



8735 Henderson Rd
Tampa, FL 33634

May 25, 2017

Dear Provider,

The Centers for Medicare & Medicaid Services (CMS) has adopted a risk adjustment payment system (RAPS) as its method for payment to health plans with Medicare members. This methodology is based strictly on diagnosis codes and not procedure codes.

WellCare Health Plans, Inc. has contracted with Altegra Health to retrieve medical charts for WellCare's Coordinated Care Plan (CCP) members.

What does this mean to you?

Altegra Health will schedule an appointment to either scan the medical chart in your office or request it be sent to Altegra Health via fax, mail or secure electronic transfer. WellCare's corporate certified coding team will perform all reviews on the medical charts retrieved by Altegra Health to ensure that our records properly reflect the clinical conditions.

Altegra Health has signed a Business Associate Agreement with WellCare stating their compliance and adherence to all Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules and regulations. In addition, all field reviewers scanning charts have signed a HIPAA-compliant confidentiality agreement. Under HIPAA, Covered Entities such as practitioners and their practices are not required to obtain patient authorization to disclose protected health information (PHI) to another Covered Entity for the purposes of treatment, payment and health care operations, as long as both parties have a relationship with the patient and the PHI pertains to that relationship.

Altegra Health will begin retrieving medical charts in May 2017. Your cooperation in helping Altegra Health complete these retrievals is appreciated.

If you have any questions regarding this project, please feel free to contact the Altegra Health Provider Relations Department at 1-855-767-2650 Monday–Friday from 8:30 a.m. to 8 p.m. You can also email ProviderRelations@AltegraHealth.com.

Thank you in advance for your cooperation.

Sincerely,

WellCare Health Plans, Inc.



211 Perimeter Center Parkway,
Suite 800
Atlanta, GA 30346

We're in this together:
Quality Health Care

8/29/2017

FAX/PHONE: (404) 955-0000

Dear Provider:

At WellCare of Georgia, we place a priority on delivering quality care to our members, your patients, to ensure they have positive outcomes and health care experience. That's why WellCare is required to periodically assess our members' medical records to ensure compliance with established guidelines in accordance with our contract with the Centers for Medicare & Medicaid Services (CMS) and requirements from federal and state regulatory agencies. Our mutual success in achieving recognition for delivering the highest quality of care at the lowest risk depends upon the supporting documentation.

Medical record reviews are performed annually and follow the parameters outlined in the WellCare Provider Handbook. You are among the PCPs randomly selected for this review. **The audit focuses on your documentation of these members' care rendered between January 1, 2016 and December 31, 2016.**

Please submit the complete medical record for the time frame listed, to include:

HIPPA Forms and Legal Guardianship, if applicable

Patient Demographics (contact information, marital status, etc.)

Screenings (Domestic Violence, TB, mammography, tobacco, etc.)

Advance Directives

Any additional documentation in the chart for the review period (labs, consults, etc.)

We have enclosed the list of specific members' medical records being requested and a copy of our medical record review tool. **Due to the limited number of charts being requested from each office, we ask that you please fax or mail the medical records to the Quality Improvement Department within 7 days of receipt.** For your convenience, our secured fax number is 1-813-327-7627. If you wish to mail the records, please address to the following:



WellCare proudly serves the *Georgia Medicaid* and *PeachCare for Kids*® members enrolled in the *Georgia Families** program and women enrolled in the *Planning for Healthy Babies** program.

NA037396_PRO_LTR_ENG State Approved 02112017

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**WellCare Health Plans, Inc.
Quality Improvement Department
211 Perimeter Center Parkway, Suite 800
Atlanta GA 30346**

If you have any questions related to this medical record review process, please contact the Quality Improvement Department at **1-888-898-3411**.

Quality care is a team effort. Thank you for playing a starring role!

Sincerely,

WellCare of Georgia

NA037396_PRO_LTR_ENG State Approved 02112017

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MEMBER LIST:

Member Name	Subscriber ID	Date of Birth	Gender

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General and Adult

General Medical Record Review

Include the member's identifying information:

- 1 Member's name (first and last name) OR identifier on one side of each page
- 2 Personal biographical information in chart: Gender **AND** age or DOB
- 3 Personal contact information in chart: Home or work numbers to contact (parents or case holder for children), **AND** address, **AND** marital status for adults
- 4 If applicable, documentation of any legal guardianship issues
- 5 HIPAA Protected Health Information Release

All records shall contain or indicate:

- 6 Record is legible to someone other than the writer, and in standard English
- 7 Allergies
- 8 If known, adverse reaction to medications
- 9 If not English, primary language spoken by the member **AND**, if applicable, any translation/communication needs are documented
- 10 Current medication list
- 11 Current diagnosis/current problem list
- 12 Summary of surgical procedures, if applicable
- Preventive Services/Risk Screening
- 13 Age-appropriate lifestyle/risk counseling (including family planning)
- 14 Documentation of screening for tobacco, alcohol or substance abuse with appropriate counseling/referrals, if needed
- 15 Documentation of screening for domestic violence with appropriate counseling/referrals, if needed
- 16 Documentation that member was provided written information regarding advance directives for members 18 years and older

Each entry should contain the following assessment:

- 17 Assessment of present health history/past history
- 18 Chief complaint – Subjective
- 19 Physical examination
- 20 Treatment plan is consistent with findings
- 21 Disposition, recommendations and instructions provided to the member
- 22 Evidence of follow-up visit, if applicable
- 23 Each entry is signed. Signature or initials of the provider, which may be a handwritten signature, unique electronic identifier or initials, with professional delineation
- 24 Each entry is dated
- Follow-up Care – if applicable
- 25 Studies/tests ordered (e.g., laboratory, X-ray, EKG) are reviewed
- 26 Continuity between PCP and specialists – Consultation note/referral reports in chart
- 27 Appropriate medically indicated follow-up after ER visits
- 28 Appropriate medically indicated follow-up after hospital admits
- 29 Patient education and instructions whether verbal, written or by telephone
- 30 If surgery is proposed, there is documentation of informed consent, including discussion with the member of a) the medical necessity of the procedure, b) the risks, and c) any alternative treatment options available.

NEW YORK and GEORGIA : Additional General Questions Specific to ONLY New York and Georgia

NY1
GA1 Assessment or counseling or education on risk behaviors and preventive actions associated with sexual activity

NY2
GA2 Assessment or counseling or education for depression/anxiety

NY2a
GA2a If yes to NY2, was there an annual depression/anxiety screening done using the PHQ-9

NY2b
GA2b If yes to NY2a, is there a PHQ-9 screening tool or score in an EMR

NY3
GA3 Assessment or counseling or education about the risks of tobacco usage

NY4
GA4 Assessment or counseling or education about the risks of substance use (including alcohol and excluding tobacco)

NY4a
GA4a If yes to NY4, was there an annual screening

NY5
GA5 Is there a referral to a BH Provider

NY6 GA6	Is the PCP providing BH treatment
HAWAII: Additional General Questions specific to Hawaii	
HI1	Documentation of current and past medical/behavioral history
HI2	Hospital discharge summaries in chart
HI3	Documentation of physician's follow-up plans for significant abnormal lab/X-ray/diagnostic test/consultation results
HI4	Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits
HI5	Patient demographics include marital status and employment if applicable
HI6	Assessment completed on risk of harming self or others or self-neglect for CCS members
HI7	Mental state exam completed for CCS members
MISSOURI: Additional General Questions specific to Missouri	
MO1	Any informed consent for office procedures
MO2	If treatment includes medication, the physician shall include in the medical record the medication dosage of any medication prescribed, dispensed or administered
NEW JERSEY: Additional General Questions Specific to New Jersey	
NJ1	Documentation of any functional or cognitive deficits, the impact on performing ADLs and IADLs and the formal and informal supports utilized by the Member to address identified needs
NJ2	Identification of current problems – Including conditions that may affect the member's ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
NJ3	Confidentiality of member's information: Does the office ensure that the confidentiality of patient information and records is protected at all times (i.e., stored in a secure place, only authorized personnel have access to the records)
NJ4	Office staff has periodic training on confidentiality and HIPAA
NJ5	Office has a process in place to monitor missed appointments
NJ6.	Behavioral health summary reports as applicable, initial evaluation and routine follow up consultations
NJ7.	Records shall contain notation of any cultural/linguistic needs of the member
NJ8	Documentation on medical records of all tests given, abnormal findings and actions taken to provide appropriate follow-up care.

Adult Medical Record Review

1	Nutritional assessment documented
2	BP, height and BMI checked every 1-2 years or as determined by practitioner
3	Documentation of vision screening; age 65+
4	Documentation of hearing screening; age 50+
5	Documentation of pneumococcal vaccine; age 65+
6	Documentation of influenza vaccine, all adults annually
7	Documentation of tetanus-diphtheria (once every 10 years)
8	Screening for dyslipidemia every 5 years, more if indicated
9	Mammogram screening – every 1-2 years for women ages 40-74
10	Colorectal cancer screening age 50 and older
11	Pap smear and chlamydia screening – every 1-3 years or per physician's recommendations (women only)
12	Osteoporosis screening (Bone Mass Measurement) – every 2 years or per physician's recommendations; women (only) ≥65 years old, or ≥ 60 years if at risk

NEW JERSEY: Additional Adult Medical Record Review Questions specific to New Jersey

NJ1	Mammograms annually for females ages 65-75
NJ2	Prostate cancer screening for men ages 65-75, at least every 2 years
NJ3	Documentation on medical records of all tests given, positive findings and actions taken to provide appropriate follow-up care to all preventive cancer screenings.



WellCare Health Plans, Inc.

WellCare of Florida, Inc.

A member of the WellCare Group of Companies

June 20, 2017

ATTENTION: MEDICAL RECORDS

In accordance with our contract with the Agency for Health Care Administration, plans are required to conduct Quality of Care reviews in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules and regulations. HIPAA, Covered Entities such as practitioners and their practices are not required to obtain patient authorization to disclose protected health information (PHI) to another Covered Entity (such as WellCare of Florida, Staywell, and HealthEase), so long as both parties have a relationship with the patient and the PHI pertains to that relationship, for the purposes of treatment, payment and health care operations. Quality assessment and improvement activities are considered health care operations.

Please submit medical records by June 27th, to resolve member's grievance

MEDICAL RECORD REQUEST FOR THE FOLLOWING HMO MEMBER:

***Please note that WellCare, Staywell and/or HealthEase is the payer.*

Member:

DOB:

ID:

DOS:

Please include the items on the list below and submit to us **by June 27, 2017**

All Clinical Records

TO INSURE PROPER ROUTING, PLEASE FAX TO 813-283-5475 OR MAIL TO:

WellCare Health Plans, Inc.
3031 North Rocky Point Drive West
Suite 600
Tampa, Fl. 33607
Phone: (813)206-3792

CONFIDENTIAL PRIVACY NOTICE: This letter and any attachment(s), if applicable, is intended for the exclusive use of the addressee(s) and may contain information that is proprietary, confidential and/or exempt from disclosure and may be Protected Health Information. If you are not the intended recipient, please contact the sender by telephone at 1-800-917-9355, ext. 8414 and destroy all copies of this message. If you are a regular recipient of our mail, please notify us if you change your address. Thank you.



WellCare Health Plans, Inc.

WellCare of Florida, Inc.

A member of the WellCare Group of Companies

July 19, 2017

ATTENTION: MEDICAL RECORDS

July 31, 2017
Records are PAST DUE,
Please submit ASAP

In accordance with our contract with the Agency for Health Care Administration, health plans are required to conduct Quality of Care reviews. Under regular insurance coverage and the Health Care Quality Improvement Act of 1996 (HIPAA) rules and regulations HIPAA, Covered Entities such as health plans and their practitioners and their practices are not required to obtain patient authorization to disclose protected health information (PHI) to another Covered Entity (such as WellCare of Florida, Staywell, and HealthEase), so long as both parties have a relationship with the patient and the PHI pertains to that relationship, for the purposes of treatment, payment and health care operations. Quality assessment and improvement activities are considered health care operations.

MEDICAL RECORD REQUEST FOR THE FOLLOWING HMO MEMBER:

***Please note that WellCare, Staywell is the payer.*

Member:

DOB:

ID:

Please include the items on the list below and submit to us within by July 26, 2017

All Clinical Records

TO INSURE PROPER ROUTING, PLEASE FAX TO 813-283-5475 OR MAIL TO:

WellCare Health Plans, Inc.
3031 North Rocky Point Drive West
Suite 600
Tampa, FL 33607
Phone: (813)206-3792

CONFIDENTIAL PRIVACY NOTICE: This letter and any attachment(s), if applicable, is intended for the exclusive use of the addressee(s) and may contain information that is proprietary, confidential and/or exempt from disclosure and may be Protected Health Information. If you are not the intended recipient, please contact the sender by telephone at 1-800-917-9355, ext. 8414 and destroy all copies of this message. If you are a regular recipient of our mail, please notify us if you change your address. Thank you.



2319 Whitney Ave., 6th Floor
Hamden, CT 06518

January 30, 2017

Dear Provider,

Each year WellCare of Connecticut, Inc. (WellCare) is required to report on clinical quality measures to the Centers for Medicare & Medicaid Services (CMS). The quality measures are based on the Healthcare Effectiveness Data and Information Set (HEDIS®) specifications developed by the National Committee for Quality Assurance (NCQA) and other state-defined measures. In compliance with the HEDIS standard, we request medical records for certain measures to collect information that typically cannot be found in a claim or an encounter.

WellCare has contracted with **XXXX Company** to collect and abstract the medical records required for completion of HEDIS review. The state agency and CMS require us to comply with NCQA auditing procedures, which include reviewing the information that Altegra Health has abstracted from the record and verifying that the record has the information they documented. Therefore, Altegra Health is required to retrieve pertinent portions of member charts when obtaining the information needed for the HEDIS audit.

XXXX has signed a Business Associate Agreement with WellCare agreeing to comply with and adhere to all Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules and regulations. Altegra Health has processes in place to safeguard the protected health information (PHI) of our members and your patients. All staff involved in collecting and reviewing charts have signed a HIPAA-compliant confidentiality agreement and are trained on HIPAA compliance rules and regulations.

When collecting the records, XXXX staff will perform one of the following activities for medical record retrieval:

- Scan and upload electronically via a secure intranet Web portal **or**
- Copy and send via UPS to Altegra Health's centralized reviewing center **and/or**
- Load onto a jump drive and send via UPS Overnight to Altegra Health's centralized review center
 - Additional EMR options are available as well, including but not limited to:
 - Remote access
 - Sending records through an FTP site
 - Downloading to a jump drive, etc.

HIPAA Rules Regarding Signed Release

Under HIPAA, Covered Entities such as practitioners and their practices are not required to obtain patient authorization to disclose protected health information (PHI) to another Covered Entity (such as WellCare), as long as both parties have a relationship with the patient and the PHI pertains to that relationship, for the purposes of treatment, payment and health care operations. Under the Privacy Rule (45 CFR 164.501), quality assessment and improvement activities are considered health care operations. Health care operations include conducting or arranging for medical record review for compliance programs. The WellCare provider handbook states that providers are required to make medical records available for quality care review purposes.

If you have any concerns regarding the HIPAA rules and would like to speak with someone about this, please call your market QI staff at the number below for assistance.

Altegra Health Medical Record Collection Process

XXXX will contact your office to schedule medical record collection between **February 1 and April 30** for Medicare member charts. You will be contacted by Altegra Health because we have identified that you are either the assigned or previous PCP of the member or have submitted a claim or encounter that relates to a HEDIS measure we are required to report to the state agency and CMS. *Due to the limited time frame to collect and abstract the medical records, we ask that your office accommodates this request for chart collection via fax, mail and on-site sessions at the earliest mutually agreeable date.* Once Altegra Health has scheduled the session, they will fax you a copy of the member pull list that will include instructions for preparing the records. If you require assistance from Altegra Health in pulling charts, you can ask for their help directly or have files ready for them when they arrive.

Please be aware that Altegra Health contracts with other health plans to collect charts for HEDIS and Medicare RAPS reviews. This limits the number of health plans that will need to schedule time in your office. If you have questions about scheduling, you can call

If you have any questions or concerns regarding the process, please call

Thank you in advance for your cooperation.

Sincerely,

WellCare Health Plans, Inc.

Frequently Asked Questions
HEDIS® 2017

WellCare® is required to collect Healthcare Effectiveness Data and Information Set (HEDIS) information annually from our participating care providers. Our network must, therefore, provide requested medical record information so we can comply with the Centers for Medicare & Medicaid Services (CMS), state and federal regulators and accreditation organization requirements. HEDIS data collection will take place between February and May. Following is additional program background and medical record collection process information. We are grateful for your collaboration in this effort.

Q1. What is HEDIS?

- A. Healthcare Effectiveness Data and Information Set (HEDIS) is a standardized set of performance measurements developed by the National Committee for Quality Assurance (NCQA) to evaluate consumer health care.

Q2. Does receipt of the HEDIS 2017 medical record collection notification letter mean I will also receive a member list from WellCare or your designee requesting medical records?

- A. Not necessarily. Members are randomly selected for inclusion to the HEDIS medical record collection process. You may receive a copy of the notification letter but may not have any patients that are included in the review so you would not receive a list. You will not need to take action unless contacted directly by WellCare or our designee. HEDIS 2017 applies to members across all of WellCare's health plans so you may receive more than one notification if you are a participating provider with our other plans.

Q3. Does HIPAA permit me to release records to WellCare or your designee for HEDIS data collection?

- A. Yes. You are permitted to disclose protected health information (PHI) to WellCare as well as vendors who are acting on our behalf as business associates. A signed consent form from the member is not required under the HIPAA privacy rule for you to release the requested information to us or the vendors. For more information about the HIPAA privacy rule, go to <http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/small-providers-small-health-plans-small-businesses/index.html> or contact WellCare.

Q4. Does the American Recovery and Reinvestment Act (ARRA) also permit me to release records to WellCare or your designee for HEDIS data collection?

- A. Yes. ARRA also allows physicians and other covered entities to disclose PHI for health care operation purposes.

Q5. Is my participation in HEDIS data collection mandatory?

- A. All WellCare network providers are required to provide the requested medical record information so that we may fulfill our state and federal regulatory and accreditation requirements, and to help ensure data submissions to the Centers for Medicare & Medicaid Services (CMS) are complete and accurate. Your contract with WellCare stipulates that you are required to comply with requests for member's medical records. If you have questions regarding member medical records please contact your Provider Relations Representative.

Q6. What is my office's responsibility regarding HEDIS data collection?

- A. You and your office staff are responsible for responding to WellCare or our designated vendor's request for medical record documentation within the specified timeframe. Our designee will contact your office to schedule a date for onsite or fax, mail, or electronic data collection. A patient list will be faxed to you the day you are contacted so the requested medical records can be prepared for the appointment or for faxing mailing to the vendor. If a patient chart included on the list we send to you is not available at your practice location, or if a patient is listed who has not received services from your practice, please notify our vendor immediately.

Q7. Do I have to participate on HEDIS 2017 medical record collection even if I participate in one of the NCQA recognition programs?

- A. Yes. NCQA recognition programs do not satisfy HEDIS data collection requirements.

Q8. Who are the vendors who will handle medical record collection on behalf of WellCare?

- A. WellCare is working with several medical record vendors that meet our high performance and customer service expectations and meet HIPAA and confidentiality criteria. As contracted entities to WellCare, they function as our partners in completing HEDIS data collection. They include:
- Altegra Health
 - CIOX Health (fka HealthPort)

Q9. How should I provide the records to WellCare or its designee?

- A. WellCare or its designee will evaluate provider demographics to determine record volume by site, HEDIS measure and geographical location to identify the most appropriate collection method. We provide many options including electronic data collection (remote access to electronic medical records and FTP uploads), onsite data collection and fax or mail. Our representative will discuss these with you.

Q10. Does the record review include members who are no longer with WellCare or deceased?

- A. Yes. Medical record reviews may require data collection related to services obtained over multiple years, including for patients who are or no longer seen by your office and those who are no longer members.

Q11. Does HIPAA permit me to release medical records for services rendered prior to the patient being a member of WellCare?

- A. Yes. You are permitted to release such records because WellCare has or had a relationship with the individual who is the subject of the information (through membership) and the requested data pertains to that relationship. The way that HEDIS reporting is structured, data from prior years relates to the relationship during the current year and thus may be disclosed. Additional details may be found at www.hhs.gov/ocr/privacy/hipaa/faq/disclosures/265.html

Q12. Am I required to provide medical records for a member who was seen by a physician who has retired, died or moved?

- A. Yes. HEDIS data collection includes medical records reviews as far back as 10 years. Archived medical records may be required to complete data collection. While a provider may no longer be at your location, the member may still see a provider in your practice.

Q13. When will WellCare or your designee need the records?

- A. Medical records should be made available on the date of the onsite review, or within five business days of receipt of the request letter, in the case of fax or mail requests.

Please note that even if you were contacted by WellCare to provide HEDIS data in 2016, it is possible you will be contacted again in 2017.

Q14. Will I be reimbursed for copies or materials you need for the medical record review?

- A. Generally, we do not reimburse for medical record copies required for HEDIS data collection. Many provider offices have protected computer technologies that make it unnecessary for you to copy records. However, provider offices without this technology will be required to make copies of the pertinent data. Your participation agreement contains additional information on reimbursement or you may contact your Network Representative.

Q15. Are risk adjustment record reviews the same as HEDIS medical record reviews?

- A. Risk Adjustment reviews are not the same as HEDIS medical record reviews. Risk Adjustment reviews capture medical record documentation to determine a Medicare member's health status and ultimately ensure accurate coding and reimbursement.

Q16. Who should I contact if I have questions regarding HEDIS data collection?

- A. Please contact the WellCare representative in the attached letter.



WellCare Health Plans, Inc.

The WellCare Group of Companies

WW CARE OF ILODA, INC • COMMERCIAL & SIVE HEALTH MANAGEMENT, INC • HEALTH ASSESSMENT OF ILODA, INC • WE CARE OF NEW YORK, INC
WELLCA CO-CORRECTIT, INC • HADN PAVIORAL IALII, I.C. • MW CNY HEATI • HAL OF IWNOS, INC • WE CO-LOUISIANA, INC.
WELLCA OF QOMILL, INC • WELCA FWCUMHOR INSURANCE, INC • WINSOR HEALTH LABS, INC • WILORHEAL I OIUP, INC • STEUNG UFEINSIRAI CI COMPANY

CONFIDENTIAL COMMUNICATION**Fax Transmittal Cover Sheet**

Company:

Fax:

Phone:

From :

Fax:

Phone:

General Fax:

General Phone:

Note: If you have questions about this fax transmittal cover sheet, please contact the individual who is listed above, in the FROM section. Thank You.

NOTES: [Secure] WellCare HEDIS 2017 Medical Record Request

Thank you for speaking with me today in regards to Kentucky HEDIS Medical Record Review. We appreciate your collaboration and attention to this request.

Please provide medical records for the attached list of members within 10 business days. If you need assistance, please contact WellCare at

Return information:

WellCare of Kentucky

Attn: HEDIS

13551 Triton Park Blvd, Ste. 1800

Louisville, KY 40223

Phone# (502) 253-5186

Fax# 813- 675-2970

CONFIDENTIAL**Privacy Notice:**

This letter and any attachments are intended for the exclusive use of the addressee(s) and may contain information that is proprietary, confidential and/or exempt from disclosure and may be Protected Health Information. If you are not the intended recipient, please notify us immediately by calling the number below. Thank you.

WellCare Health Plans, Inc.

Privacy Office

1-888-240-4946

		<h2 style="text-align: center;"><u>Procedure</u></h2>																											
Manual Section: Corporate Policy and Procedures, Health Services Area, Quality Improvement		Procedure Name: Healthcare Effectiveness Data & Information Set (HEDIS)																											
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Prior Procedure Number(s)		<input checked="" type="checkbox"/>	NJ23 QI-055-PR-001	Issue Date: 2/6/09																									
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Medicare (SNP) AR, CA, CT, FL, GA, HI, IL, KY, LA, MS, NJ, NY, SC, TN, TX Medicaid: FL, GA, HI, IL, KY, MO, NJ, NY <input checked="" type="checkbox"/> Other: FL Healthy Kids		<i>Lines of Business and Applicable State(s)</i>	State Agency Approval Date <small>(Attach supporting evidence)</small>	MO <small>(State Abbreviation)</small>	02/28/17 <small>(Date)</small>																								
<i>Electronic Approvals are located in C360</i>																													

Procedure:

1. Annually, the Plan generates HEDIS® and other performance measure data reports from claims, encounter, membership, practitioner, vendor and other data.
2. Annually, the Chief Medical Director (CMD), Quality or designee, contracts with a NCQA-certified HEDIS® auditor as required by CMS and the state Medicaid agencies. A timeline is developed per the HEDIS® auditor guidelines.
3. Annually, for the HEDIS submission process, the Chief Medical Director (CMD), Quality or designee, contracts with a Medical Record Review vendor to conduct the hybrid medical record review.
4. The HEDIS® Roadmap is completed by the Corporate Reporting and Analytics department and subject matter experts from Claims, Encounters, IT, Customer Service, Configuration,

Enrollment, Provider Contracting, QI departments, Credentialing, Finance, Training, EDI, Operations and Front-end.

5. The HEDIS® Roadmap is submitted to the auditors, as required, by the timeline indicated by the auditors each year.
6. All applicable data are extracted from data warehouses using the process and system outlined in the HEDIS® Roadmap each year.
7. The extracted data are then sent to Inovalon (our HEDIS-certified vendor) to be loaded into Quality Spectrum Insight-XL system, which serves as the HEDIS® Repository for HEDIS® measures and state specific performance measures, according to the step actions as described in the HEDIS® Roadmap.
8. HEDIS® rates and state-specific performance measures are calculated from Quality Spectrum Insight-XL using the NCQA Volume 2 HEDIS Technical Specifications for the current reporting year and state-specific technical specifications as applicable.
9. The Sample for Medical Record Review is generated from Quality Spectrum Hybrid Reporter by Inovalon. The provider chases are identified during this process and sent to the QI department to ensure the accuracy of the data.
10. Using Quality Spectrum Hybrid Reporter system, the QI department scrubs the provider data to ensure addresses, phone numbers, names and provider types are accurate and complete.
11. The Corporate Reporting and Analytics Department reviews the data for validation and the data are submitted to the MRR Vendor for the Vendor and / or the market to conduct the medical record reviews. For the markets which collect their own medical records, these medical records are sent directly to the Vendor. The Vendor abstracts all data into their system. The Vendor returns data to the Plan three times a week during the HEDIS® season and it is uploaded into Quality Spectrum Hybrid Reporter.
12. The QI Department conducts inter-rater reliability on the MRR Vendor according to the HEDIS® Roadmap documentation and meets weekly with the MRR Vendor to ensure the project is on track.
13. The Chief Medical Director (CMD), Quality or designee, meets weekly and as needed throughout the project to oversee the MRR Vendors' progress, identify issues and escalate them as needed.
14. The HEDIS® auditors conduct the onsite audit.
15. IT completes the first and second claim lag processes to ensure all recently submitted claims and an encounter are accounted for, and sends these data to Inovalon to upload into the Quality Spectrum Insight system.
16. The HEDIS® Auditors choose the measures for the MRR Validation Audit according to NCQA's published timeline for the current year.
17. The-QI Department collects and prepares the medical records for the MRR Validation Audit and submits them to the HEDIS® Auditor as appropriate.

18. Inovalon extracts the rates from Quality Spectrum Hybrid Reporter and aggregates these data with the data in Quality Spectrum Insight-XL to produce the final HEDIS rates. Inovalon then extracts this data into the IDSS for rates reported to NCQA and produces the Medicare Patient Level Files and all state-specific patient level files required. After Inovalon aggregates the data, the Corporate Reporting and Analytics department extracts the data from Quality Spectrum Insight into the state-specific format according to CMS and state requirements to send to the auditors.
19. For HEDIS rates reported to NCQA, the auditors approve the HEDIS® rates and apply the auditor lock to the IDSS. Once this lock is applied, no changes can be made and the rates are submitted to NCQA.
20. For HEDIS and / or performance measures not reported to NCQA, Corporate Reporting and Analytics department extracts data from Quality Spectrum Insight-XL and inputs the data into the appropriate state required submission tool. The tools are sent to the auditor to review the rates.
21. The HEDIS auditor approves the rates and applies a lock if required.
22. The Plan reports the HEDIS® rates by product annually to all required state/federal agencies and regulatory bodies according to the due dates determined by NCQA and/or regulatory body whichever takes precedence.
23. The HEDIS® auditor completes the Final Audit Statement (FAS) for each LOB, as appropriate, and submits to the Plan according to the appropriate deadline.
24. The HEDIS® auditor completes, the Final Audit Report (FAR) for each LOB, as appropriate, and submits to the Plan within 30 days after finalizing the rates.
25. The Corporate Reporting and Analytics department, IT, QI, and Chief Medical Director (CMD), Quality, completes the Internal Certification Form for internal tracking.
26. The Senior Vice President, Chief Medical Officer signs the attestation via the NCQA portal and submits to NCQA by June 15th.
27. The Corporate Reporting and Analytics Department submits the, FAS, and final rates to the Field QI Department lead for final submission to the state agencies as appropriate.
28. The QI Director in the market assures the signed ICF, rate tools and or IDSS, and the FAS are submitted to the appropriate agencies as required by the NCQA due date and contracted due date for each market.
29. The QI Director in the market assures the FAR is submitted to the appropriate agencies as required by the NCQA due date and contracted due date for each market.



WellCare Health Plans, Inc.

WellCare of Florida, Inc.

A member of the WellCare Group of Companies

ATTENTION: MEDICAL RECORDS

In accordance with our contract with the Agency for Health Care Administration (AHCA) health plans are required to conduct Quality of Care reviews. Under Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules and regulations HIPAA, Covered Entities such as practitioners and their practices are not required to obtain patient authorization to disclose protected health information (PHI) to another Covered Entity (such as WellCare of Florida, Staywell, and HealthEase), so long as both parties have a relationship with the patient and the PHI pertains to that relationship, for the purposes of treatment, payment and health care operations. Quality assessment and improvement activities are considered health care operations.

MEDICAL RECORD REQUEST FOR THE FOLLOWING HMO MEMBER:

***Please note that WellCare and/or Staywell is the payer.*

Member:

DOB:

ID:

DOS:

Please include the items on the list below and submit to us within **7 business days**.

All Clinical Records

TO INSURE PROPER ROUTING, PLEASE FAX TO 813-283-5475 OR MAIL TO:

[REDACTED]
WellCare Health Plans, Inc.
3031 North Rocky Point Drive West
Suite 600
Tampa, FL 33607
Phone: (813)206-3792

CONFIDENTIAL PRIVACY NOTICE: This letter and any attachment(s), if applicable, is intended for the exclusive use of the addressee(s) and may contain information that is proprietary, confidential and/or exempt from disclosure and may be Protected Health Information. If you are not the intended recipient, please contact the sender by telephone at 1-800-917-9355, ext. 8414 and destroy all copies of this message. If you are a regular recipient of our mail, please notify us if you change your address. Thank you.

			Policy		
Manual Section: Corporate Policy and Procedures, Health Services Area, Quality Improvement			Policy Name: Quality of Care Issues Policy		
Policy Number: C7-QI-053			Issue Date: 12/1/05	Page: 1 of 33	
Prior Policy Number(s): NJ23 QI-053			Related Procedure(s):		
Applicable to:			(Check One)		
<input checked="" type="checkbox"/>	Health Services	<i>Area</i>	New <small>(Date policy was created)</small>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	Quality Improvement	<i>Department</i>	Reviewed <small>(No changes to policy)</small>	<input checked="" type="checkbox"/>	04/17/2017
<input type="checkbox"/>			Revised <small>(Content changes made to policy)</small>	<input type="checkbox"/>	
<input type="checkbox"/>			Repealed <small>(Policy is no longer active)</small>	<input type="checkbox"/>	
			<i>All Associates</i>		
Medicare: AR, CA, CT, FL, GA, HI, IL, LA, MS, NJ, NY, SC, TN, TX Medicaid: FL, GA, HI, IL, KY, MO, NJ, NY Exchange: KY, NY <input checked="" type="checkbox"/> Other: FL Healthy Kids, NY-LTC			State Agency Approval Date <small>(Attach supporting evidence)</small>	MO AHCA MHD <small>(State Abbreviation)</small>	02/28/17 6/10/13 7/3/14 <small>(Date)</small>
			<i>Electronic Approvals are located in C360</i>		

Authority/Purpose:

The purpose of this policy is to ensure that WellCare Health Plans, Inc., and its affiliates and subsidiaries (collectively, "WellCare," the "Company," or the "Plan") are in compliance with applicable statutes, regulations, administrative rules, and contract requirements governing quality of care.

Definitions:

See Attachment A.

Policy Statement:

It is the policy of the Company to maintain an accurate and consistent means of identifying, investigating, tracking, trending, and reporting potential and/or actual quality of care (QOC) issues.

Issues are tracked and trended by volume or occurrence and submitted for review and incorporation into the Peer Review process.

Procedures:

Quality of Care (QOC) Issues

QOC issues may be identified by members, family/caretaker of member, providers, regulatory agencies, data mining/reports including Hospital Acquired Condition(s) (HAC)/Never Should Have Happened Event(s) or any department within WellCare, including but not limited to, Customer Service, Grievance, Regulatory Affairs, Provider Relations, Risk Management, Health Services (Utilization Management (UM), Case Management (CM), Disease Management (DM), Quality Improvement (QI), Claims or the Medical Director(s)).

At a minimum, the Company aggregates samples of member complaints by reason, showing rates related to the total member population. The Company collects and reports complaints relating to, at least, the following major categories:

- QOC
- Access
- Attitude and Service
- Billing and Financial Issues
- Quality of Practitioner Office Site

Member Generated QOC Issues

A. CORPORATE

1. Potential QOC complaints are initiated verbally or in writing by members (or members' authorized representatives).
2. Member generated QOC complaints that are received through customer service call center are routed to the grievance department via queue routing.
3. Written member generated QOC complaints are mailed directly (or internally directed) to the grievance department at the following address:

WellCare Health Plans, Inc.
Grievance Department
PO Box 31384
Tampa, Florida 33631-3384

4. The designated grievance staff logs all complaints into the grievance database for reporting and tracking.
5. Member generated potential QOC issues are processed by the grievance department in accordance with established WellCare grievance departmental policies and procedures.
6. The nurse reviews all complaints to determine the nature of the QOC issue. She/he refers those involving a Behavioral Health (BH) diagnosis (Mental Health (MH) or Substance Abuse (SA)

diagnosis), and/or those involving a BH QOC category if co-morbid, being treated for a medical condition, to a licensed BH reviewer for consultation.

7. The nurse reviews information including, but not limited to, claims, physician complaint profile data, customer service notes, appeals, and grievances and medical records, as needed.
 - a. If additional information is required, the nurse sends an information request letter to all appropriate identified provider(s). The nurse reviewer and/or licensed BH reviewer document the information request(s) on the provider performance issue referral form (PPIR) (Attachment B) and log the information request. Using the fax numbers on top of the PPIR form, the request is faxed to the applicable market. Once completed by the market, the PPIR is sent back to the corporate grievance department.
 - b. If no additional information is required, the nurse reviewer and/or licensed BH reviewer prepare a written analysis of the information and log the analysis.
8. The findings are reviewed with the corporate Medical Director (medical and/or behavioral), to determine if there is evidence of a deviation from the standard of care.
9. Review is based on the assessment of the physician response and medical record documentation in relationship to provider and/or health plan policies and procedures, regulatory and/or accreditation standards, and/or industry accepted clinical practice guidelines.
10. If the peer review standard of care is met, under the direction of the corporate Medical Director, the nurse reviewer and/or licensed BH reviewer may close the case, ensuring appropriate data entry of case disposition and creation/release of member closure letter.
 - a. Provider case closure without any follow-up recommendations is:
 - i. Logged in both the action field and the notes field of Xcelys.
 - ii. Stated in a member determination letter signed by the corporate Medical Director.
 - b. Provider track and trend recommendations are:
 - i. Documented on the corrective action plan worksheet.
 - ii. Logged in both the action field and the notes field of Xcelys.
 - iii. Stated in a member determination letter signed by the corporate Medical Director.
 - iv. Reviewed by market QI staff on a monthly basis to assess for trends.
11. If there is concern the peer review standard of care is not met, the corporate Medical Director:
 - a. Documents preliminary concerns in the (PPIR) form.
 - b. Sends the PPIR form and all related materials reviewed to the market for review and further assessment by the market.
12. Quality of care complaints may be in regard to a denial of services. These cases will be directed to the appeals department for simultaneous review with the grievance.
13. Members may submit QOC concerns to the QIO. If the member has submitted a QOC concern to the QIO and to WellCare, the health plan will recognize the authority of the QIO with respect to timely submission of requested information/documentation.

B. MARKET

1. The market Medical Director (medical and/or behavioral) may refer a QOC case to an internal or external peer reviewer when additional specialty expertise is needed to evaluate the appropriateness of care.
2. The market Medical Director (medical and/or behavioral) documents action steps and results on the PPIR form.
3. Credentials/Peer review committee staff coordinate follow-up on cases that result in peer review committee action for physician sanction or termination.
 - a. The market Medical Director (medical and/or behavioral) refers cases to the credentialing (peer review) committee that meets the following criteria:
 - i. Quality review suggests a pattern of inappropriate care.
 - ii. Cases requiring further peer review opinion

Non-Member Generated QOC Issues

1. All non-member generated QOC issues are routed directly to the market QI department via the creation of a QOC referral in the Medical Management System. All QOC referrals by corporate staff are reviewed by the corporate Medical Director before documenting in the Medical Management System. The corporate Medical Director (medical and/or behavioral) include recommendations for disposition in the documentation to the market.
2. Market QI staff assess QOC issues through the Quality Referral SharePoint report at a minimum of monthly and review all referrals to determine the nature of the QOC issue. Staff reviews documentation and track and trend recommendations in the market designated logging system.
3. Market QI staff manage closure timeframes for cases that are not designated as track and trend by the corporate Medical Director, create files as per department operating procedures and forward to the assigned QI staff member.
4. The designated QI staff gathers information including, but not limited to, claims, physician complaint profile data, customer service notes, grievances, and medical records, as needed.
 - If additional information is required, the assigned QI staff member sends an information request letter to the appropriate identified provider(s) and documents the information requested in the quality/nurse review summary section of the PPIR form and then logs the information requested and follow-up dates in the designated logging system.
 - If no additional information is required, the designated QI staff member prepares a written analysis of the information in the quality/nurse review summary section of the PPIR form and logs the analysis in the designated logging system.
5. The Market QI staff review the findings with the market Medical Director (medical and/or behavioral) to determine if there is evidence of a deviation from the standard of care.
6. Reviews are based upon the assessment of all pertinent medical record documentation in relation to the issue, provider compliance with health plan policies and procedures, regulatory and/or accreditation standards, industry standards of care, and/or industry accepted clinical practice guidelines.
 - a. If the peer review standard of care screening criteria is met, under the direction of the market Medical Director, the assigned QI staff member may close the case, ensuring appropriate data entry of case disposition.

- b. If there is concern that the peer review standard of care is not met, the BH/PH Medical Director will:
 - i. Document preliminary concerns in the referral section of the PPIR form.
7. QI department staff meet with the market Medical Director (medical and/or behavioral) at a frequency appropriate to the urgency of the situation to discuss case specifics and receive further instruction regarding additional information needs or action to be taken.
8. The market Medical Director (medical and/or behavioral) may refer a QOC case to an internal or external peer reviewer when additional specialty expertise is needed to evaluate the appropriateness of care.
9. The market Medical Director (medical and/or behavioral) refers cases to the credentialing (peer review) committee that meets the following criteria:
 - a. Quality review suggests a pattern of inappropriate care;
 - b. Cases requiring further peer review opinion.
10. The market Medical Director (medical and/or behavioral) documents the determination in the Medical Director review section of the PPIR form as follows:
 - a. Substantiated (there is evidence of a deviation from the standard of care);
 - b. Unsubstantiated (there is no evidence of a deviation from the standard of care).
11. The market Medical Director (medical and/or behavioral) documents the outcome classification on the Medical Director review section of the PPIR form as follows:
 - a. No adverse event;
 - b. Adverse event.
12. The market Medical Director (medical and/or behavioral) documents the action(s) to be taken on the Medical Director review section of the PPIR form and forwards the case to the QI staff.
13. The market QI staff:
 - a. Coordinate case file presentation to the credentials/peer review committee and receive response of case disposition from the market Medical Director (medical and/or behavioral).
 - b. Document the determination and outcome classification in the designated logging system.
 - c. Document the action to be taken.
14. Credentials (peer review) committee staff coordinate follow-up on cases that result in peer review committee action of physician sanction or termination.
15. Market QI department staff coordinate follow-up on cases with track and trend recommendations or a corrective action plan:
 - a. The track and trend recommendations or corrective action is documented in the corrective action plan worksheet and logged into the designated logging system.
 - b. The details of the track and trend recommendations or corrective action plan are documented in the designated logging system. A determination letter endorsed by the market Medical Director (medical and/or behavioral) is sent to the involved provider(s) for cases in which the provider(s) was asked for a response to the issue or if corrective action plans are needed.

Tracking and Reporting:

1. The QOC issues are tracked via the market grievance report and the complaint report which includes all open cases and corrective action plans related to complaints, grievances, quality of service and quality of care issues.
2. The Market QI department submits quarterly reports to the Utilization Medical Advisory Committee (UMAC) including, but not limited to, trended reports, open and closed case tracking, corrective action plans, and any identified QI issues or trends that need further discussion or follow-up.
3. The grievance and complaint report of QOC trends is reviewed during the QOC investigation process and the re-credentialing process.
4. QOC issues that require National Practitioner Data Bank (NPDB), state regulatory and/or other agency reporting are reported by the credentialing department. Action is taken by the credentialing committee serving as the peer review committee.
5. Cases that require risk management reporting are forwarded to the Market compliance officer.
6. Sentinel events are reported as per state law.
7. If the QOC classification changes to Quality of Service (QOS), the grievance department is notified and updates their records to show the correct labeling.

Addenda: State specific

- A – Georgia
- B – Kentucky
- C – Missouri
- D – Florida MMA
- E – Illinois

Attachment(s):

- A – Definitions
- B – Provider Performance Issue Referral (PPIR) Form
- C – Health Services Potential Quality of Care Workflow
- D – PQOC Medical Director Review Form (Internal form used by the Appeals Department)
- E – Nurse Review Form (Internal form used by the Florida market)
- F – Quality of Care Categories

Addendum A - Georgia Timeframes

Type	Timeframe to Acknowledge	Timeframe for Resolution	Reference
Medicaid Member			DCH Contract
Grievance	10 Business Days from Time of Receipt	Within 90 Calendar Days of the Filing Date	4.14.1.5 The Contractor shall acknowledge receipt of each filed Grievance and Administrative Review in writing within ten (10) Business Days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance and Appeal resolutions.
			4.14.2.3 The Contractor shall provide written notice of the disposition of the Grievance as expeditiously as the Member's health condition requires but must be completed within ninety (90) Calendar Days of the filing date.
Grievance Extension	N/A	14 Calendar Days	4.14.3.4.4 If the Contractor extends the timeframe for the decision and issuance of Notice of Proposed Action according to Section 4.11.2.5, the Contractor shall give the Member written notice of the reasons for the decision to extend Grievance if he or she disagrees with that decision. The Contractor shall issue and carry out its determination as expeditiously as the Member's health requires and no later than the date the extension expires.
Reporting Requirements			
Type of Grievance Report	Data Elements to include in tracking	Frequency	
Member	1. Summary of problems 2. Name of the grievant 3. Date of Grievance 4. Date of Decision 5. Disposition	Quarterly	4.14.8.1 The Contractor shall log and track all Grievances, Proposed Actions, Appeals and Administrative Law Hearing requests, as described in Section 4.18.4.8
			4.14.8.2 The Contractor shall maintain records of Grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of the Grievance, date of the decision and the disposition.
			4.14.8.5 The Contractor shall submit quarterly Grievance System Reports to DCH as described in Section 4.18.4.8.1
Provider	1. # of Complaints by type 2. Type of assistance given 3. Administrative disposition	Quarterly	4.18.4.3 Provider Complaints Report 4.18.3.1 Pursuant to Section 4.9.8.2 the Contractor shall submit a Provider Complaints Report that includes, at a minimum, the following: i. Number of complaints by type; ii. Type of assistance provided; and iii. Administrative disposition of the case.
Grievance System Report	1. # of Complaints by type 2. Type of assistance given 3. Administrative disposition	Quarterly	4.18.4.8.1 Pursuant to Section 4.14.8.5 the Contractor shall submit a summary of Grievance, Appeals and Administrative Law Hearing requests. The report shall, at a minimum, include the following: i. Number of complaints by type ii. Type of assistance provided; and iii. Administrative disposition of the case

Addendum B - Kentucky

Procedures:

Member and Non-Member Generated QOC Issues

1. Potential QOC complaints may be initiated verbally or in writing by members or members' authorized representatives.
2. Member generated PQOC complaints that are received through customer service call center are routed to the Kentucky market Grievance Department via queue routing.
3. Written member generated PQOC complaints are mailed directly (or internally directed) to the Kentucky market Grievance Department at the following address:

WellCare of Kentucky
Grievance Department
13551 Triton Park Blvd.
Suite 1800
Louisville, Kentucky 40223

4. The designated grievance staff logs all complaints into the grievance database for reporting and tracking.
5. Member generated potential QOC issues are processed by the Grievance Department in accordance with established WellCare grievance departmental policies and procedures.
6. All non-member generated QOC issues may also be generated and are routed directly to the market QI Department via the creation of a PQOC referral in the Medical Management System. All PQOC referrals by staff are reviewed by the market Medical Director before documenting in the Medical Management System. The market Medical Director and/or BH Medical Director includes recommendations for disposition in the documentation.

PQOC QI Process

1. The Kentucky QI Nurse Reviewer reviews all complaints to determine the nature of the PQOC issue.
2. The Kentucky QI Nurse Reviewer reviews all information including, but not limited to, claims, physician complaint profile data, customer service notes, appeals, and grievances and medical records, as needed and follows the process below:
 - a. New referrals/requests are processed within two (2) business days from the date the new referral was received. The Kentucky Nurse Review Form is completed by the Kentucky QI Nurse Reviewer as part of the new referral process. The Kentucky QI Nurse Reviewer references the disposition section and the tracking and trending section of the tracking log to see if the provider(s) have had a previous PQOC. If the provider(s) has had a previous PQOC, the Nurse Reviewer notes this in the Kentucky Nurse Review Form.
 - b. If additional is required, the Kentucky QI Nurse Reviewer or the QI Coordinator calls the provider(s) to verify the location/address to send/fa the request from information.

- c. The Kentucky QI Nurse Reviewer sends an information request letter (certified, if mailed) to all appropriate identified provider(s) within two (2) business days from the date the new referral was received.
- d. If no additional information is required, the Kentucky QI Nurse Review prepares a written analysis of the information on the case worksheet of the Kentucky Nurse Review Form (Kentucky's PPIR Form) and logs the analysis on the Disposition Tracking Sheet.
- e. The Kentucky Nurse Reviewer updates the tracking sheet with the designated information.
- f. If additional information is needed, or if no information has been received from the initial request, the Kentucky QI Nurse Reviewer and/or the QI Coordinator sends up-to-three (3) information request letters (certified if mailed) in regards to the PQOC within a time period of 90 days.
- g. If after 90 days, no information has been received, the KY QI Nurse Reviewer discusses the case with the market Medical Director (medical and/or behavioral health).
- h. The market Medical Director (medical and/or behavioral health) decides if the provider is to be placed in a track and trend status, or if an additional letter from the Medical Director requesting the information is to be sent (certified).
- i. If the decision is made to place the provider in a track and trend status, the Kentucky QI Nurse Reviewer notes the recommendation/plan in the market's tracking system for tracking and trending, and sends a notification to the Credentialing Committee to be noted in the provider's file and presented at the time the provider goes through the re-credentialing process. Providers who are placed on "track and trend" are monitored for 12 months from the date they are placed in a "track and trend" status. The Kentucky QI Nurse Reviewer notes this on the tracking sheet (step 12).
- j. If a letter from the market Medical Director (medical and/or behavioral health) is sent, the Kentucky QI Nurse Reviewer or QI Coordination sends the letter (certified) to the provider(s).
- k. If no information is received within 30 days from the date of the final letter, the process follows the above process for placing the provider on tracking and trending (steps h-i).
- l. The tracking and trending section of the tracking sheet is referenced each time a PQOC is received checking for a previous PQOC.
- m. If the requested information is received, the Kentucky QI Nurse Reviewer follows the below process for processing PQOCs (steps 9-14).
- n. If an additional/previous PQOC(s) is found, the Kentucky QI Nurse Reviewer notifies the market Medical Director (medical and/or behavioral health) and he/she follows the above process to request information for the current PQOC (steps a-c; e-o).
- o. If the requested information is received, the process follows the process below (steps 9-14) for PQOCs. However, the Credentialing Department is notified by the Kentucky QI Nurse Reviewer the provider has an additional PQOC for inclusion in the provider's file for discussion at the time of re-credentialing.
- p. If upon market Medical Director (medical and/or behavioral) review, the Medical Director decides additional information is needed from a provider from whom medical records were not originally requested, the Kentucky QI Nurse Reviewer follows the above process (steps a-c; e-o) to request records. At this point, the time period for receipt of requested medical records is extended for a period of up to 90 days from the date of the additional record request, but not to exceed 180 days from the date of the original referral for completion.

3. The Kentucky QI Nurse Reviewer summarizes the PQOC on the Kentucky Nurse Review Form and reviews the information and findings with the market Medical Director (medical and/or behavioral health), to determine if there is evidence of a deviation from the standard of care.
4. Review is based on the assessment of the physician response and medical record documentation in relationship to provider and/or health plan policies and procedures, regulatory and/or accreditation standards, and/or industry accepted clinical practice guidelines.
5. If the peer review standard of care is met, under the direction of the market Medical Director (medical and/or behavioral), the Kentucky QI Nurse Reviewer may close the case, ensuring appropriate data entry of case disposition into the tracking log and creation/release of member PQOC closure letter.
 - a. Provider case closure without any follow-up recommendations is:
 - i. Logged in both the action field and the notes fields of Access Database.
 - ii. Stated in a determination letter endorsed by the market Medical Director (medical and/or behavioral health).
 - iii. Noted on the tracking sheet.
 - b. Provider track and trend recommendations are:
 - iv. Documented on the corrective action plan worksheet in the tracking sheet.
 - v. Logged in both the action field and the notes fields of Xcelys.
 - vi. Stated in a determination letter endorsed by the market Medical Director (medical and/or behavioral health).
6. Providers who were placed on "track and trend" and have been monitored for 12 months from the date they were placed in a "track and trend" status and have not had another PQOC referral; the Kentucky QI Nurse Reviewer removes the provider from "track and trend" status and sends an update to the Credentialing Committee.
7. If there is concern that the peer review standard of care is not met, the market Medical Director (medical and/or behavioral health) documents preliminary concerns in the Medical Director Review form and the information is sent to the Credentialing Peer Review Committee.
8. Credentials/Peer Review Committee staff coordinate follow-up on cases that result in Credentialing Peer Review Committee action of physician sanction or termination.
 - a. The market Medical Director (medical and/or behavioral health) refers cases to the Credentialing Peer Review Committee that meet the following criteria:
 - i. Quality review suggests a pattern of inappropriate care
 - ii. Cases requiring further peer review opinion that find deviation from the standard of care
9. If a provider is sent to the Credentialing Peer Review Committee, the PQOC remains open pending the outcome of the Committee. The Kentucky QI Nurse Reviewer notes this on the tracking sheet. Once the Credentialing Peer Review Committee makes its decision/recommendation, the Kentucky QI Review Nurse notes the outcome on the tracking sheet and in the Access Database. If the Committee decision is to allow the provider to remain participating with the Plan (sanction), the provider is placed on track and trend, for a minimum of 12 months, and the Kentucky QI Nurse Reviewer notes this in the tracking log. If the decision is to terminate the provider from participating with the Plan, the Kentucky QI Nurse Reviewer notes this on the tracking sheet.

10. If additional information is received after a PQOC has been closed, the Kentucky QI Nurse Reviewer reviews the additional information with the market Medical Director (medical and/or behavioral health) and the Medical Director determines if there is to be any changes to the original recommendations. The Medical Director may decide to:

- a. Uphold the original decision;
- b. Send an additional response letter, acknowledging receipt of the information and the determination; or
- c. Refer to the Credentialing Peer Review Committee

The Kentucky QI Nurse Reviewer notes the Medical Directors decision in the tracking sheet and Access Database and:

- a. Sends the additional Medical Director letter (if instructed to do so by the Medical Director); or
- b. Sends a member PQOC closure letter

11. Once the case is closed, the file is scanned by the QI Coordinator and retained electronically.

The process for non-member generated QOC issues follows the steps outlined above in this policy and on pages four through five.

The process for tracking and reporting follow the steps outlined on pages five and six of this policy.

Addendum C – Missouri Care

Summary of Applicable Guidelines and Procedures:

Quality of Care (QOC) Issues

QOC issues may be identified by members, family/caretaker of member, providers, regulatory agencies data mining/reports including Hospital Acquired Condition(s) (HAC)/Never Should Have Happened Event(s) or any department within Missouri Care, including but not limited to, Member Services, Complaints Grievances and Appeals (CGA), Regulatory Affairs, Provider Relations, Risk Management, Health Services (Utilization Management (UM), Case Management (CM), Disease Management (DM), Quality Improvement (QI), Claims or the Medical Director(s)).

Procedure:

Member Generated QOC Issues

1. Potential QOC complaints are initiated verbally or in writing by members or members' authorized representatives.
2. Member generated QOC complaints that are received through member services are routed to the CGA department.
3. Written member generated QOC complaints are mailed to the CGA department at the following address:

Missouri Care
2404 Forum Blvd
Columbia, Missouri 65203

4. The designated CGA staff logs all complaints, grievances and appeals into the CGA database for reporting and tracking.
5. Member generated potential QOC issues are processed by the CGA department in accordance with established CGA departmental policies and procedures and refers potential QOC issues to the Missouri Care Nurse.

Non-Member Generated QOC Issues

1. All non-member generated QOC issues are routed directly to the Missouri Care Nurse via Quality of Care Intake Form.

Quality of Care Investigation

1. The Missouri Care Nurse reviews potential QOC information including, but not limited to, claims, PQOC Database, health services notes, CGA notes, and medical records, as needed.
 - If additional information is required, the Missouri Care Nurse sends an information request letter to all appropriate identified provider(s). The Missouri Care Nurse logs the information requests on the PQOC Database.

- If no additional information is required, the Missouri Care Nurse prepares a written analysis and reviews the findings with the CMO/BMD to determine if there is evidence of a deviation from the standard of care. The PPIR form is completed and the information is logged into the PQOC Database.
- 2. The Missouri Care Nurse reviews the findings with Missouri Care Chief Medical Officer/Behavioral Medical Director to determine if there is evidence of a deviation from the standard of care.
- 3. Reviews are based upon assessment of physician response, medical record documentation against provider and/or health plan policies and procedures, regulatory and/or accreditation standards, and/or industry accepted clinical practice guidelines.
 - If the peer review standard of care screening criteria is met, under the direction of the Missouri Care Chief Medical Officer/ Behavioral Medical Director, the Missouri Care Nurse may close the case, ensuring appropriate data entry of case disposition.
 - If there is concern that the peer review standard of care is not met, the Missouri Care Chief Medical Officer/Behavioral Medical Director will document preliminary concerns in the referral section of the PPIR form.
- 4. The Missouri Care Nurse meets with Missouri Care Chief Medical Officer/ Behavioral Medical Director at a frequency appropriate to the urgency of the situation to discuss case specifics and receive further instruction regarding additional information needs or action to be taken.
- 5. The Missouri Care Chief Medical Officer/ Behavioral Medical Director may refer a QOC case to an internal or external peer reviewer when additional specialty expertise is needed to evaluate the appropriateness of care.
- 6. The Missouri Care Chief Medical Officer/ Behavioral Medical Director refers cases to the Utilization Management Medical Advisory Committee (UMAC) Committee and/or Credentialing (peer review) Committee that meets either or both of the following criteria:
 - Quality review suggests a pattern of inappropriate care
 - Cases requiring further peer review opinion
- 7. The Missouri Care Chief Medical Officer/ Behavioral Medical Director documents the impact to member/severity on the Medical Director review section of the PPIR form as follows:
 - None
 - Minor
 - Major
 - Critical
- 8. The Missouri Care Chief Medical Officer/ Behavioral Medical Director documents the determination on the Medical Director review section of the PPIR form as follows:
 - Substantiated (there is evidence of a deviation from the standard of care)
 - Unsubstantiated (there is no evidence of a deviation from the standard of care)
- 9. The Missouri Care Chief Medical Officer/ Behavioral Medical Director documents the adverse labeling on the Medical Director review section of the PPIR form as follows:
 - No adverse event
 - Adverse event

10. The Missouri Care Chief Medical Officer/ Behavioral Medical Director documents the classification on the Medical Director review section of the PPIR form as follows:

- Procedural Issues
- Delay/Omission of Care
- Post-Op Complications
- Medication Issues
- Death or Serious Disability
- Patient Safety
- Quality of Services (QOS)

11. The Missouri Care Chief Medical Officer/Behavioral Medical Director documents the action(s) to be taken on the Medical Director review section of the PPIR form as follows:

- No Further Action
- Obtain Additional Information
- Request Written Feedback from Provider
- Medical Director Follow-up with Practitioner
- Audit Medical Records
- Refer to Specialist for Peer Review
- Refer to UMAC Committee for Peer Review
- Refer to Credentialing/Peer Review Committee
- Request Corrective Action Plan

12. The Missouri Care Chief Medical Officer/ Behavioral Medical Director documents the final disposition to be taken on the Medical Director review section of the PPIR form and forwards the case to the Missouri Care Nurse:

- Track & Trend
- Corrective Action Plan Resolved – Track & Trend
- Physician Sanction – Track & Trend
- Termination

13. The Missouri Care Nurse:

- Coordinates case file presentation to the UMAC Committee and/or Credentialing (peer review) Committee, as needed, and receive response of case disposition from the Missouri Care Chief Medical Officer/Behavioral Medical Director.

14. Credentials (peer review) committee staff coordinate follow-up on cases that result in peer review committee action of physician sanction or termination.

15. The Missouri Care Nurse coordinates follow-up on cases that require track and trend recommendations or a corrective action plan:
 - Documents the action to be taken.
 - The details of the track and trend recommendations of corrective action is documented on the corrective action plan worksheet and logged in the PQOC Database.
 - Documents the impact to member, determination, adverse labeling, classification, actions to be taken and final disposition in the PQOC Database.
16. A determination letter endorsed by the Missouri Care Chief Officer/ Behavioral Medical Director is sent to the involved provider(s) for cases in which the provider(s) was asked for a response to the issue or if corrective action plans are needed.
17. Occasionally, Quality of Care complaints are also complaints regarding a denial of services. These cases will be directed to appeals area and will be reviewed simultaneously with the grievance complaint.

Tracking and Reporting:

1. The QOC issues are tracked via the PQOC Database and the Corrective Action Plan Worksheet; if applicable.
2. The designated CGA staff logs all complaints, grievances and appeals into the CGA database for reporting and tracking.
3. The Missouri Care Nurse submits quarterly QOC Issues reports to the UMAC Committee including, but not limited to, trended reports, open and closed case tracking, corrective action plans, and any identified QI issues or trends that need further discussion or follow-up.
4. The QOC trends are reviewed during the QOC investigation process and the re-credentialing process.
5. The credentialing department reports QOC issues that require National Practitioner Data Bank (NPDB), state regulatory and/or other agency reporting. Action is taken by the credentialing committee which acts as the peer review committee.
6. Cases that require risk management reporting are forwarded to the regional compliance officer.
7. Sentinel events are reported as per state law.
8. If the QOC classification changes to Quality of Service (QOS), the complaints, grievances and appeals department is notified to review and updates their records to show the correct labeling, if applicable.
9. The Missouri Care Nurse reviews all potential quality of care problems, both physical and behavioral health with the QI Senior Manager for continuous assessment and improvement of the quality of care provided to members.

State RFP

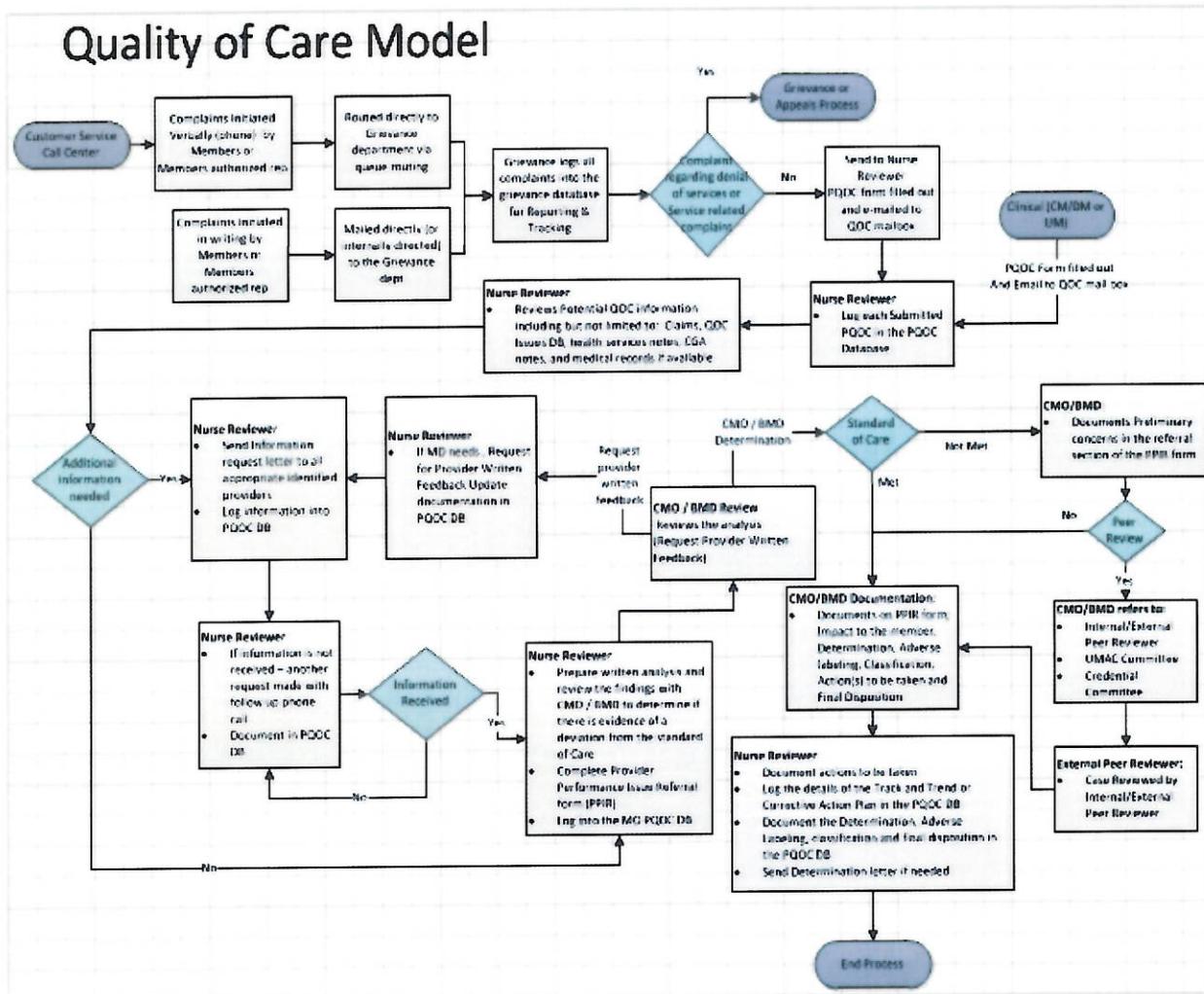
The health plan shall comply with all the state agency's quality assessment and improvement programs as described herein and when periodically reviewed and updated by the state agency. The state agency shall provide the health plan with no less than ninety (90) calendar days' notice of any changes in the format requested. The health plan shall comply with all subsequent changes specified by the state agency. The health plan shall participate in the state agency's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The health plan shall be held accountable for the ongoing monitoring, evaluation, and actions as necessary to improve the health of its members and the care delivery systems for those members. The health plan shall be held accountable for the quality of care delivered by providers. The health plan shall have a quality assessment and improvement program which integrates an internal quality assessment process that conforms to Quality Improvement System for Managed Care (QISMC) and additional current standards and guidelines prescribed by CMS.

In addition to internal monitoring of quality of care, the health plan shall submit reports to the state agency regarding the results of their internal monitoring, evaluation, and action plan implementation. The reports shall include targeted health indicators monitored by the state agency and specific quality data periodically requested by the Federal government. The reports will be in the format and frequency specified by the state agency and located and periodically updated on the MO HealthNet website at Health Plan Reporting Schedule and Templates (<http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/>). The report format shall be periodically reviewed and updated by the state agency. The state agency shall provide the health plan with no less than ninety (90) calendar days' notice of any changes in the format requested. The health plan shall comply with all subsequent changes specified by the state agency. The health plan shall participate in all data validation activities pertaining to such reports, as requested by the state agency.

Addendum C – Missouri Care (Continued)

Quality of Care Model – MO Care

Quality of Care Model



Addendum D – Florida MMA

Critical and Adverse Incidents Reporting Requirements

- A. Staywell will develop and implement an incident reporting and management system for adverse or critical incidents.
- B. Staywell will require participating service providers and direct service providers to report adverse incidents to Staywell.
- C. Staywell will require MMA providers to report adverse incidents to the managed care plan within forty-eight (48) hours of the incident.
- D. Staywell will provide appropriate training and take corrective action as needed to ensure its staff, participating providers, and direct service providers comply with critical incident and adverse requirements.
- E. Staywell will immediately report to the Department of Children and Families' Central Abuse Hotline any suspected cases of abuse, neglect or exploitation of enrollees, in accordance with s.30.201 and Chapter 415, F.S. Staywell will maintain documentation related to the reporting of such events in a file, separate from the enrollee's case file. Such file shall be made available to the Agency upon request.
- F. Staywell will implement and maintain a risk-management program.
- G. Enrollee quality of care issues must be reported and a resolution coordinated with Staywell's Quality Management Department.
- H. Staywell will report a summary of adverse and critical incidents to the Agency, as specified in Section XIV, Reporting Requirements, and in the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.
- I. Staywell will report suspected unlicensed ALF's and AFCH's to the Agency, and shall require its providers to do the same pursuant to 408.812 F.S.

Staywell will not require provider submission of adverse incident reports from the following providers: health maintenance organizations and health care clinics reporting in accordance with s. 641.55, F.S.; ambulatory surgical centers and hospitals reporting in accordance with s. 395.0197, F.S.; assisted living facilities reporting in accordance with s. 429.23, F.S.; nursing facilities reporting in accordance with s. 400.147, F.S.; and crisis stabilization units, residential treatment centers for children and adolescents, and residential treatment facilities reporting in accordance with s. 394.459, F.S. Adverse incidents occurring in these licensed settings will be reported in accordance with the facility's licensure requirements.

Addendum E – Illinois
Critical Incident Reporting

General LTSS Requirements

- A. WellCare has policies and implement procedures for Critical Incident (CI) reporting and management for incidents that occur in a NF/SCNF or home and community-based long-term care service delivery setting, including: community alternative residential settings, adult day care centers, other HCBS provider sites, and a member's home. WellCare's policy and procedures address the process to report potential violations of criminal law to local law enforcement authorities.
- B. WellCare's CI system had been developed in accordance with the direction provided by the Department of Healthcare and Family Services (HFS) and other State entities responsible for the oversight and investigation of CIs including use of all forms, tools and report formats required by the State.
- C. WellCare staff will be familiar with the statutory, regulatory and state agency requirements regarding critical incident reporting.

In all LTSS provider contracts, WellCare will require full adherence to the mandatory training and reporting requirements set forth in the HFS contract Section 5.19; Table 1; and Attachments XIII, XVII, XVIII, XIX and those applicable to Illinois Department on Aging (IDoA), Adult Protective Services (APS), and the Department of Human Services (DHS-DRS).

- D. Critical Incidents will include but are not be limited to the following incidents as defined by DHS-DRS and IDoA:

DHS – DRS

- Death, HSP customer
- Death, Other parties
- Physical abuse of customer
- Verbal/Emotional abuse of customer
- Sexual abuse of customer
- Exploitation of customer
- Neglect of customer
- Sexual Harassment by provider
- Sexual Harassment by customer
- Sexually problematic behavior
- Significant medical event of provider
- Significant medical event of customer
- Customer arrested, charged with or convicted of a crime
- Provider arrested, charged with or convicted of a crime
- Fraudulent activities or theft on the part of the customer or the provider

- Self-Neglect
- Customer is missing
- Problematic possession or use of a weapon by a customer.
- Customer displays physically aggressive behavior
- Property damage by customer of \$50 or more
- Suicide attempt by customer
- Suicide ideation/ threat by customer
- Suspected alcohol or substance abuse by customer
- Seclusion of a customer
- Unauthorized restraint of a customer
- Media involvement/media inquiry
- Threats made against DR Falsification of credentials or records S/HSP Staff
- Report against DHS/HSP employee
- Bribery or attempted bribery of a HSP Employee
- Fire / Natural Disaster

IDoA

- Physical Abuse
- Sexual Abuse
- Emotional Abuse
- Confinement
- Passive Neglect
- Willful Deprivation
- Financial Exploitation

Reporting and Monitoring Requirements

- A. WellCare will identify and track critical incidents and will review and analyze critical incidents to address potential and actual quality of care and/or health and safety issues. WellCare will regularly review the number and type of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of LTSS delivery.

- B. WellCare will require its staff members and contracted LTSS providers to report, respond to, and document critical incidents as specified by WellCare, regulatory requirements and as indicated below.
1. WellCare's staff and contracted LTSS providers report critical incidents to WellCare in accordance with applicable requirements. WellCare will develop and implement a critical incident reporting process to comply with DHS-DRS and IDoA requirements. The maximum timeframe for reporting an incident to WellCare will be twenty-four (24) business hours and immediately to the appropriate state agency upon notification.
 2. Suspected abuse, neglect, and exploitation of members are immediately reported in accordance with the State agency requirements.
 - To report abuse/neglect/exploitation of persons with a mental illness, a developmental or physical disability including those residents of Department of Human Services (DHS)-operated facilities call the **Office of the Inspector General (OIG)** 24-hour Hotline **1-800-368-1463 Voice/TTY**
 - To report Elder Abuse for elders and adults and people with disabilities between the ages of 18-59 living in the community not residing in a nursing home, call the [Elder Abuse 24-Hour Hotline](#) at **1-866-800-1409 (Voice), 1-888-206-1327 (TTY)**
 - To report abuse/neglect for those in Hospitals or Nursing Homes call the Illinois Department of Public Health (IDPH) Hotline **1-800-252-4343**
 - Reports regarding Enrollees in Supportive Living Facilities (SLF) must be made to the Department of Healthcare and Family Services' SLF Complaint Hotline at **1-800-226-0768**
 - To report abuse or neglect of a child call the Department of Children and Family Services' Child Abuse Hotline **(800) 25-ABUSE (1-800-252-2873)**
 3. Staff members and contracted LTSS providers immediately (which shall not exceed twenty-four hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.
 4. Contracted LTSS providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by WellCare. WellCare will review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.
 5. Staff members and contracted LTSS providers cooperate with any investigation conducted by WellCare, its designee or outside agencies, including law enforcement.
 6. Providing appropriate training and taking corrective action as needed to ensure its staff members, contracted LTSS providers, the fiscal intermediary, and workers comply with critical incident requirements.
- C. The maximum timeframe for reporting an incident from the time the LTSS provider or WellCare's staff member discovers or is informed of the incident will be twenty-four (24) hours.
1. The initial report of an incident may be submitted verbally, in which case the person/agency/entity making the initial report will submit a follow-up written report twenty-four (24) hours from the time the HCBS provider or the Contractor's staff member discovers or is informed of the incident, and respond to any emergency needs of members.

2. Requiring that WellCare staff members and contract LTSS providers immediately (which will not exceed twenty-four hours) take steps to prevent further harm to any and all members from the time the HCBS provider or WellCare's staff member discovers or is informed of the incident, and respond to any emergency needs of members.
3. Requiring that contracted LTSS providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation to WellCare within the timeframe specified by WellCare. The timeframe for submitting the report will be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, will be no more than thirty (30) calendar days after the date of the incident. WellCare will review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

Attachment A - Definitions

Definitions:

Adverse Event: An untoward, undesirable, and usually unanticipated incident that occurs while a member is receiving healthcare services. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no permanent effect on the patient.

Enterprise Medical Management Application (EMMA): System used by the Company to perform automated, integrated Care, Case, Disease and Utilization management for its members.

Quality of Care (QOC): The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current medical knowledge.

Quality of Service (QOS): The degree to which the process for delivery of health care and/or health plan services are consistent with current policy and procedures.

Referral to Quality (RQU): Case note type used to classify quality referrals in EMMA.

Trend – Three or more occurrences within a rolling six month period or five occurrences in one year.

Sentinel Event: Defined by The Joint Commission (TJC) as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness.

Severity codes: - the impact to the member will be categorized by the following severity codes:

- **0 None** - There is no impact on the quality, performance or functionality of a patient.
- **1 Minor** – A low-to-medium impact problem. One which allows the patient to continue to function. This may be a minor issue with limited loss or no loss of functionality or impact to the patient.
- **2 Major** - A problem where the patient's system is functioning but in a severely reduced capacity. The situation is causing significant impact to portions of the patient's health. The system is exposed to potential loss or interruption.
- **3 Critical** - A catastrophic problem which may severely impact the patient.

Xcelys: System used by the Company to access provider and member information.

Attachment B**Provider Performance Issue Referral (PPIR) Form**

This form must be used for all QOC and QOS communication between Corporate and the Regions.

Confidential Fax Numbers / Circle Applicable Health Plan

CT: 800-793-4454	FL: 813-283-9309	GA: 877-277-1810	OH: 216-901-4186	HI: 866-291-3526
TX / LA: 888-822-8210	MO: 312-630-2022	IL: 312-630-2022	NY / NJ: 800-793-4454	KY: 502-253-5253

Referred to QI Date:	Close By Date:
QI Case Reference #:	Clinical Staff Member:

Please complete all entries that are required to process this case; additional information should be placed in the notes section. This top section is to be completed by the corporate representative who is sending the event to the region.

Member Name:	DOB:
Member ID Number:	DOS:
Provider / Attending Name:	Facility Name:
Provider PIN:	PCP Name:
Specialty:	PCP PIN:

Code/Trigger:	Issue Type – choose below	A/G File Number:	
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Classification:

- Procedural Issues Death or Serious Disability
 Delay/Omission of Care Patient Safety
 Post-Op Complications Quality of Service (QOS)
 Medication Issues

Corporate Representative to describe the issue:

--

Market Level Nurse Reviewer's Summary: (Provide narrative, chronological summary of events including available clinical / non-clinical information and any identified trends)

Date	Source	

Provider Trends such as other QOC and/ or QOS occurrences or complaints:

Date submitted for Medical Director Review_____

Medical Director Review Form

QI Receipt Date:	QI Case Reference Number:	Clinical Staff Member:
Member Name:	Member ID #:	DOB:

Impact to Member / Severity: (check one)

O 0 None - There is no impact on the quality, performance or functionality of a patient.

O 1 Minor – A low-to-medium impact problem. One which allows the patient to continue to function. This may be a minor issue with limited loss or no loss of functionality or impact to the patient.

O 2 Major - A problem where the patient's system is functioning but in a severely reduced capacity. The situation is causing significant impact to portions of the patient's health. The system is exposed to potential loss or interruption.

O 3 Critical - A catastrophic problem which may severely impact the patient.

SUBSTANTIATED LABELING - Check One

Unsubstantiated	Substantiated
Substantiated - there is evidence of a deviation from the standard of care.	<input type="checkbox"/>
Unsubstantiated - there is no evidence of a deviation from the standard of care.	

ADVERSE LABELING - Check One

No Adverse Event	Adverse Event
Adverse Event: An untoward, undesirable, and usually unanticipated event that occurs while a member is receiving healthcare services. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no permanent effect on the patient.	
Classification:	
<input type="radio"/> Procedural Issues	<input type="radio"/> Death or Serious Disability
<input type="radio"/> Delay/Omission of Care	<input type="radio"/> Patient Safety
<input type="radio"/> Post-Op Complications	<input type="radio"/> Quality of Service (QOS)
<input type="radio"/> Medication Issues	

Medical Director Recommendations: (check all that apply)
<input type="radio"/> O No Further Action

- Obtain Additional Information (specify below)*
- Request Written Feedback from provider
- Medical Director Follow-up with Practitioner
- Audit Medical records
- Refer to Network Management
- Refer to Specialist for Peer Review
- Refer to Credentialing/Peer Review Committee as appropriate
- Track & Trend

Additional Information Requested (Specify additional information and/or feedback needed, OR, Specify type of specialty review and pertinent questions to address.):

Medical Director Signature:

Date:

If Additional Information is gathered, please complete the next page.

**Confidential and Privileged Communication
FOR INTERNAL USE ONLY**

Medical Director Review Form
Additional Information

If Applicable:

Additional Information Received on (Date):		
Medical Director Review of Additional Information, if applicable:		
<input type="radio"/> No Further Action		<input type="radio"/> Refer to Credentialing Committee for Peer Review
<input type="radio"/> Track & Trend		<input type="radio"/> Other (specify):
Comments:		
Medical Director Signature:		Date:
Is the Provider aware of all information going to Credentialing/Peer Review Committee?		
<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Applicable

**Confidential and Privileged Communication
FOR INTERNAL USE ONLY**

Credentialing Committee Peer Review Form

Case:	QI Receipt Date:	Clinical Staff Member:
Member Name:	Member ID #:	DOB:

Date of Credentialing/Peer Review Committee Review:

Credentialing Committee Peer Review Findings if applicable (check one):

- No evidence of substandard medical care or adverse outcome identified – No Issue.
- Known medical/surgical complication with no serious adverse outcome or affect to member – no substandard medical care identified, track and trend
- Questionable Medical Care (see below)
- Care Provided Does Not Appear to be Consistent with Community Standards (see below)

Credentialing Committee Peer Review Recommendations: (check all that apply)

- | | |
|---|--|
| <input type="radio"/> No Further Action
<input type="radio"/> Track & Trend
<input type="radio"/> Written Feedback
<input type="radio"/> Medical Director Follow-up with Practitioner
<input type="radio"/> Audit Medical records
<input type="radio"/> Refer to Network Management for Provider education | <input type="radio"/> Corrective Action Plan
<input type="radio"/> Referral to Like-Specialist Peer Review
<input type="radio"/> Provider Monitoring (not to exceed 12 months)
<input type="radio"/> Provider Sanctions
<input type="radio"/> Recommend Termination
<input type="radio"/> Additional Information Needed (specify in comments) |
|---|--|

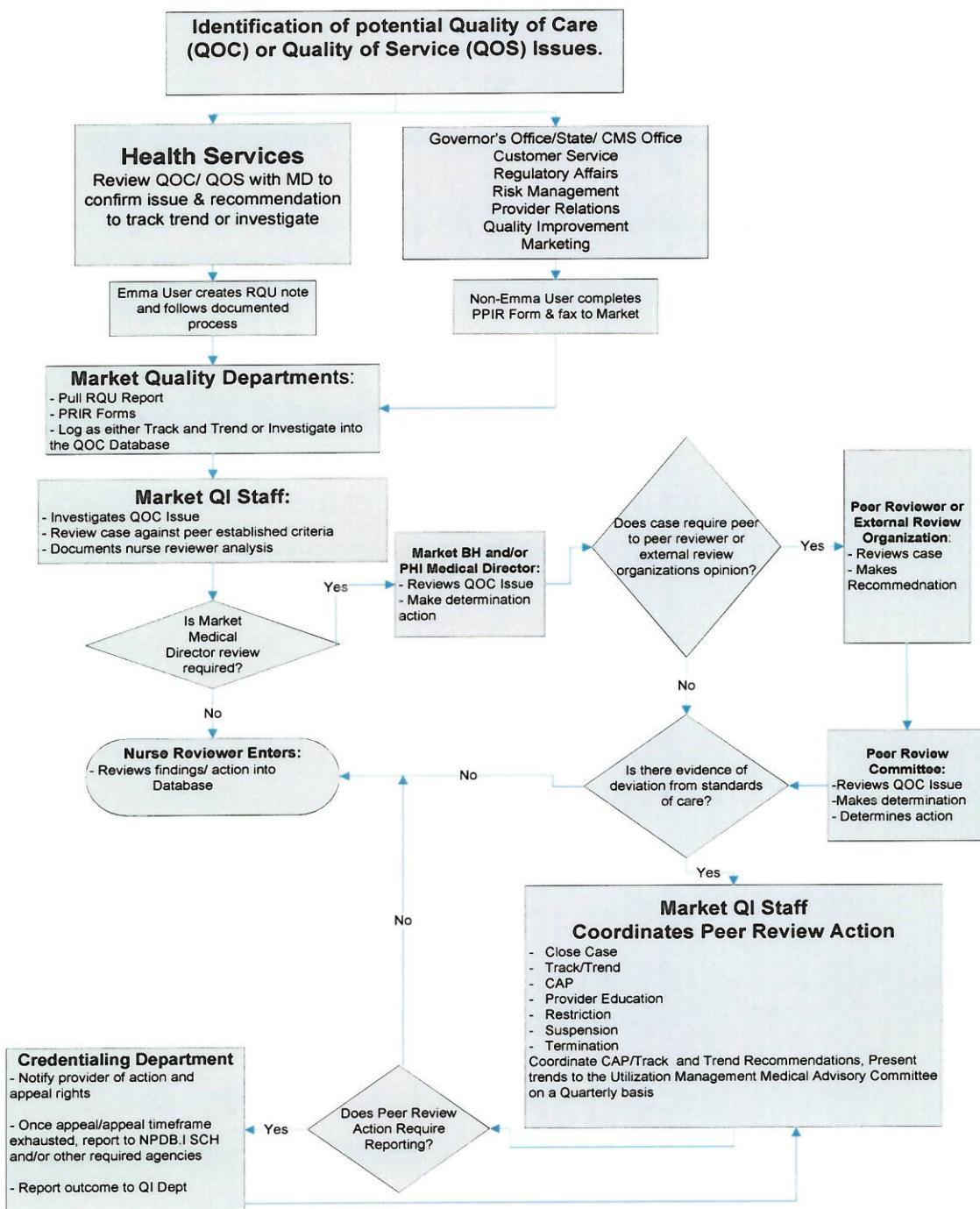
COMMENTS
Date letter sent to Provider: Date database updated:

End of PPIR Form – Last updated January 15, 2010

Attachment C

Health Services Potential Quality of Care Workflow

N/A for Missouri



Attachment D**PQOC Medical Director Review Form**
N/A for Missouri

Member Name:	Member ID #:
POQC Receipt Date:	PQOC Case Reference Number:
Review Nurse: Review Date:	
Reviewer's Summary:	

MEDICAL DIRECTOR DETERMINATION**Impact to Member / Severity: (check one)**

O 0 **None** - There is no impact on the quality, performance or functionality of a patient.

O 1 **Minor** – A low-to-medium impact problem. One which allows the patient to continue to function. This may be a minor issue with limited loss or no loss of functionality or impact to the patient.

O 2 **Major** - A problem where the patient's system is functioning but in a severely reduced capacity. The situation is causing significant impact to portions of the patient's health. The system is exposed to potential loss or interruption.

O 3 **Critical** - A catastrophic problem which may severely impact the patient.

Medical Director Recommendations: (check all that apply)	
<input type="checkbox"/> No Further Action <input type="checkbox"/> Obtain Additional Information (specify below)* <input type="checkbox"/> Request Written Feedback from provider <input type="checkbox"/> Medical Director Follow-up with Practitioner <input type="checkbox"/> Refer to Regional Medical Director (QOC)	
Additional Information Requested (Specify additional information and/or feedback needed, OR, Specify type of specialty review and pertinent questions to address.):	
Medical Director Signature:	Date:

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Attachment E

NURSE REVIEW FORM

N/A for Missouri

Impact to Member / Severity: (check one)

- 0 None** - There is no impact on the quality, performance or functionality of a patient.
- 1 Minor** – A low-to-medium impact problem, which allows the patient to continue to function. This may be a minor issue with limited loss or no loss of functionality or impact to the patient.
- 2 Major** - A problem where the patient's system is functioning but in a severely reduced capacity. The situation is causing significant impact to portions of the patient's health. The system is exposed to potential loss or interruption.
- 3 Critical** - A catastrophic problem which may severely impact the patient.

Unsubstantiated	<input type="checkbox"/>	Substantiated	<input type="checkbox"/>
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No Adverse Event	<input type="checkbox"/>	Adverse Event	<input type="checkbox"/>
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Adverse Event: An untoward, undesirable, and usually unanticipated event that occurs while a member is receiving healthcare services. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no permanent effect on the patient.

Classification:

- Procedural Issues Medication Issues
- Delay/Omission of Care Death or Serious Disability
- Readmit less than 30 days Post-Op Complications
- Patient Safety Quality of Service (QOS)
- Inadequate assessment / Misdiagnose Other

Comments:

Nurse Signature:	Date:
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Communication
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Attachment F – Quality of Care Categories

The following categories are used at the intake level when an event initially comes into the process. These event types are not all inclusive as not all categories are listed here.

QOC Category	Types
Procedural Issue	Surgery performed on wrong side of patient's body
	Surgery performed on the wrong patient
	A foreign body left in a patient after surgery
	Anesthesia-related event that lead to death or serious disability
	Inappropriate/incorrect performance of a procedure
	A medical procedure that actually or has the potential to cause a patient's death, paralysis, coma, or other major permanent loss of function
Medication Issue	A medication error that actually or has the potential to cause a patient's death, paralysis, coma, or other major permanent loss of function. Includes but not limited to: omission error, dosage error, dose preparation error, wrong time, and wrong rate of administration, wrong administrative technique, and wrong patient
Delay/Omission of Care	Performance of a test
	Medical or surgical consultations
	Treatment or procedure
	Misdiagnosis
	Inadequate assessment
	Failure to comply with reporting laws
Death or Serious Disability	Medical or surgical consultations
	Treatment or procedure
	Performance of a test
	Misdiagnosis
	Inadequate assessment
	Suicide/homicide or attempted suicide/homicide that results in serious injury or disability while in a health care facility
Post-op Complications	Wound Infection resulting in increased LOS
	Wound dehiscence resulting in increased length of stay and/or return to surgery
	Hemorrhage
	Perforation, laceration or tear
	Admission after outpatient surgery
Patient Safety	Patient abduction from the facility
	Sexual assault/harassment
	Nosocomial infection
	Fall
	Restraint-related
	Transfusion-related

Neglect, physical, emotional or sexual abuse while being cared for in a health care facility

Suicide attempt resulting in the need for medical care either during treatment or within 30 days of discharge from any BH level of care, and directly relating to a BH condition

--Inpatient, Residential elopement from a behavioral health facility

--Self-inflicted injury while in an inpatient, residential or outpatient treatment facility

--Violent assaulting behavior on others or self, requiring hospitalization or involving potential for serious threat to life, either during treatment or within 30 days of discharge from a BH level of care



WellCare of Kentucky
HEDIS 2017 Reporting Project
Location Pull List

**** PLEASE RETURN PULL LIST WITH REQUESTED RECORDS ****

Name:
Address:
Phone: Fax:

Please provide medical records for the attached list of members within 10 days.

Return Information:

Phone: (502) 253-5186
Secure Fax: 813-675-2970
WellCare of Kentucky
Attn: HEDIS
13551 Triton Park Blvd, Suite 1800
Louisville, KY 40223

Member Name	Date of Birth	Sex	Measure	Chase ID	Altegra Chart ID	Earliest DOS	Last DOS	Not My Patient
			DIABETES CARE					

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Printed: 12/8/2017

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