

Overview

Risk management is a multidisciplinary process used to identify and mitigate, to the extent possible, risk levels. The following are recommendations regarding medical practice risk management. These recommendations are informational only. Providers should develop their own risk management policies and procedures to assist in reducing medical practice risks.

Patient Information

Physicians should remind members to be aware of the Plan's covered benefits and requirements. Physicians should also teach members their role in the health care process.

Members are expected to:

- Inform their physician of changes in their health history;
- Inform their physician of care and medications rendered by other providers;
- Keep appointments;
- Follow advice and instructions and ask questions.

Receptionists should be required to ask members if any insurance, address or telephone information has changed and to verify with the Plan that the individual still has coverage.

Patient Education

Physician-patient communication is an essential component in effective risk management. Improved communication reduces the risk of patient dissatisfaction and helps to mitigate potential liability.

Physicians and other care providers can increase patient satisfaction through:

- Development of a collaborative relationship with patients that enhances their understanding of the clinical and economic reasons for medical decisions that are made regarding their care in a

resource-constrained environment;

- Involving patients in the development of their care plans;
- Helping patients to create reasonable expectations of care delivery.

**HIPAA
Compliance**

Care providers should ensure that proper safeguards are in place to ensure member privacy through the development of:

- Policies and procedures that maintain confidentiality of stored, maintained or transmitted information;
- Periodic organizational and facility assessments;
- Periodic training of staff members in HIPAA compliance.

Staff Training

Staff members should be educated on the Plan's policies and procedures by the provider or office manager. The provider's support staff is a reflection of the provider's practice and is important in ensuring patient satisfaction. Support staff should be instructed to be courteous and respectful to all patients.

**Occupational Risk
Exposures
to Blood**

Health care workers are at risk for occupational exposure to bloodborne pathogens, including hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV). Exposures occur through needlesticks or cuts from other sharp instruments contaminated with an infected patient's blood or through contact of the eye, nose, mouth or skin with a patient's blood. Important factors that may determine the overall risk for occupational transmission of a bloodborne pathogen include the number of infected individuals in the patient population, the chance of becoming infected after a single blood contact from an infected patient and the type and number of blood contacts.

Care providers should follow CLIA and OSHA rules if they draw blood or perform procedures in their offices.

Other Sources of Information

- ***Hepatitis***

For additional information about hepatitis B virus (HBV) and hepatitis C virus (HCV), call the Hepatitis Information line at (888) 4-HEPCDC (888-443-7232) or visit CDC's hepatitis Web site at:

www.cdc.gov/ncidod/diseases/hepatitis/index.htm.

Anyone believing they have had a reaction or adverse event should report it to his/her health care provider. The Vaccine Adverse Event Reporting System at (800) 822-7967 receives reports from health care providers and others about vaccine side effects.

- ***Human immunodeficiency virus (HIV)/
Acquired Immunodeficiency Syndrome (AIDS)***

Information specialists who staff the CDC National AIDS Hotline at (800) 342-2437 can answer questions, provide information on HIV and AIDS and direct people to local resources. The HIV/AIDS Treatment Information Service at (800) 448-0440 can also be contacted for information on the clinical treatment of HIV/AIDS. For free copies of printed material on HIV and AIDS, please call or write:

The CDC National Prevention Information
Network

P.O. Box 6003

Rockville, MD 20849-6003

Telephone: (800) 458-5231

Web site: www.cdcnpin.org

Additional information about occupational exposures to bloodborne pathogens is available on CDC's Hospital Infections Program's Web site at <http://www.cdc.gov/ncidod/dhqp/index.html>, on CDC's

National Institute of Occupational Safety and Health's Web site at www.cdc.gov/niosh or call (800) 35-NIOSH (800-356-4674).

Glove Use for Phlebotomy

Gloves should reduce the incidence of blood contamination of hands during phlebotomy (drawing blood samples), but they cannot prevent penetrating injuries caused by needles or other sharp instruments.

The likelihood of hand contamination with blood containing HIV, HBV or other bloodborne pathogens during phlebotomy depends on several factors:

- The skill and technique of the health care worker;
- The frequency with which the health care worker performs the procedure (other factors being equal, the cumulative risk of blood exposure is higher for a health care worker who performs more procedures);
- Whether the procedure occurs in a routine or emergency situation (where blood contact may be more likely); and
- The prevalence of infection with bloodborne pathogens in the patient population.

The likelihood of infection after skin exposure to blood containing HIV or HBV will depend on the concentration of virus (viral concentration is much higher for hepatitis B than for HIV), the duration of contact, the presence of skin lesions on the hands of the health care worker and – for HBV – the immune status of the health care worker.

Gloves should always be available to health care workers who wish to use them for phlebotomy.

In addition, the following general guidelines apply:

- Use gloves for performing phlebotomy when the health care worker has cuts, scratches or other

breaks in his/her skin;

- Use gloves in situations where the health care worker judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative patient;
- Use gloves for performing finger and/or heel sticks on infants and children;
- Use gloves when persons are receiving training in phlebotomy.

Selection of Gloves

The Center for Devices and Radiological Health, FDA, has responsibility for regulating the medical glove industry. Medical gloves include those marketed as sterile surgical or nonsterile examination gloves made of vinyl or latex. General purpose utility ("rubber") gloves are also used in the health care setting, but they are not regulated by FDA since they are not promoted for medical use. There are no reported differences in barrier effectiveness between intact latex and intact vinyl used to manufacture gloves. Thus, the type of gloves selected should be appropriate for the task being performed.

**Universal
Precautions for
Infection Control****Waste Management**

Universal precautions are not intended to change waste management programs previously recommended by CDC for health care settings. Policies for defining, collecting, storing, decontaminating and disposing of infective waste are generally determined by institutions in accordance with state and local regulations. Information regarding waste management regulations in health care settings may be obtained from state or local health departments or agencies responsible for waste management.

From the Department of Health & Human Services and Centers for Disease Control and Prevention (CDC)

Web site: <http://www.cdc.gov>

Incident Reporting

Any injury, regardless of degree, or any adverse or unexpected occurrence incurred by a provider or member should be reported to the Plan.

Incidents are statutorily defined as any untoward or adverse event that results in death, serious impairment of bodily function or any other result that requires medical intervention other than minimal first aid treatment. Serious incidents shall be reported to the Plan's risk manager immediately as these incidents must be reported within 48 hours. The Risk Management department telephone number can be found on the **Quick Reference Guide**.

Examples of such incidences are death, fetal death, brain damage, spinal damage, surgical procedure performed on the wrong patient, wrong site or wrong surgical procedure performed.

Other incidents required to be communicated to the Plan include: a slip or fall by a patient or family member, medication error, reaction requiring treatment, abusive patient or family member, a theft or loss from provider's office, malfunction or damage of equipment during treatment, accusations of malpractice by a patient or family member and non-compliance with potential to be life threatening. An Incident Report form, included in the **Forms** section of this manual should be used to report all incidents to the Plan's risk manager.

Further reporting to the Plan's insurance carrier and governmental agencies, as appropriate, shall be arranged within the prescribed time frames by the Plan's risk manager. Physicians are reminded that serious negative events or incidents which occur in a provider's office or facility must be reported to the Agency for Health Care Administration (AHCA) directly by the provider.

Fraud, Waste and Abuse

WellCare is committed to the prevention and deterrence of health care fraud, waste and abuse in compliance with federal and state laws, regulations and contractual requirements and believes that aggressive, proactive prevention methods are effective tools in reducing risk.

WellCare created a comprehensive approach to prevent and detect patterns of suspected fraud, waste and abuse by placing special emphasis on heightening provider, member and associate awareness about common fraud, waste and abuse indicators, analysis of potentially fraudulent claims, implementation of fraud detection devices and applications and encouraging WellCare associates, members and others to report suspected incidents.

WellCare established a Special Investigations Unit to oversee the fraud, waste and abuse program for its health plans. The Special Investigations Unit detects anomalies, irregularities and other indicators of suspected health care fraud, waste and abuse, investigates reported allegations and detected incidents of suspected fraud, waste and abuse and reports its findings to corporate leadership, federal and state agencies, law enforcement and prosecutors.

The Special Investigations Unit also develops and conducts education and training on the preventing, detection and reporting of incidents of suspected fraud, waste and abuse. Providers may request fraud, waste and abuse awareness training by contacting your WellCare Provider Relations Representative.

Ohio Administrative Code**5101:3-1-29 Medicaid Fraud, Waste and Abuse**

Fraud is defined as an intentional deception, false statement or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or another person. It includes any act that constitutes fraud under applicable federal or state law. If fraud is suspected or apparent, referral of the case to the attorney general's Medicaid fraud control unit and/or the appropriate enforcement officials will be made.

Waste and *abuse* are defined as practices that are inconsistent with professional standards of care, medical necessity, or sound fiscal, business or medical practices; and constitute an over-utilization of

Medicaid-covered services and result in an unnecessary cost to the Medicaid program.

Some examples of health care fraud include:

- Falsifying medical records, notes, diagnostic test results, reports, claims or any financial, administrative or clinical documents used to validate services;
- Billing for services, supplies or equipment not furnished to or used by the Plan member;
- Providing false and intentionally misleading information regarding Plan coverage, limitations and exclusions to WellCare members;
- Misrepresentations of dates, frequency, duration or description of services rendered or the identity of the recipient of the service or who provided the service;
- Billing for non-covered or non-chargeable services, supplies or equipment disguised as covered or chargeable services;
- Duplicate billings, i.e., billing more than once for the same service, multiple providers billing for the same service and member on the same day, billing the Plan and the member for the same services or submitting claims to both the Plan and other third parties without making full disclosure of relevant facts to all parties;
- Providing payment or other inducements to a Plan member in exchange for the use of his/her identification card or using Plan member identification information with or without the permission of the Plan member to submit claims for the purpose of obtaining wrongful payment;
- Unlawful kickbacks, gratuities or other inducements made with the intent to increase referrals;

- Reciprocal billing, i.e., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed;
- Practicing medicine without a valid license or with an expired or revoked license, or while excluded from participation in any state or federal health care program;
- Agreements or arrangements between providers and members that result in billings or claims for unnecessary costs or charges to the Plan, i.e., providing health care services, supplies or equipment to an ineligible person that is in possession of a member's WellCare identification card, or any fraudulent scheme involving the use of member information to submit false claims;
- Any other intentional misrepresentation of a material fact or facts regarding the provision of health care services for the purpose of obtaining wrongful payment.

Some examples of health care waste and abuse include:

- A pattern of waiving member (patient) co-pay or deductible;
- Billing WellCare for services and supplies that are in excess of the contracted rate;
- Direct or balance billing of WellCare members where prohibited;
- A pattern of claims for services that are not medically necessary, or if necessary, not to the extent rendered;
- Providing health care services of inferior quality, i.e., services that do not meet accepted standards of care;

- Provision of services in an inappropriate setting or at an excessive level of care;
- Failure to maintain adequate clinical or financial records;
- Refusal to furnish or allow access to medical, financial or other required records.

State and federal agencies, law enforcement, prosecutors and WellCare vigorously investigate incidents of suspected health care fraud, waste and abuse. Fraudulent actions can result in criminal or civil penalties.

Providers are cautioned that un-bundling, fragmenting, up-coding and other similar activities designed to manipulate the International Classification of Diseases (ICD), Physicians' Current Procedural Terminology (CPT), the Health care Common Procedure Coding System (HCPCS) and/or Universal Billing (UB) Revenue codes as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered. In addition, providers are reminded that medical records and other documentation must be legible and support the level of coding indicated on claims.

Providers engaged in fraud, waste and abuse may be subjected to:

- Warnings;
- Corrective action plans;
- Administrative sanctions;
- Suspensions or terminations as authorized providers;
- Loss of licenses;
- Civil and/or criminal prosecutions;
- Fines;
- Other penalties.

To report suspected health care fraud, waste and abuse involving a provider, member or others, please refer to

the **Quick Reference Guide** of this manual and call our confidential Trust hotline.