Loss Prevention & Medical Records

Medical practice risk management recommendations to help reduce managed care risks.

These recommendations are informational only. Providers should also develop their own risk management policies and procedures to assist each individual office in reducing managed care risks.

Patient Information

Please remind members to be aware of the Plan's covered benefits and requirements. It is important to educate them regarding their role in the health care process, i.e., the need to inform you of changes in health history, care or medications rendered by other providers such as specialists, to keep appointments, follow advice and instructions, and to ask questions.

Receptionists should ask members if any insurance, address or telephone information has changed and verify with the Plan that the individual still has coverage. Verify medications, allergies and changes in health history. Many diagnosis claims can be attributed to failure to update the patient's history at regular intervals.

Staff Training

Staff members should be educated on managed care principles. Protect your practice or group from liability claims fueled by negative attitudes. Poor attitudes that reflect contempt (i.e., spending as little time as possible with Plan members, extraordinary waiting times, etc.) can be interpreted as discriminatory.

Documentation

Each physician should maintain a complete medical record for each Plan member according to professional practice standards, as well as state and federal requirements. The physician's medical records should be available for utilization and quality review studies. Implementing the following documentation guidelines can reduce practice risks:

1. **Documentation should be descriptive.** Specific reference is made to symptoms that could be indicative of cancer; documentation of lesions should detail size, location, color and texture and the amount of time the patient says

it has been present. Draw anatomical pictures if such forms are not available.

2. **Clearly document follow-up instructions.** This includes activity limitations, medications, referrals to specialists, further testing, and subsequent appointments. Make sure patients understand instructions given.

3. **Obtain and document informed refusal.** Inform patients of adverse outcomes and consequences of not undergoing recommended tests or procedures.

4. **Use of a problem list is recommended.** This is a significantly important documentation tool and is helpful only if used consistently. It should contain space for chronic disease/condition and any acute problems being followed. Columns for date and for problem identification and resolution should be included.

5. **Document all telephone calls from the patient and response to them.** The time the call was received, by whom, and the time it was returned needs to be detailed. Fully document any advice given or diagnosis made.

6. **A follow-up/recall system needs to be in place.** To avoid failure to diagnose claims a system to follow-up on abnormal lab results, assure that the patient returns to recheck conditions as indicated by the physician, and to assure that the patient sought consultation after referral needs to be established. Also, patients like to know if test results are normal. In addition, the physician should initial all test results to show verification of review.

7. **Always document attempts to contact the patient.** Depending on the seriousness of the condition, you may want to send a certified letter with return receipt.

8. **Consistently adhere to standard medical record documentation guidelines; specifically:**

   - All entries should be neat, complete, clear, concise and timely; include all recommendations and essential findings.
   - Sign entries with complete name, date, time of occurrence, time documented, and professional designation.
   - Corrections are to be made by a single line through the inaccurate material, dated and initialed. Records should not be altered.
   - Use only standard abbreviations and symbols.
   - If records are handwritten, they must be legible.
   - Late entries should include date and time of occurrence and date and time of documentation.
   - Record details of informed consent discussions.

All participating Primary Care Physicians should maintain complete and accurate fiscal records, as well as medical and social records, for all Plan members. Records should be made available for quality care review studies by the Plan, authorized representatives of regulatory agencies, PRO and accreditation agencies, and should comply with requirements issued as a result any such review or audit.

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. The Risk Management Department phone number can be found

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

Other incidences which are 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, non-compliance with potential to be life threatening.

An Incident Report form shall be utilized for the reporting of all incidents to the Plan's Risk Manager. For your convenience there is a sample form in section 16. You may also obtain the forms from your Provider Relations Representative.

Further reporting to WellCare's insurance carrier and governmental agencies, as appropriate, shall be arranged within the prescribed time frames by the Plan's Risk Manager.

Fraud & Abuse

As you know, the New York State Department of Insurance and the federal government have very concise guidelines on the mandatory reporting of claims that are suspicious. In addition, your contract clearly delineates that: any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

As a result of our legal obligations, WellCare has established an anti-fraud program according to New York Statutes, with a Special Investigations Unit. We routinely audit, and when necessary, investigate claims submitted to us for payment of services. Common errors in billing include:

1. Billing for non-chargeable/non-covered services.

2. Reciprocal billing – billing for services rendered for another provider.
3. Submitting duplicate claims for services rendered.
4. Any other unsound fiscal practices (up-coding, unbundling).

Upon investigation, it may be necessary to elicit your cooperation in an effort to resolve questions regarding suspicious claims. While it is important to follow policies and procedures and maintain internal controls to prevent fraud and abuse, WellCare is committed to balancing prompt claims processing with effective claims control at all times.

Should you need to report an incidence of fraud or suspected fraud, please call the Special Investigations Unit (SIU) hotline number: (866) 678-8355.