OIG finds violations of state and federal laws, it works with law enforcement and the Department of Justice to take the appropriate action.

Misuse of public funds affects each person who lives in Wisconsin. The Department encourages the public to report any fraudulent use of public assistance dollars through our fraud hotline 1-877-865-3432 or through the fraud reporting website https://www.reportfraud.wisconsin.gov. You may upload supporting documentation and reports in the Portal as well.

The OIG and its partners need as much information as possible to conduct a complete investigation. That should include:

- Complainant information including date of complaint and contact information
- Member information (Medicaid ID, birthdate, location information, etc.)
- Provider information (Medicaid ID, NPI, location information, etc.)
- Detailed description of allegation and how the allegation was identified
- Potential overpayment amount (if appropriate)
- Time frame in which allegation occurred
- Whether there is an ongoing investigation (if appropriate)
- Whether there is a credible allegation of fraud
- Any and all supporting documentation to support the allegation including claims data, documentation reviewed, or any other analysis

OIG uses the information in the complaint to begin a thorough investigation. This may include expanding the review to all relevant claims and encounter data or reaching out for additional information from the original complainant. OIG then determines the next course of action depending on the findings of the case. Potential outcomes could include an unsubstantiated claim due to lack of evidence, a corrective action plan to mitigate similar issues in the future, or a credible allegation of fraud to Medicaid Fraud Control and Elder Abuse Unit (MFCEAU).