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| **DEPARTMENT OF HEALTH SERVICES**  Office of the Inspector General  F-02296B (10/2019) | | **STATE OF WISCONSIN** | | |
| medicaid fraud control elder abuse unit referral FEEDBACK: Used in partnership with HMOs, MCOs, and IRIS | | | | |
| The Office of the Inspector General (OIG) and agencies representing health maintenance organizations (HMOs), Family Care managed care organizations (MCOs), and IRIS (Include, Respect, I Self-Direct) collaborate to complete a referral form whenever a credible allegation of fraud is suspected.  This form provides feedback to the partner agency on the information submitted on F-02296. Written feedback will only be provided in the sections where OIG made corrections or provided additional information.  If you have questions, please contact your OIG primary contact listed in section 27.  OIG Case ID Number: Case Number | | | | |
| Case Name  Case Name | | | Date of Feedback  Date of Feedback | |
| OIG Decision  Choose One | | Medicaid Fraud Control and Elder Abuse Unit Decision  Choose One | | |
| complainant information | | | | |
| 1. Date Reported to State | | | | |
| Choose Date | | | | |
| 2. Name – Complainant (Last, First) | | | | |
| Name | | | | |
| 3. Street Address | | | | |
| Street Address | | | | |
| City | | | State | Zip Code |
| City | | | State | Zip |
| 4. Phone Number (include area code) | 5. Email Address | | | |
| Phone | Email | | | |
| subject information | | | | |
| 6. Name – Agency | | | | |
| Agency | | | | |
| 7. Name – Subject (Last, First) | | | | |
| Subject | | | | |
| 8. Street Address | | | | |
| Street Address | | | | |
| City | | | State | Zip Code |
| City | | | State | Zip |
| 9. Phone Number (include area code) | 10. Email Address | | | |
| Phone | Email | | | |
| 11. Provider Identification Number | | 12. Provider Type | | |
| Provider Identification Number | | Provider Type | | |
| description of misconduct | | | | |
| 13. Centers for Medicare & Medicaid Services Category of Service | | | | |
| Category | | | | |
| 14. Date(s) of Conduct | | | | |
| Date(s) | | | | |
| 15. Reasons for Referral | | | | |
| Reasons | | | | |
| 16. Executive Summary | | | | |
| Summary | | | | |
| 17. Amount Paid to Provider During Past Three Years – HMO, MCO, IRIS | | | | |
| $Amount | | | | |
| 18. Amount Paid to Provider During Past Three Years – Fee-for-Service | | | | |
| $Amount | | | | |
| 19. Scope of Audit | | | | |
| Scope | | | | |
| 20. Medicaid Statutes, Rules, Regulations, or Policies Violated | | | | |
| Statutes/Rules/Regulations/Policies | | | | |
| Medicaid Statutes | | | | |
| Wis. Stat. § 49.45 (3)(f)  Wis. Stat. § 49.49 (4m)  Wis. Stat. § 946.91  Wis. Stat. § 49.485  Misappropriation of the person’s funds or property | | | | |
| DHS Rules, Regulations, and Policies | | | | |
| Wis. Admin. Code ch. 105  Wis. Admin. Code ch. 106  Wis. Admin. Code ch. 107  DHS Handbook Provisions  Other, Specify: Other | | | | |
| case summary | | | | |
| 21. Background | | | | |
| Background | | | | |
| 22. Summary of Action Taken by the Program (Managed or Long-Term Care) | | | | |
| Summary | | | | |
| 23. Summary of Action Taken by OIG | | | | |
| Summary | | | | |
| 24. Exhibits | | | | |
| Exhibits | | | | |
| 25. Conclusion | | | | |
| Conclusion | | | | |
| PROVIDER TYPE INFORMATION | | | | |
| 26. Provider Type Summary | | | | |
| Summary | | | | |
| oig primary contact | | | | |
| 27. Name – OIG Contact (Last, First) | | | | |
| OIG Contact | | | | |
| 28. Phone Number (include area code) | 29. Email Address | | | |
| Phone | Email | | | |
| AGENCY PRIMARY CONTACT | | | | |
| 30. Name – Agency Contact (Last, First) | | | | |
| Agency Contact | | | | |
| 31. Phone Number (include area code) | 32. Email Address | | | |
| Phone | Email | | | |
| 33. Agency of Affiliation | | | | |
| Agency | | | | |
| GENERAL FEEDBACK | | | | |
| 34. General Feedback | | | | |
| General Feedback | | | | |
| 35. Program Integrity Opportunities | | | | |
| Program Integrity Opportunities | | | | |