Office of the Inspector General Overview

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Green Bay Coders Presentation
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About the OIG

- The Office of the Inspector General (OIG) protects Wisconsin taxpayers by preventing, identifying, and investigating fraud, waste, and abuse in public assistance programs administered by the Department of Health Services (DHS).
- The OIG's program integrity activities uphold DHS' mission, vision, and values to protect and promote the health and safety of the people of Wisconsin while managing public resources responsibly.

OIG Mission and Vision

- **Mission**: Protecting the people of Wisconsin by preventing, detecting, and investigating fraud, waste, and abuse of DHS programs.

- **Vision**: The OIG is an influential leader in program integrity, leveraging cutting edge strategies with the greatest impact protecting taxpayers and public program beneficiaries.

OIG Staffing

- The OIG has 108.3 staff positions that include:
  - 98.8 Full Time Equivalent (FTE) positions
  - 9.5 Contractor or Limited Term Employment (LTE) positions

Anthony Baize
Inspector General

Tabitha Ramminger
Deputy Inspector General

Section Responsibilities

Safeguarding DHS programs from fraud, waste, and abuse.

About OIG Sections

- The OIG consists of the following 7 sections:
  - Administrative Office
  - Business Intelligence Section
  - Clinical Program Integrity and Compliance Section
  - Program Integrity and Compliance Section
  - Fraud Investigation and Recovery Enforcement Section
  - Internal Audit Section
  - Provider Enrollment and Research Section

Administrative Office

- Provides administrative and professional support for all OIG functions.
- Consists of the following team members:
  - The Inspector General, Deputy Inspector General, Budget and Policy Analyst, and Communications Specialist.
  - Office support staff who oversee daily administrative and front desk duties.
  - Nurse Consultants who manage the Payment Integrity Review program.

Payment Integrity Review Program

- Implemented on April 1, 2023 for ForwardHealth providers.
- Authorized under Wis. Admin. Code DHS §§§ 106.08(3)(d), 106.11, and 107.02(2) to prevent potential fraud, waste, and abuse by allowing the OIG to:
  - Proactively review select, provider-submitted claims prior to payment to ensure that federal and state requirements are met.
  - Offer enhanced, compliance-based technical assistance to meet the specific needs of providers.
  - Increase monitoring of high risk benefit and service areas.

Business Intelligence Section

- Provides data analytics and vendor support for OIG operations, including:
  - Responding to internal and external data requests.
  - Leading and supporting OIG-based systems development.
  - Assisting with business automation and process support.
  - Documenting procedures.

Clinical Program Integrity and Compliance Section

- Subdivided into 2 units that consist of Registered Nurses who focus on the clinical activities of providers, including:
  - Conducting Medicaid post-payment audits through provider-focused teams.
  - Conducting Medicaid Caregiver Background Check audits.
  - Supporting provider investigation and enrollment review activities.
  - Providing program integrity-focused education and technical assistance.

Program Integrity and Compliance Section

- Subdivided into 2 units that consist of Financial Auditors, Registered Nurses, and Certified Medical Coders who are responsible for:
  - Conducting Medicaid post-payment audits through provider-focused teams.
  - Auditing cost reports from Rural Health Centers (RHC), Federally Qualified Health Centers (FQHC), and facilitates interim and quarterly payments.
  - Auditing the federal Electronic Health Records (EHR) Incentive program.
  - Providing program integrity-focused education and technical assistance.

Provider-Focused Teams

- To develop provider-specific strategies that enhance program integrity and reduce or eliminate fraud, waste, and abuse, CPICS and PICS were matrixed into 8 provider-focused teams below in early 2019:

- **CPICS-led teams:**
  - Homecare
  - Primary Care and Specialty
  - Rehab/Restore
  - Mental Health and Substance Use

- **PICS-led teams:**
  - Managed and Long Term Care
  - Pharmacy
  - County/Institutional
  - Service Fulfillment

Audit Process

- Identify audit scope.
- Mail Records Request letters to providers or run data.
- Receive records or conduct onsite visit to obtain records.
- Review records and issue preliminary findings letter and report.
- Review rebuttal and amend findings, as appropriate.
- Issue Notice of Intent to Recover letter.
- Participate in the appeal, if one is filed.
- Establish accounts receivable to collect overpayments.
- Complete any provider education or other measures.

Common Audit Findings

The following audit findings list is not intended to be all inclusive:

- Billing in excess of services provided
- Bundled services billed individually (unbundling)
- Duplicate billing
- Lack of documentation
- Lack of a prescriber's order
- Incorrect procedure codes
- Services are not medically necessary

Common Coding Error Audit Findings

- Upcoding, or billing in excess of services provided, is a common coding error audit finding.
- When upcoding occurs, a higher level code was billed than was provided or supported by documentation. Examples include:
  - A preventative office visit was coded and billed as 99396, while documentation supports 99212.
  - A provider bills for surgical tooth extraction D7210, despite documentation that only supports regular extraction D7140.
  - A provider bills for 60-minute psychotherapy encounter 90837, despite documentation listing only 45 minutes for code 90834.

Common Coding Error Audit Findings

- Unbundling, or billing several procedures separately, is another common coding error audit finding.
- When this occurs, multiple codes are billed rather than using a single comprehensive code. Examples include:
  - Separately billing component codes for a basic metabolic panel (82330,82374, 82435, 82565, 82947, 84132, 84295, and 84520) rather than billing comprehensive panel code 80047.
  - Billing for pulse oximetry 94760, despite this being included with same day Evaluation and Management (E/M) visit vital signs.

Audit and Recoupment Authority

- Audit authority is codified in Wis. Stat. § 49.45(2)(b)(4).
- Recoupment authority is codified in Wis. Stat. § 49.45(3)(f) and Wis. Admin. Code DHS § 108.02(9).
- OIG has the authority to recoup overpayments when:
  - The service was **not** provided.
  - The claim was **not** accurate.
  - The claim was **not** appropriate.

Other Mitigation Options

- In addition to recoupment, the OIG has the following tools to mitigate audit-discovered fraud, waste, and abuse:
  - Education and technical assistance.
  - Intermediate Sanctions under Wis. Admin. Code § DHS 106.08.
  - Termination from Medicaid under Wis. Admin. Code § DHS 106.06.
  - Referral to a partner agency for further investigation and possible prosecution.

Fraud Investigation, Recovery and Enforcement Section

- Responsible for mitigating recipient fraud and supporting Women, Infants, and Children (WIC) program vendor compliance through 3 units:
  - Public Assistance Reporting Information System (PARIS) and Trafficking Enforcement Unit.
  - Investigation and Technical Assistance Unit.
  - WIC Vendor and Integrity Unit.

PARIS and Trafficking Enforcement Unit

- Activities are authorized under 7 CFR § 273.16, 7 CFR § 273.18, and Wis. Stat. § 49.78 and include:
  - Investigating Wisconsin FoodShare member fraud pertaining to:
    - Cases of dual benefits in 2+ states.
    - Trafficking QUEST cards, which is the selling of FoodShare benefits.
    - Members associated with disqualified retailers.
  - Establishing overpayments and Intentional Program Violations.
  - Maintaining the State Law Enforcement Bureau (SLEB).
  - Providing technical assistance to county and tribal agencies related to duplication and benefit recovery efforts.

Investigation and Technical Assistance Unit

- Also authorized under 7 CFR § 273.16, 7 CFR § 273.18, and Wis. Stat. § 49.78, activities include:
  - Investigating large scale fraud rings.
  - Investigating internal eligibility worker-related employee fraud.
  - Supporting local agencies with beneficiary fraud investigations.
  - Coordinating with law enforcement agencies and other partners on multi-jurisdictional investigations.
  - Processing Intentional Program Violations.
  - Providing technical assistance to county and tribal agencies related to program integrity and benefit recovery.

WIC Vendor and Integrity Unit

- Authorized under 7 CFR § 246, Wis. Stat. § 253, and Wis. Admin. Code § DHS 149, activities include:
  - Processing WIC vendor applications and terminations.
  - Providing customer service.
  - Conducting vendor program integrity and compliance investigations.
  - Assisting local WIC agencies with monitoring social media and investigating program violations.
  - Resolving issues, managing contracts, and participating in eWIC procurement.
  - Monitoring approved product and food price lists and setting not-to-exceed reimbursement levels.
  - Issuing vendor claims, civil monetary penalties, or sanctions for program violations.
  - Recovering funds from vendor violations.
  - Responding to vendor complaints.
  - Monitoring the WIC vendor fraud hotline.

Internal Audit Section

- Consists of experienced auditors who are responsible for:
  - Conducting independent, objective assurance and consulting activities.
  - Investigating improper activities by DHS employees.
  - Conducting DHS-wide Risk Assessments.
  - Performing system and operational control audits.
  - Performing independent audits of contracted agencies.

Provider Enrollment and Research Section

- Consists of investigators, researchers, reviewers, and Fraud Hotline staff who are responsible for:
  - Vetting moderate and high risk providers for Medicaid program enrollment and revalidation.
  - Managing the OIG's fraud reporting tools.
  - Investigating and referring reported concerns to the appropriate regulatory agency for possible prosecution.

Medicaid Provider Enrollment

- Staff fulfill this responsibility by:
  - Evaluating each provider's application materials during initial enrollment and each subsequent revalidation in accordance with Affordable Care Act and Wis. Admin. Code DHS § 105 requirements.
  - Conducting research to determine whether the enrollment should be approved or denied/terminated based on requirements in Wis. Admin. Code DHS §§ 106.06 or 106.08.
  - Identifying if any enrollment conditions should be applied to approved providers, such as Payment Integrity Review.

Credible Allegations of Fraud Referrals

- Staff investigate allegations and develop Credible Allegations of Fraud (CAF) referrals.
- Federal law requires the OIG to refer all CAF to the Wisconsin Department of Justice (DOJ) – Medicaid Fraud Control and Elder Abuse Unit (MFCEAU) in accordance with 42 CFR § 455.21.
- If the referral is accepted, the OIG suspends Medicaid payments to the provider during the investigation, unless there is a good cause exception as defined under 42 CFR § 455.23(e).

Valued Partnerships

Collaborating with federal, state, and other key partners.

Key Federal Partner Agencies

- U.S. Dept. of Agriculture – Food and Nutrition Service
- U.S. Dept. of Health and Human Services (HHS) – Office of the Inspector General (OIG)
- U.S. Dept. of Justice:
  - Drug Enforcement Administration
  - Federal Bureau of Investigation
- U.S. Dept. of the Treasury – Internal Revenue Service

Key State Partner Agencies

- Dept. of Agriculture, Trade and Consumer Protection
- Dept. of Children and Families
- Dept. of Justice – Medicaid Fraud Control and Elder Abuse Unit
- Dept. of Revenue
- Dept. of Safety and Professional Services
- Office of the Commissioner of Insurance

Other Key Partners

- Association of Inspectors General
- County and Tribal Income Maintenance Agencies
- eGovernment Payment Council – Retailer Recertification Workgroup
- International Association of Financial Crimes Investigators
- National Association of Medicaid Program Integrity
- National Health Care Anti-Fraud Association
- National WIC Association
- United Council on Welfare Fraud
- Wisconsin Association on Public Assistance Fraud

Success Stories

Helping DHS save millions of tax payer dollars annually.

David Guerrero Success Story

- David Guerrero, Jr., was sentenced to 32 months imprisonment for conspiracy to defraud Medicare and Medicaid.
- He was ordered to pay over $1 million dollars in restitution.
- He billed for medically unnecessary medications and tests and paid kickbacks to induce referrals.
- His co-defendant, Alex Shister, has not yet been sentenced.
- Read the US DOJ press release to learn more: https://www.justice.gov/usao-edwi/pr/milwaukee-man-sentenced-federal-prison-conspiracy-defraud-medicare-and-medicaid

Lisa Hofschulz Success Story

- Lisa Hofschulz, an advanced practice nurse prescriber, and her husband, the clinic's business manager, were convicted for their involvement in a drug trafficking conspiracy and "pill mill" operation.
- Hofschulz did not properly assess patients and gave prescriptions and refills for opioids for $200 in cash.
- One of Hofschulz's patients died of an overdose.
- Hofschulz was sentenced to 20 years in federal prison. Her husband was sentenced to three years.
- Read the Milwaukee Journal Sentinel news story here: https://www.jsonline.com/story/news/crime/2021/08/13/wauwatosa-clinic-owners-convicted-running-illegal-pill-mill/8121934002/

Samir Mullick Success Story

- Dr. Samir Mullick, who does business as Pediatric Associates, agreed to pay $706,599 for violating the False Claims Act.
- Dr. Mullick submitted claims to Medicaid that relied on falsified diagnosis codes to justify unnecessary testing and treatment.
- This case was prosecuted by HHS-OIG based on a complaint from a whistleblower who will receive a share of the settlement amount.
- Read the US DOJ press release to learn more: https://www.justice.gov/usao-edwi/pr/pediatric-associates-samir-mullick-md-sc-and-dr-samir-mullick-agree-pay-over-700000

Mavi Kuldip Singh Success Story

- Mavi Kuldip Singh pled guilty to three misdemeanor charges – unauthorized use of a public assistance voucher and two counts of knowingly trafficking food stamps.
- Singh was ordered to pay $18,000 in restitution and permanently barred from the FoodShare program as a vendor or participant.
- Singh is the owner of a Williamson Street gas station in Madison. Singh trafficked FoodShare benefits for cash.

In the Headlines

- Other high profile cases that were referred to US DOJ include:
  - New Jersey Man and Company Operating Nursing Homes and Assisted Living Facilities in Wisconsin Charged with Health Care Fraud (02/02/2023 Press Release)
  - Milwaukee Pharmacy Chain to Pay Over $2 Million to Resolve False Claims Act Allegations (01/28/2022 Press Release)
  - Brookfield Doctor Sentenced to Eighteen Months' Imprisonment for Drug Crimes (11/03/2022 Press Release)
  - Milwaukee Area Community Support Program Facilities Agree to Pay $390,080 to Resolve False Claims Act Allegations (09/03/2021 Press Release)
  - Private Duty Nurse Charged with Over $28,000 in Medicaid Fraud (11/11/2020 Press Release)

Report Fraud, Waste, and Abuse

- Help us combat fraud, waste, and abuse in DHS programs.
- The OIG encourages everyone to report suspected concerns by calling 877-865-3432 or visting www.reportfraud.wisconsin.gov.

Thank you for your interest!

Please ask questions now.