
Overview	WellCare's Risk Management Program includes an overview of medical practice risk management, incident reporting and guidelines for the prevention, detection, investigation, reporting, corrective actions and education/training related to fraud and abuse.
Medical Practice Risk Management	The following recommendations regarding medical practice risk management are informational only. Providers should develop their own risk management policies and procedures to assist in reducing medical practice risks.
Patient Information	<p>Physicians should remind members to be aware of the Plan's covered benefits and requirements and teach them their role in the health care process:</p> <ul style="list-style-type: none">• Inform their physician of changes in health history;• Inform their physician of care and medications rendered by other providers;• Keep appointments; and• Follow advice and instructions and to ask questions. <p>Receptionists should be required to ask members if any insurance, address or telephone information has changed and verify with the Plan that the individual still has coverage. During the exam, a health care professional should verify medications, allergies and changes in health history.</p>
Staff Training	Provider support staff members should be educated on the Plan's policies and procedures. 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.
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 needle sticks 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.

Most exposures do not result in infection. Following a specific exposure, the risk of infection may vary with factors such as these:

- The pathogen involved;
- The type of exposure;
- The amount of blood involved in the exposure; and
- The amount of virus in the patient's blood at the time of exposure.

Physicians should have in place a system for reporting exposures in order to quickly evaluate the risk of infection, inform patients (and support staff) about treatments available to prevent infection, monitor patients for side effects and to determine if infection occurs. This may involve blood tests of the source patient and offering appropriate post-exposure treatment.

To Prevent Occupational Exposures

Many needle sticks and other cuts can be prevented by using safer techniques (e.g., not recapping needles by hand), disposing of used needles in appropriate sharps disposal containers and using medical devices with safety features designed to prevent injuries. Many exposures to the eyes, nose, mouth or skin can be prevented by using appropriate barriers (e.g., gloves, eye and face protection gowns) when contact with blood is expected.

If An Exposure Occurs

No scientific evidence shows that using antiseptics or squeezing the wound will reduce the risk of transmission of a

bloodborne pathogen. Using a caustic agent such as bleach is not recommended. Immediately following an exposure to blood:

- Wash needle sticks and cuts with soap and water;
- Flush splashes to the nose, mouth, or skin with water; and
- Irrigate eyes with clean water, saline, or sterile irrigants.

Following Any Blood Exposure

- Report the exposure to the appropriate authorities responsible for managing exposures. Prompt reporting is essential because, in some cases, post-exposure treatment may be recommended, and it should be started as soon as possible.
- Discuss the possible risks of acquiring HBV, HCV and HIV and the need for post-exposure treatment with the injured person. All health care personnel should have already received hepatitis B vaccine, which is extremely safe and effective in preventing HBV infection.

Other Sources Of Information

- **HBV and HCV**
For additional information about hepatitis B and hepatitis C, call the hepatitis information line at 1-888-4-HEPCDC (1-888-443-7232) 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 (1-800-822-7967) receives reports from health care providers and others about vaccine side effects.

- **HIV**
Information specialists who staff the CDC National AIDS Hotline (1-800-342-2437) can answer questions or provide information on HIV infection and AIDS and as well as local resources. The HIV/AIDS Treatment Information Service (1-800-448-0440) can also be contacted for information on the clinical treatment of HIV/AIDS. For free copies of printed material on HIV infection and AIDS, please call or write the CDC National Prevention Information Network, P.O. Box 6003, Rockville, MD 20849-6003, telephone 1-800-458-5231, Internet address www.cdcnpin.org.

Additional information about occupational exposures to bloodborne pathogens is available on CDC's Hospital Infections Program's Web site at www.cdc.gov/ncidod/hip or on CDC's National Institute of Occupational Safety and Health's Web site at www.cdc.gov/niosh or call 1-800-35 NIOSH (1-800-356-4674).

Universal Precautions for Infection Control

Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as hand washing and using gloves to prevent gross microbial contamination of hands. Because specifying the types of barriers needed for every possible clinical situation is impractical, some judgment must be exercised.

The risk of nosocomial transmission of HIV, HBV and other bloodborne pathogens can be minimized if health care workers use the following general guidelines:

1. Take care to prevent injuries when using needles, scalpels and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments; and when disposing of used needles. Do not recap used needles by hand; do not remove used needles from disposable syringes by hand; and do not bend, break or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpel blades and other sharp items in puncture-resistant containers for disposal. Locate

the puncture-resistant containers as close to the use area as is practical.

2. Use protective barriers to prevent exposure to blood, body fluids containing visible blood and other fluids to which universal precautions apply. The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated.
3. Immediately and thoroughly wash hands and other skin surfaces that are contaminated with blood, body fluids containing visible blood, or other body fluids to which universal precautions apply.

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:

1. The skill and technique of the health care worker;
2. 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);
3. Whether the procedure occurs in a routine or emergency situation (where blood contact may be more likely); and
4. 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.

Although not accurately quantified, the risk of HIV infection following intact skin contact with infective blood is certainly much less than the 0.5 percent risk following percutaneous needlestick exposures. In universal precautions, all blood is assumed to be potentially infective for bloodborne pathogens, but in certain settings (e.g., volunteer blood-donation centers) the prevalence of infection with some bloodborne pathogens (e.g., HIV, HBV) is known to be very low. Some institutions have relaxed recommendations for using gloves for phlebotomy procedures by skilled phlebotomists in settings where the prevalence of bloodborne pathogens is known to be very low.

Institutions that judge that routine gloving for all phlebotomies is not necessary should periodically reevaluate their policy. Gloves should always be available to health care workers who wish to use them for phlebotomy.

In addition, the following general guidelines apply:

1. Use gloves for performing phlebotomy when the health care worker has cuts, scratches or other breaks in his/her skin.
2. 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.
3. Use gloves for performing finger and/or heel sticks on infants and children.
4. 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. The following general guidelines are recommended:

1. Use sterile gloves for procedures involving contact with normally sterile areas of the body.
2. Use examination gloves for procedures involving contact with mucous membranes, unless otherwise indicated, and for other patient care or diagnostic procedures that do not require the use of sterile gloves.
3. Change gloves between patient contacts.
4. Do not wash or disinfect surgical or examination gloves for reuse. Washing with surfactants may cause "wicking," i.e., the enhanced penetration of liquids through undetected holes in the glove. Disinfecting agents may cause deterioration.
5. Use general-purpose utility gloves (e.g., rubber household gloves) for housekeeping chores involving potential blood contact and for instrument cleaning and decontamination procedures. Utility gloves may be decontaminated and reused but should be discarded if they are peeling, cracked, or discolored, or if they have punctures, tears, or other evidence of deterioration.

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 and Human Services and Centers for Disease Control (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 involving Plan members shall be reported to the Plan's Risk manager immediately as these incidents must be reported within 48 hours. The Risk Management department phone number can be found in the **Quick Reference Guide**.

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

Other incidents involving Plan members which are required to be communicated to the Plan include: a slip or fall, 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, non-compliance which may potentially be considered life-threatening. An Incident Report form, included in the **Forms** section, 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 appropriate regulatory agency directly by the provider.

Fraud and Abuse

The Plan is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. The Plan has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Effective detection tools have been developed to identify patterns of health care service use, including over utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement, and the Plan vigorously investigate incidents of suspected fraud and abuse. Service providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians' Current Procedural Terminology (CPT), the Health care Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual 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 care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

To report suspected fraud and abuse, please refer to your state-specific **Quick Reference Guide** of this manual and call our confidential Trust Program hotline.

Fraud and Abuse Definitions

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes Fraud under applicable federal or State law.

Some examples of health care fraud include, but are not limited to the following:

- Falsifying any medical record, note, diagnostic test result, report, claim, or any financial, administrative or clinical documents used to validate services.
- Billing for services, supplies, or equipment not actually furnished to any health plan member.
- Providing false and intentionally misleading information regarding health plan coverage, limitations, and exclusions to any health plan member.
- Misrepresentation of any date of service, frequency, duration, or description of any service, or the identity of the recipient of such services, or the identity of the service provider.
- Billing for non-covered or non-chargeable services, supplies, or equipment disguised as any covered or chargeable service.
- Duplicate billings (e.g., billing more than once for the same service, multiple providers billing for the same service for the same member on the same day, billing the health plan and the member for the same services, or submitting claims to both the health plan and other third parties without making full disclosure of relevant facts to all parties).
- Providing payment or other inducement to any health plan member in exchange for the use of their identification card or other member information with or without the permission of the health plan member for the purpose of obtaining wrongful payment.
- Receipt or offering of any unlawful kickback, gratuity, or other inducement made with the intent to increase referrals.
- Reciprocal billing (e.g., billing or claiming services

furnished by another provider or furnished by the billing provider in a capacity other than claimed).

- Practicing medicine or other health care without a valid license, or with an expired or revoked license, or without proper credentials, or while excluded from participation in any federal or state health care program.
- Any agreement or other arrangement between a provider and a health plan member that results in claims for unnecessary costs or charges to the health plan (e.g., providing health care services, supplies, or equipment to an ineligible person that is in possession of a health plan member's identification card, or any fraudulent scheme involving the use of member information to submit false claims).
- Any other intentional misrepresentation of a material fact regarding the provision of health care services for the purpose of obtaining wrongful payment.

Abuse is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program.

Some examples of health care abuse include, but are not limited to the following:

- Unauthorized waiver or reduction of applicable member co-payment or deductible.
- Billing for services, supplies or equipment in any amount in excess of the applicable Federal and/or State fee schedules, negotiated or contract rate.
- Direct or balance billing of health plan members where prohibited.
- Billing for services that are not medically necessary, or

if medically necessary, not to the extent actually provided.

- Providing health care services of an inferior quality (i.e., services that do not meet generally accepted standards of care), or in an inappropriate setting, or at a level of care that is in excess to medical necessity.
- Failure to fully document services according to generally accepted standards (i.e., records must be legible, clearly document the services provided, etc.) and maintain adequate clinical, financial, and other records substantiating claims.

Special Investigations Unit

A corporate Special Investigations Unit (SIU) has been established according to federal and state statutory, regulatory and contractual requirements and includes management, investigators, analysts, medical coding auditors and claim review specialists. SIU capabilities include pre-payment and retrospective reviews, provider profiling models, performance metrics, data mining, analysis and reporting, and specialized business partner arrangements to augment in-house resources. The mission of the corporate SIU is outlined below:

- Comply with applicable federal and state statutory, regulatory, and contractual requirements regarding fraud, waste, and abuse;
- Effectively detect, investigate and report suspected fraud, waste, and abuse;
- Identify and recover overpayments caused by error, fraud, waste, or abuse;
- Assist in the development of anti-fraud plans, policies and procedures, and fraud and abuse awareness, education and training materials;
- Assist in conducting education and training for associates, providers, members, first-tier, delegated and related entities on fraud and abuse awareness

and other related topics according to established training schedules; and

- Assist in conducting vulnerability assessments, auditing and monitoring activities of first-tier, delegated and related entities.

Education and Training

The Provider Relations department is responsible for distributing provider manuals and other information, as well as conducting provider education and training. Providers may contact the Provider Relations department to arrange education and training, or answer questions regarding health plan benefits, coverage, limitations and exclusions, policies and procedures, provider rates and contracting issues, claims, fraud and abuse awareness, and other information.

Business and Medical Records

Providers are required to maintain books, records, documents, and other evidence pertaining to the costs and expenses to the extent and in such detail as will properly reflect all services for which claim payments are made.

Providers are required to preserve and make available all of its records pertaining to services rendered to Plan members for a period of seven years from the date of final payment under their provider agreement, and for such period, if any, as is required by applicable statute. If a provider agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for period of seven years from the date of termination or of any resulting final settlement.

Inspection and Release of Business and Medical Records

Pursuant to the requirements of 42 CFR 434.6(a)(5) and 42 CFR 434.38, providers are required to make all books, documents, papers, provider records, medical records, financial records, data, surveys and computer databases available for examination and audit by the Plan, the Georgia Department of Community Health (DCH), the State Attorney General, the State Health Care Fraud Control Unit, the State Department of Audits, or authorized state or federal personnel.

Providers are required to release medical records (i.e., the complete, comprehensive records of a Member including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Member's participating Primary Care physician or Provider, that document all medical services received by the Member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable DCH rules and regulations, and signed by the medical professional rendering the services) as may be authorized by the Member, or as may be directed by the Plan, appropriate agencies of the state, or the United States government.

Any records requested hereunder shall be produced immediately for onsite review or sent to the requesting authority by mail within 14 calendar days following a request. All records shall be provided at the sole cost and expense of the provider.