



State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

May 31, 2013

Honorable Members of the Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Committee Members:

Thank you for your inquiry into the regulatory oversight of abortion services under Wisconsin law. Following are responses to questions raised in your letter.

Regulatory Oversight of Abortion Clinics in the State of Wisconsin

1. Question: Does your state license abortion clinics or those facilities and providers who perform abortions? If so, please identify what information must be provided or requirements must be met for a facility or provider to be licensed. In addition, please identify the number of abortion clinics licensed in your state for each year from 2008-2013.

Response: Wisconsin does not license abortion clinics. The oversight of abortion services in the State of Wisconsin may be provided either by the Wisconsin Department of Health Services (WDHS) or the Wisconsin Department of Safety and Professional Services (WDSPPS). This is based on whether services are delivered within a regulated setting, such as a hospital, as outlined below, or within an unlicensed setting but by a Wisconsin licensed physician.

The WDHS conducts regulatory oversight of hospitals under Chapter 50 of the Wisconsin Statutes. Under these provisions, hospitals maintain the certificate of approval, or license, to serve patients who are in need of acute care services and are under the care of the physician and other hospital staff.

In addition to oversight under Wisconsin licensing laws, the WDHS serves as an agent of the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), under section 1864 of the Social Security Act for the regulation of hospitals and ambulatory surgery centers under Medicare conditions of participation. Our Medicare oversight functions are performed under auspices of the federal regional office of CMS located in Chicago.

Under the Medicare reimbursement standards, CMS provides reimbursement for covered clinic services in the following situations:

- As an outpatient service of a Medicare-certified hospital (provider based service designation). Such a location would be a free-standing clinic that serves Medicare beneficiaries under the hospital's Medicare or Medicaid certification.
- As a separately Medicare-certified Ambulatory Surgery Center (ASC). NOTE: ASCs are not licensed under Wisconsin law, thus the only authority to conduct oversight is under federal laws.

The WDHS may investigate or seek federal government approval to investigate (under certain situations) allegations regarding the abortion service if the abortion services are provided at the state-licensed hospital, at a clinic covered under the hospital's status as a Medicare provider, or at a separately Medicare-certified ASC.

Abortion services (clinics) that are not under WDHS oversight under state law or Medicare/Medicaid certification may fall within the jurisdiction of the WDSPPS because these services are provided by physicians.

The WDSPPS and the licensing boards attached to that department credential a wide range of health care providers, but there is no credential for providers of abortions.

2. Question: For the years 2008-2013, please identify each abortion clinic for which your state has suspended or revoked its license and the reason for this action.

Response: For the period 2008 – 2013, the WDHS has not suspended or revoked a license relating to abortion services because Wisconsin does not license abortion clinics.

3. Question: Does your state conduct inspections of abortion clinics or facilities that perform abortions? If so please identify the number of clinics that your state has inspected for each year from 2008 – 2013. In addition, please identify how an inspection is conducted and what information examined in the course of an inspection.

Response: Division of Quality Assurance (DQA) has regulatory authority over hospitals and ASCs that may perform abortions; however, Wisconsin cannot confirm if hospitals or ASCs are or are not performing abortions.

DQA conducts inspections of hospitals using survey protocol from the State Operations Manual (SOM) and DHS 124 Administrative rules governing hospitals:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf.

http://docs.legis.wisconsin.gov/code/admin_code/dhs/110/124.pdf

DQA also conducts inspections of ASCs using survey protocols from the SOM:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_1_ambulatory.pdf

DQA does not have authority over free standing clinics that are not under the hospital's Medicare provider number, such as abortion clinics. Below are the number of hospital and ASC

surveys conducted from 2008-2013; however, there are no specific survey requirements related to abortions.

	Number of Surveys *					
	2008	2009	2010	2011	2012	2013 (YTD)
ASC	6	6	16	23	15	7
Hospital	202	214	217	151	185	82

* includes all survey types, including recertifications, complaints, and revisits

Outpatient physician offices and clinics such as the abortion clinic are not regulated in Wisconsin. (Survey protocol for hospitals and ASCs attached)

4. Question: Does your state monitor complaints or adverse health events relating to abortions? If so, how are these complaints filed or processed? How many complaints relating to abortions or abortion clinics have been filed for each year from 2008-2013?

Response: DQA monitors complaints and triages incoming complaints related to hospitals and ASCs in accordance with the SOM . A complaint may originate from a variety of sources. These sources include direct telephone calls from complainants; mail including e-mail; referrals (including caregiver incident reports from the DQA/Office of Caregiver Quality); results of an unrelated survey; a complainant presenting in person; or from the hotline maintained by the DQA. Allegations may come from the patient, patient's family members, other health care providers, concerned citizens, public agencies, or from media reports. Although DQA has not received complaints related to abortions in hospitals or ASCs, if an allegation of regulatory non-compliance were received, it would be triaged and assigned to a surveyor for investigation under the appropriate federal and state regulations as mentioned above.

The WDSPS is a complaint-driven agency and receives complaints from a variety of sources including consumers, co-workers and employers. Two complaints related to abortion services were filed in the period from 2008 to 2013. Both of these complaints were filed in 2010.

4a. Question: Please explain how your state investigates the complaints it receives relating to abortions. In addition, please explain how many investigations, including those that included inspections of abortion clinics, have resulted from complaints filed for each year from 2008-2013.

Response: DQA has not investigated any abortion related complaints in hospitals or ASCs from 2008-2013. If an allegation was investigated, the federal and state survey protocols would be followed (attached).

The WDSPS and the attached licensing boards investigate complaints involving abortions in the same manner as they investigate other types of complaints against licensed professionals.

Complaints proceed through a process involving an initial screening, an investigation if necessary, a legal review, prosecution if appropriate and a final action by the licensing board. In the time period from 2008 to 2013 two investigations were conducted. These investigations were the result of the two complaints filed in 2010.

The WDSPPS does not specifically track or code abortion cases in the computer system. The statistics in this response were developed from a survey of staff employed during the time period.

5. Question: Please explain whether your state, including state professional licensure boards, has initiated any disciplinary actions against facilities or health care providers relating to abortions? Please identify the number of disciplinary actions taken in each year from 2008-2013 and the underlying violation or reason for the action.

Response: The authority of DQA is limited to enforcement of the quality of care regulations, which in most instances do not dictate a physician's practices. Complaints related to professional practice, including practice of physicians, nurses, and other licensed professionals would be referred to the Wisconsin Department of Safety and Professional Services.

The Wisconsin DSPS and the attached licensing boards did not initiate any disciplinary actions against providers relating to abortions.

6. Question: Please provide copies of the rules and regulations that govern facilities and licensed health care providers in your state that perform abortions, including the rules and regulations that specifically govern how abortions are conducted in your state.

Response: A wide range of statutes and rules govern the practice of physicians in Wisconsin. Rules specific to abortions are set out in Wisconsin Administrative Code Chapter Med 11. Please click the following link to access these regulations:

https://docs.legis.wisconsin.gov/code/admin_code/med/11

6a. Question: Which of these laws is your agency tasked with enforcing and how do you enforce them?

Response: As discussed previously, Wisconsin cannot affirm if hospitals perform abortions or not; however, Wisconsin State hospital regulation is DHS 124, which is enforced by DQA. DHS 124 can be found at: http://docs.legis.wisconsin.gov/code/admin_code/dhs/110/124.pdf

Violations of Wisconsin Administrative Code Chapter Med 11 would be enforced by the Wisconsin Medical Examining Board. A complaint of a violation of these rules would be handled in the same manner as other complaints. Complaints proceed through a process involving an initial screening, an investigation if necessary, a legal review, prosecution if appropriate and a final action by the licensing board.

7. Question: What actions has your state taken since 2005 to ensure that, at every licensed health care facility that provides abortions, there is a designated individual to report suspected medical neglect (including withholding of medically indicated treatment from disabled infants with life-

Honorable Members of the Committee on Energy and Commerce

May 23, 2013

Page 5

threatening conditions) of born-alive infants to the state child protective services agency? Has the state received any such notifications and what were the outcomes?

Response: The Wisconsin Department of Children and Families does not maintain a list of designated contacts nor is it making annual contacts.

If there are additional questions regarding oversight over abortion services in the State of Wisconsin, please contact the following individuals:

Alex Ignatowski, Legislative Advisor
Wisconsin Department of Health Services
(608) 266-3262

Respectfully,



Kitty Rhoades
Secretary

Enclosure

Division of Quality Assurance

PROCEDURE SUMMARY

Title Acute Care Compliance Section Complaint Management Procedure		
Original Effective Date 5/12/92	Revision Effective Date 12/02/09	Procedure Number 3212
Bureau Responsible for Procedure Health Services Section (BHS)	Bureau(s) Affected by Procedure BHS & BTLE Section	
Providers Affected Hospitals (including general acute, alcohol, critical access, psychiatric and rehabilitation hospitals and units, and swing beds); home health agencies, hospice agencies, end stage renal disease facilities, ambulatory surgery centers, outpatient physical therapy/speech pathology providers, comprehensive outpatient rehabilitation facilities and rural health clinics.		
Purpose of Procedure To describe and differentiate screening and investigation of complaints.		
List of Applicable Rules, Regulations, Statutes, State Operations Manual (SOM) or State Agency Performance Standards (SAPS) DHS 105, 106, 107, 124, 131, and 133, Chapter 51.64, State Agency Performance Standards (SAPS) #6, Centers for Medicare and Medicaid Services (CMS) State Operations Manual (SOM) Chapter 5, Complaint Procedures.		
Reason for Most Recent Revision To include references to Personal Care Worker (PCW) Agencies, and End State Renal Dialysis (ESRD) involuntary discharge procedures, and to amend information on due dates to align with the CMS requirements.		
Summary of Changes Update to DQA responsibilities for PCW and ESRD. Correct due date calculation information.		
Related DQA Procedures 1260, Referrals; 3216, NLTC Citing Guidelines		

LIST OF FORMS AND ATTACHMENTS USED IN THIS PROCEDURE
 Hyperlink the available forms and attachments noting NC (no change), new or revised.

Name of Form or Attachment	Effective Date	Status
BHS Complaint Processing Desk Instructions	7/1/2005	Revised
Letters acknowledging complaint receipt and outcome	Varies	NC
CMS State Operations Manual, Chapter 5, Complaint Procedures		
Complaint Processing Timelines	5/21/04	Revised
S&C Memo 04-09: Guidelines to Support Management of	7/1/05	Revised
Complaints/Incidents Tracking System (ACTS)	11/13/04	New
S&C Memo 05-27: Interim Timeliness Guidelines to Support the Entry of		
Data into the ACTS & Revisions to Field Definitions in ACTS	5/12/05	New
S&C Memo 04-23: Procedures in the Event of Fire in Medicare/ Medicaid		
Certified Health Care Facility	3/11/04	New
Reportable Death Review Committee forms/procedures		
Region V ACTS NLTC Complaint/Incident Processing Guide	Unknown	Unknown
	12/28/04	Revised

HISTORY OF REVIEWS AND REVISIONS			
		Review Dates	Revision Dates
		Please see history for dates previous dates.	Please see history for dates previous dates.
Signature – Bureau Director	Date Signed	Signature – Deputy Administrator	Date Signed
Alfred C. Johnson /s/	12/22/2009	Jane Walters /s/	01/04/2010
Signature – Bureau Director	Date Signed		
Cremear H. Mims /s/	12/29/2009		

PROCEDURE

I. COMPLAINT OVERVIEW

A complaint is received when the Division of Quality Assurance (DQA) obtains information from a stakeholder who believes regulatory action should be taken regarding a specific allegation(s). A complaint may originate from a variety of sources. These sources include direct telephone calls from complainants; mail including e-mail; referrals (including caregiver incident reports from the Office of Caregiver Quality); results of an unrelated survey; a complainant presenting in person; or from the home health hotline maintained by the Division of Quality Assurance. Allegations may come from the patient, patient's family members, other health care providers, concerned citizens, public agencies, or from media reports. In some cases, the complainant may request anonymity. Complainants may be anonymous, or may give contact data with the understanding that the source of the complaint will not be revealed during the complaint investigation. These complainants shall be informed that, in the rare circumstance of post-survey legal action, their names may be released during the legal proceedings.

The Bureau of Health Services (BHS) complaint coordinator receives and reviews the allegations to determine whether an assertion of regulatory noncompliance has been alleged and whether DQA has jurisdiction or authority to act on the allegation.

The complaint coordinator captures complete information necessary to prioritize and plan investigation of the allegations, including: information about the complainant and other individuals involved; specifics about the allegation, such as the type of incident, time, place, etc.; the frequency and pervasiveness of the allegation; the provider or supplier name and location; how and why the complainant believes the allegation occurred; whether the complainant initiated any other course of action; and what expectations or desires the complainant may have for resolution or remedy. (Suggested questions are listed on the Intake tab in ACTS.)

The complaint coordinator provides a complainant with information that assists in resolving his/her conflicts. Such information includes an explanation of the scope of authority of Bureau; BHS and the Centers for Medicare and Medicaid Services' (CMS) procedures for handling complaints; anticipated time frames and course of action; other appropriate sources of assistance; and BHS contact information for follow up purposes. See CMS Survey & Certification memo 04-09, Guidelines to Support Management of Complaints and Incidents and the National Implementation of the ASPEN Complaints/Incidents Tracking System (ACTS).

For the BHS Complaint/Incident Processing Desk Instructions detailing complaint processing and data entry instructions see Attachment 1.

II. OPENING COMPLAINTS

Screening determines whether an allegation of actual regulatory noncompliance has been made and whether DQA has jurisdiction or authority to act on the allegation. Complaint screening also determines the level of response required per BHS protocols and CMS requirements.

BHS complaints are promptly screened by the complaint coordinator, or by BHS management staff. Once it is determined that the allegation(s) falls within DQA's authority, the complaint coordinator triages the intake to determine the severity and urgency of the allegations, so that appropriate and timely action can be pursued in accordance with the State Operations Manual (SOM).

Priority categories from the federal data system are:

A - IJ (Immediate Jeopardy)

B - Non-IJ High

- C - Non-IJ Medium
- D - Non-IJ Low
- E - Non-IJ Admin Review/Offsite Investigation
- F - Referral-Immediately
- G - Referral-Other
- H - No Action Necessary

The priority category assigned to an allegation determines if a complaint will be investigated and how quickly it will be investigated. See CMS S&C memo 04-09, Guidelines to Support Management of Complaints and Incidents and the National Implementation of the ASPEN Complaints/Incidents Tracking System (ACTS) for a full description of the priority categories.

A. IJ (Immediate Jeopardy) is defined as, "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." Intakes are assigned this priority if the intake information indicates immediate corrective action is necessary because a provider's or supplier's alleged noncompliance may have caused, or is likely to cause, serious injury, harm, impairment or death to a patient. Such complaints must be investigated within 2 working days of receipt of complaint for non-deemed providers/suppliers, and within two working days of receipt of regional office (RO) authorization for deemed providers/suppliers. IJ also includes all EMTALA allegations. Federally authorized EMTALA investigations and federally mandated reports of death due to restraint/seclusion must be completed within 5 working days after authorization. Death alleged to be due to uncorrected defects in the physical environment or abuse causing serious injury by staff remaining in direct patient care are examples of IJ priorities. (See S&C Memo 04-23, regarding reporting deaths or serious injury from fire.) DQA must initiate onsite survey within two working days of receipt of information about fires resulting in serious injury or death.

B. Non-IJ High is defined as harm that impairs mental, physical and/or psychosocial status of such consequence to the person's well being that a rapid response is indicated. This level of complaint is represented by specific rather than general information, such as, descriptive identifiers, individual names, date/time/location of occurrence, description of harm, etc. This category includes the death investigations mandated under Wis. Stats. 50.04(2t) and 51.64(1) (deaths in psychiatric treatment areas caused by suicide, restraint, or psychotropic medications). State mandated death reports are assigned a due date within 14 days from the date of receipt of the report of the death. Other Non-IJ High complaints are assigned a due date for completion between 10 and 30 calendar days after receipt of the complaint, depending on the urgency and credibility (e.g., specific information) of the complaint. An isolated death alleged to be due to provider noncompliance, a pattern of nosocomial infection, and a pattern of development of severe pressure ulcers during hospitalization are examples of Non-IJ High priorities.

C. Non-IJ Medium is defined as noncompliance that has caused or may cause harm that is limited in consequence and, although not causing actual harm, may impact the care and treatment of patients. Non-immediate jeopardy complaints for providers with deemed status that are authorized by CMS require an onsite survey within 45 calendar days after approval by the RO. Examples of Non-IJ Medium priorities include: inadequate pain control following surgery; medication errors without serious effect; lengthy waits in the ER for persons with urgent though not EMTALA level medical problems; failure of nursing to notify the physician of a change in condition (without serious negative outcome); and discharge of a patient needing home health follow-up without adequate referral.

D. Non-IJ Low is defined as situations that may have caused physical, mental and/or psychosocial discomfort. An onsite survey may be scheduled within 120 calendar days. Examples of this priority include allegations that

the call light was not answered timely causing discomfort and irritation to the patient, allegations that visitors were improperly restricted, or allegations that a dietary consult was not obtained timely (with absence of serious negative outcome).

E. Administrative Review/Offsite Investigation is the priority used for complaints/incidents that are triaged as not needing an onsite investigation, but are investigated by an off-site, desk review to ensure compliance with the Federal requirements. The additional information is adequate in scope and depth to determine that an onsite investigation is not necessary; however, BHS has discretion to review the information at the next onsite survey. These allegations are potential regulatory violations with a low probability of resulting in actual harm or complaints with no allegation of actual harm. An on-site desk review consists of phone calls and/or letters to the provider and a summary of provider's actions in relation to the complainant's concerns. The provider may be asked to submit written documentation addressing the concern raised.

F. Referral - Immediately is the priority used for complaints/incidents so serious as to require referral or reporting to another agency, board or network immediately for investigation. Serious caregiver abuse reported by the provider who has already taken steps to protect the patients is an example of this priority. (See DQA Procedure Summary #1260, Referrals; DQA Memo # 04-004, Referrals to the Office of Caregiver Quality; BHS Memo # 01-004, BHS Caregiver Complaint Management Procedures; and the worksheet instructions titled, Attachment 2, Referrals From BHS, 3/5/04, updated 7/1/05.)

G. Referral - Other is the priority used for complaints/incidents that will be referred to another agency, board or network for investigation, or for informational purposes.

H. No action necessary is the priority used when adequate information about the incident/complaint yields the conclusion that BHS can determine with certainty that no further investigation, analysis, or action is deemed necessary. For all cases except EMTALA, that do not allege immediate jeopardy, and at BHS's discretion an intake may not require a new onsite investigation, if at a previously completed survey, the same events were investigated; the previously completed survey evaluated the appropriate individuals, including those identified in the intake; and the situation did not worsen. These types of intakes should be linked to the appropriate survey that has already reviewed the issue. Samples in this category may include:

- complaints that represent an isolated incident with minor negative outcome or low probability of resulting in harm;
- complaints in which the complaint incident occurred over one year from the date of receipt of the complaint, except in extraordinary circumstances;
- complaints about subjects outside the regulatory authority of DQA, such as billing issues;
- referrals to or from other agencies or DQA sections which lack substantial probability of provider noncompliance with regulations enforced by DQA;
- complaints alleging violation of Federal regulations in deemed providers that CMS has not authorized for investigation for which there is no allegation of violation of State regulations. This includes EMTALA allegations, most Discharge Planning allegations, some Patient Rights allegations such as allegations of failure to evaluate seclusion/restraint done for behavioral control within one hour, or restraint complaints that are medical only.

DQA/BHS enforces State regulations in hospital, home health, and hospice. The priority definitions above apply to the decision as to whether State only investigations are conducted. If another agency, such as MetaStar or the Office of Caregiver Quality, has or plans to investigate a complaint that is also referred to DQA/BHS/ACCS, investigation will be conducted only if:

- the allegations rise to medium or high priority, and
- actions of the other agency are not predicted to result in correction of provider deficient practice.

DQA/BHS and CMS Region V follow the procedures outlined in the CMS State Operations Manual (SOM). CMS Region V determines whether a complaint against a deemed provider alleges one or more Condition-level(s) of noncompliance. DQA/BHS conducts investigation of deemed hospitals, home health agencies, and ambulatory surgery centers under federal authority after it receives authorization via ACTS. Complaints alleging substantial noncompliance by deemed providers and suppliers that are authorized by CMS are investigated in accordance with CMS deadlines. Complaints alleging noncompliance by non-accredited providers and suppliers are investigated per the SOM.

The BHS complaint coordinator initiates data entry of the complaint record into ACTS and assigns a surveyor to an on-site or desk investigation as appropriate to the designated priority. See the BHS Complaint Processing Desk Instructions.

III. COMPLAINTS NOT OPENED

Assess written or telephone complaints using priorities described in Sections II.

Enter the complaint in ACTS.

No action necessary complaints are summarized in ACTS for future reference. Surveyors are expected to review the ACTS summary for these allegations prior to future surveys for subsequent investigations or other survey activities at the provider.

End State Renal Dialysis (ESRD) providers are required to report to DQA when a patient is involuntarily discharged. These reports should be entered in ACTS as an unopened entity-reported incident. See attachment 1.

IV. INVESTIGATION & CLOSURE

The surveyor investigates all assigned complaints in accordance with the State Operations Manual. See the online SOM at: <http://www.cms.hhs.gov/manuals/downloads/som107c05.pdf>

The surveyor follows the guidance of Region V ACTS NLTC Complaint/Incident Processing Guide, System Instructions for Deemed NLTC Complaints and Incidents. The surveyor chooses the Findings Text box on the Allegation Tab, then describes survey tasks and summarizes the investigative process and results. The Guide describes linking the investigation to the complaint/incident intake(s) via the "Full Investigation Properties" button or the investigation tab. If the investigation is not linked to the complaint/incident, linking the deficiencies is not possible. The surveyor links deficiencies to allegations by clicking the link deficiencies button below the list of allegations after citing the deficiencies. If deficiencies were cited that were unrelated to the allegations, they should not be linked to any allegations. In accordance with the Guide (quoted below), the surveyor enters allegation findings, substantiated vs. unsubstantiated, and reasons why.

A substantiated allegation is an allegation that did occur and is verified by evidence. An allegation is considered substantiated based on the finding about the individual or specific situation named by the complainant in his or her allegation; or, other residents or patients reviewed or similar situations, even if the noncompliance was corrected for the specific individual(s) named by the complainant in the allegation.

- A. Federal deficiencies related to the allegation are cited.
- B. State deficiencies related to the allegation are cited

C. No deficiencies related to the allegation are cited The SA determined that the allegation did occur. However, at the time of the investigation, the provider had taken action necessary to prevent the deficient practice, and/or the allegation was not serious enough to warrant citing deficiencies. (This is not applicable for EMTALA; for EMTALA see the State Operations Manual at §3410.)

D. Referral to appropriate agency After investigation, the complaint/incident was forwarded to the appropriate agency.

An unsubstantiated allegation is an allegation where evidence cannot support that the allegation did occur.

A. Allegation did not occur Evidence indicates that the allegation did not occur.

B. Lack of sufficient evidence The SA is unable to verify that the allegation did occur because of insufficient evidence. e evidence is inconclusive.

C. Referral to appropriate agency After investigation, the complaint/incident was referred to the appropriate agency.

If the investigation (EMTALA or deemed) was not authorized by the RO and is not going to be investigated under State regulations, the BHS complaint coordinator will change the priority to "no action necessary" and close the complaint/incident on the actions/close tab. If the complaint is not authorized but will be investigated under State regulations, the BHS complaint coordinator will change the intake subtype on the Intake Tab to "state licensure."

For on-site investigations see the Non-Long Term Care Citing Guidelines document. The surveyor should contact the complainant prior to the on-site visit to verify the allegations and determine if the complainant has further information. The surveyor should also phone the complainant when the on-site investigation is completed, and explain the tasks completed and the findings, and advise the complainant that they will be receiving a letter of response. If there are unusual circumstances affecting the post-survey phone call, the surveyor should consult with the supervisor.

For desk investigations, the assigned surveyor completes desk investigation survey by the date due. Surveyor refers survey packet (investigation form, supporting documents, and surveyor notes) to the office operations associate for entry in Aspen Central Office and then forward to BTLE.

At periodic scheduling meetings utilizing reports from ACTS, supervisors monitor complaint investigation progress. At the conclusion of a complaint investigation, supervisors review complaint materials and the Statement of Deficiencies using the Principles of Documentation. The complaint packet includes a packet checklist specific to provider type to assure that all required documents are completed and a survey record to assure that processing and follow-up are congruent with requirements including timeliness. Attachment 3 describes the internal checklist and survey record forms per provider types, which include complaint surveys. Supervisors sign appropriate documents and forward to the office operations associate.

The BHS office operations associate (OOA) sends the complaint investigation survey to BTLE if the complaint was federally authorized (a deemed provider or EMTALA) or has condition level cites. If a complaint is substantiated with cites or unsubstantiated with cites, the OOA enters survey information in ASO (670 time, dates in survey properties, plan of correction dates in "properties"). If a complaint is unsubstantiated or substantiated with no cites, the OOA will enter 670 time in ASO, print the 2567, and forward the packet to BTLE. The BTLE section processes the documents and sends to CMS RO V as required.

If the complaint was investigated under DHS 124 only or in a hospital that is either non-accredited or has lost deemed status, and has cites below the condition level, the BHS OOA processes the complaint. The OOA

serves the Statement of Deficiencies, prepares applicable follow up notes, begins ACO data entry, and sends the packet to the BTLE section for processing and data entry into the federal complaint subsystem as required.

Any complaint for any non-long term care (LTC) facility that has a Medicare number must come to BTLE for complaint processing. The BTLE staff person completes ACTS data entry, uploads and then closes the complaint. If the complaint concerns a facility that is state-licensed only, the complaint can go directly to the DQA File Center.

For a table of which staff is responsible for complaint closures according to complaint type, see Attachment 4.

BTLE staff will assure that the following ACTS fields are completed:

- Investigated by (required for priorities IJ through IJ Low)
- Check the "Forward to RO/MSA" box: only check this box when the following conditions are met: all SA required fields, as defined by the Guide and S&C Memorandum 04-09, have been completed including the CMS-670 and CMS-2567; the completed package has been sent in the mail (see NOTE below); a narrative is available for viewing (see section II-C, subsection iii)
- NOTE: In addition to the forms and information obtained in ACTS by the RO, i.e., the CMS-2567, CMS-670, allegation findings/narrative report, etc, there are several forms still required to be mailed to RO for completion of the complaint/incident review process. These forms are detailed in Appendix D of the Region V ACTS NLTC Complaint/Incident Processing Guide—under "Forms to be Mailed to the RO."

If an authorized complaint is referred to the SA from the RO, then the RO will complete the following field. Otherwise, BTLE completes the following field:

- Acknowledgement date (will reflect on the CMS-562 and will be uploaded to OSCAR, the SA should complete this field at the time they acknowledge the complaint/incident in accordance with SOM 3260). No acknowledgement date is required for an entity-reported incident or an anonymous complainant.

BTLE also completes the following fields:

- Proposed Actions-Federal: Can only be entered if an onsite investigation is scheduled. Will appear as #12 on the CMS-562;
- Proposed Date-Federal: According to S & C Memorandum 04-09, attachment 3, this is the date of the notice sent to the provider/supplier informing the provider/supplier of actions that may be taken as a result of the investigation findings. If the provider/supplier is in compliance, the proposed action date is the date the provider/supplier is notified that it is in compliance. (The date of the exit conference can be entered here.)
- Overall findings: this field will populate from the findings entry on the allegation tab.
- "Forward to RO/MSA" Check box and date: this check box and date will carry forward from the investigation tab; see the section J for instructions on this field.

If the investigation was of a death, reportable under Wisconsin Statutes Chapter 51.64, the OOA sends two copies of the complaint investigation summary, the Statement of Deficiencies if any, and the state death report forms to the BHS Reportable Death Review Committee member.

For guidance on ACTS data entry timeframes, see Attachment 5.

For guidance on ACTS required fields, see Attachment 6.

ATTACHMENT 1: BHS COMPLAINT/INCIDENT PROCESSING DESK INSTRUCTIONS

After assessing and determining a priority level, the complaint coordinator records the complaint in the federal complaint system, ACTS.

NOTE: Adjust the due date to reflect the priority of the complaint. State mandated entity reports of deaths resulting from suicide or use of psychotropic medications should be assigned an investigation due date within 14 days of the receipt date. Complaints prioritized as non-IJ Medium should be given a due date of 45 calendar day (ACTS will calculate either working or calendar days), entered on the Intake Tab. Complaints prioritized as IJ, non-IJ high, deaths resulting from use of restraint or seclusion, or EMTALA will have shorter due dates: 5 days from CMS authorization for EMTALA, 2 days from CMS authorization for IJ, and 10 to 30 calendar days for non-IJ High. A change in due date of up to six months from the date of intake may be made if the complaint is prioritized as non-IJ low, is being investigated under State authority only, or when an extension of due date is made by supervisors or CMS due to unique circumstances. Due dates may be extended to coincide with a scheduled recertification survey in the interests of efficiency, or when required by unit scheduling needs.

For complaints in category E, desk reviews only, the complaint coordinator assigns a surveyor who may be the lead worker. For complaints that will not be investigated, no data is entered in the CMS complaint system. In ACTS, use the "findings/text" box on the Allegations Tab to describe what action was taken (such as referring the caller to MetaStar, Department of Regulation and Licensing) and to describe rationale (i.e., allegations do not describe a regulatory violation). Close the complaint in the Actions/Close Tab by checking the flagged Finalized checkbox and reason closed checkbox (usually, "no jurisdiction"). The date field auto-dates.

ACTS Data Entry:

Open ACTS and use the Find field or the provider on the alphabetic list of the drop down to locate the provider/supplier. Highlight the provider and left click to the menu. Choose New Intake.

On the **Intake** top tab screen enter appropriate data into the following fields:

- Intake staff section: the State Agency and your name are defaults. Change this if that is not accurate.
- Assignment section:
 - Intake Type: choose Complaint or Entity Reported Incident from the dropdown.
 - Intake Subtype: choose appropriate subtype from drop-down menu. Choose A, federal, for complaints that will be investigated in non-accredited providers and for complaints in deemed providers that will be submitted to CMS. Choose B, state licensure, for investigations that will be conducted under State authority only. After a complaint categorized as A is disapproved by CMS, change the subtype to B if a State only investigation is planned. If no investigation will be conducted, choose C, No State or Federal compliance issue.
 - Received by: choose from the drop down the method of receipt, i.e., Email, Telephone, etc. Complaints received via the online complaint system are considered "Email."
 - Location received: default is the region where the provider is located; if the provider is not in the Madison region but the complaint was received in Madison, change to BHS-MADISON.
 - Responsible parties: click the + Add S.A. and choose Crenear Mims, Marsha Musillami, Jan Heimbruch, and Mark Andrews under S.A. Click the + Add R.O. and choose Michael Potjeau and Heather Lang for deemed and accredited hospital, home health, hospice or ASC complaints.
 - Responsible team: defaults to the region where the provider is located. Change to the region where the surveyor assigned to do the complaint investigation is located. For EMTALA, federal only complaints, or no investigation complaints, scroll to the bottom of the regional office choices in the drop down and make it blank.

Complainants, Residents/Patients, Alleged Perpetrators section:

- Enter the last and first name of the complainant and click the + Add button. If the complainant's name is already in ACTS, ACTS will display the entry. If the complainant is the same person, select the existing entry. If it is not, click NEW (lower left corner) to add this name as a new entry. To change the address phone number etc., as necessary, click "Modify" by the existing name. If the complaint is anonymous, click the button labeled "Add Anonymous." (Required)
- Enter the last and first name of the patient and click the + Find/Add button. If the patient's name is already in ACTS, ACTS will display the entry. If the patient is the same person, select the existing entry. If it is not, click NEW (lower left corner) to add this name as a new entry. Enter the patient's gender.

Source section:

- Scroll down to this section and check the applicable box describing the source of the complaint. (Required)

Response Information section:

Check the box describing the priority of the complaint (required). If the complaint is a federal only complaint that is not authorized by CMS, the priority must be changed to H, no action necessary, before the complaint can be closed in ACTS. For complaints in deemed facilities that are not authorized by CMS and that the State does not plan to investigate under state authority only, the complaint coordinator completes this action at the time the federal decision is received and the complaint is closed.

The "investigate within" box is below the box of priority choices (required). Assign a date derived from the priority of the complaint. For Non-IJ Medium complaints, enter 45 calendar days, using the ACTS calculator.

If CMS authorizes an investigation in an accredited provider, change the due date to 45 calendar days from CMS authorization.

The beginning and end dates of the intake will fill in automatically. Type over these dates if correction is required.

State only complaints generally have a lower priority than complaints that have a federal component, and the time frame may be extended up to six months. This includes providers that have a state license, but no Medicare certification in Wisconsin (such as HHA branches in Wisconsin whose home agency is Medicare certified in a bordering state), and when implemented, Personal Care Worker agency complaints. If the complaint is prioritized as "A-IJ" or "B-Non-IJ High," the complaint will be investigated within ten, 30, or 45 calendar days depending on the severity of the allegations.

Attachments:

For complaints received by mail:

The original letter and any supporting documentation goes to the OOA, who makes a copy and forwards to the assigned surveyor for inclusion in the packet. Original documents may also be scanned into a pdf format and attached to ACTS via the "Attach" button at the bottom of the Intake tab page. The OOA faxes material to CMS as needed by CMS.

Complaints about home health and hospice providers received via the Home Health Hotline are begun in ACTS by BTLE section staff. Review the ACTS entries, prioritize the complaint, assign a due date, and fill out the "Activities" tab in ACTS for surveyor assignment and response letter assignment.

On the **Allegation** top tab screen enter appropriate data into the following fields:

Allegations section:

For complaints other than EMTALA, go to the allegations tab, click on the Add icon, and choose the category that applies to the allegation. There may be more than one category. Click OK. Enter the content of the allegation in the appropriate category. Start with a "key:" patients are assigned numbers, and everyone else is assigned letters. An explanatory sentence above the key, especially for "other" (i.e., "This part of the complaint alleges that the medical record was not made available when requested by the patient.") may be helpful.

If the complaint was received via e-mail, cut and paste the e-mail into the appropriate allegation category. For complaints or entity reported incidents involving patient death in a hospital due to restraints or seclusion, after the Allegation is completed, a box will appear on the Allegations tab titled Deaths Associated with the Use of Restraints/Seclusion. This box will auto populate with the patient name and death type. Fill in the fields for Reported, Date of Death, and Setting. CMS will fill in the fields for AO Notify, To P&A, RO Notify, CO Notify. These fields must be completed before the complaint can be closed.

On the **EMTALA** top tab screen section:

Go to this tab if the allegation is EMTALA. Check the boxes for "create EMTALA allegation" and "request RO approval." These allegations will open automatically on the allegations tab. Check the box indicating the type of emergency alleged. Then go to the Allegations tab and enter the content of the allegation(s).

On the **Deemed** top tab screen section:

Check the box by the flag requesting RO approval. Check the deemed box if it is not auto-checked for deemed providers.

On the **Activities** top tab screen section:

Go to "Activities" tab in ACTS and fill in "letter to complainant" and "schedule onsite investigation" assignments with staff names if the complaint is being opened. First, click "add" and pick the type of action ("letter to complainant" and "schedule onsite investigation"). Click SA and add the name of the staff responsible, then click OK at the bottom of the box. Each task must be assigned separately. Click "add" to assign the next task and repeat choosing the task, assigning specific staff, and clicking "OK." Do not assign a surveyor to EMTALA or "federal only" until CMS decides the approval status of the complaint.

The complaint coordinator assigns a surveyor, using criteria of geographical proximity, workload balance, training needs, other surveyor responsibilities, and special competencies. Supervisors communicate needs for change of assigned surveyor to the complaint coordinator. Complaint assignments are reviewed in bimonthly surveyor meetings to maximize efficient use of surveyor time and resources.

Next Steps:

When complaint intake is completed, send an e-mail with facility name, ACTS # in the subject line to CMS if the complaint is EMTALA, an accredited facility, or a potential IJ. Using the Outlook resend function, resend the e-mail, and for non-accredited and State authority only complaints, send an original e-mail, to:

- Office operations associate(OOA) responsible for the letter of acknowledgment;
- assigned surveyor;
- both supervisors.

Add the due date in bold in the subject line.

The OOA sends an acknowledgement letter to complainant, if applicable, and starts a document file consisting of a copy of the letter, and any supporting documentation.

Save these e-mails in the shared Outlook folders.

For ESRD complaints, notify Network #11 by e-mail of the provider and content of the complaint (see the worksheet, Attachment 7, Collaboration With ESRD Network # 11). For reports of involuntary discharge of patients from an ESRD, the DQA staff receiving the report asks, or asks the provider to e-mail with specific responses that can be cut and pasted into the ACTS "Allegations" section, (1) reason for involuntary discharge, (2) summary of provider efforts to solve the problem causing the discharge, and (3) actions the provider has taken to assure that the patient continues to receive dialysis. The report is entered in ACTS as an entity reported incident, and closed at the same time unless the content of the report suggests that onsite investigation is warranted.

When PCW regulation is implemented, a section for PCW complaints should be added to the binder.

On-line complaints processing:

BHS complaint intake staff will check the BHS/OCQ email box (DHFSDQABHSACCS) at least twice a day or set up an email box rule to forward received emails to their personal email box.

If the complaint is not going to be opened, cut and paste the online form into an Outlook e-mail, title it with the name of the complainant and the facility (i.e. "Brewster re Psych Co Hospital), and send it to the complaint coordinator. These e-mails will be saved in an Outlook folder that will track all online complaints received.

If the complaint is going to be opened, or if it may be opened, cut and paste the complaint into a Word document; do a "save as" using complainant name and provider name and save at O:\BQA\BHS\BHS. Complaints\Online complaints*.doc. Example: O:\BQA\BHS\BHS. Complaints\Online complaints\Brewster re Rock Co Psych.doc

Answer the complainant via e-mail. Attach the Word document that is a copy of the online information. Blind copy yourself, complaint coordinator, and ACCS OPA. If the complaint is being opened, this e-mail will be the acknowledgment letter. If further information is needed, request it in the e-mail. If complaint coordinator is only away for a day, direct the complainant to respond to complaint coordinator and give complaint coordinator the e-mail address and phone number. If complaint coordinator is away for more than a day, direct the complainant's response to the back-up staff.

Move your e-mail response into the Shared Folder in Outlook that is labeled "Online Complaints" If the complaint concerns solely an ACCS provider, this folder should have an e-mail that tells the complainant whether or not the complaint is being opened. If the complaint concerns allegations of abuse, neglect, or misconduct by a licensed professional, respond back to OCQ for OCQ investigation only for referral to another agency.

From this point forward, for complaints being opened, process according to Procedure 3212, including ACTS data entry. The WORD document should be attached in ACTS.

Hotline Complaint Processing

BHS complaint intake staff will check the 1-800-642-6552 number twice a day. For home health, hospice, hospital, and ESRD, call the access number 1-8020. Upon the system answering, press **, 608-300-5203.

When prompted, enter passcode 300-5203. The AODA/MH mail box is accessed at 1-8020, then ** 608-300-5204, passcode 300-5204.

Complaints will be triaged using the established process described above.

Section Chiefs will be notified of opened or pending complaints.

ATTACHMENT 2: REFERRALS FROM BHS

If call concerns disputed billing, Consumer Hotline: 1-800-422-7128., Wisconsin Department of Agriculture, Trade, & Consumer Protection

Physician practice issue when patient was a Medicare beneficiary: MetaStar, Inc. 1-800-362-2320, or write 2909 Landmark Place, Madison, WI 53713.

Personal Care Worker agencies, Medicaid program contacts include:

- Helen Derrickson at (608)261-7782
- Kerry Cantwell at (608)266-3142
- Cindy Zander (608) 261-4955

If the provider is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the person may file a complaint with JCAHO by writing to:

JCAHO
1 Renaissance Boulevard,
Oakbrook Terrace, IL 60181

Or contact JCAHO by calling 1-800-994-6610, or by e-mail to complaint@jcaho.org

Complaints about individual providers licensed by the Department of Regulation & Licensing: (608) 266-7482.

Complaints about Family Care:

- Contact member rights specialist at the CMO. This is usually by county; get more information from Monica Deignan. CMO phone numbers at <http://dhfs.wisconsin.gov/Medicaid2/handbooks/familycare/index.htm>
- Milwaukee is: CMS Quality Improvement Coordinator at (866)229-9695
- Monica Deignan, 1 West Wilson, Madison WI, Rm 518, phone 608 261-7807

Persons possibly eligible for services from Aging and Disability Resource Centers contact:

<http://dhfs.wisconsin.gov/medicaid6/handboooks/familycare/pdfs/appendix2.pdf> except, LaCrosse RC is (608) 785-6050 and Milwaukee RC is (414)289-5950.

Mental Health and AODA consumers: each provider is required under HFS 94 to have a grievance system, the results of which can be appealed.

Ambulance complaints: Bureau of Emergency Medical Services & Injury Prevention, Emergency Medical Services Section is (608) 266-1568 in the old phone book. EMS phone # on the intranet is 608/ 266-9781. This is in the Division of Public Health.

Privacy complaints: HIPAA, Region V - U.S. Department of Health & Human Services

233 N. Michigan Ave. - Suite 240

Chicago, IL 60601

(312) 886-2359; (312) 353-5693 (TDD)

(312) 886-1807 FAX

<http://www.hhs.gov/ocr/hipaa/>

Medicare Fraud: 1(800) 447-8477

Medicaid Recipient Hotline: 1(800) 362-3002

Medicaid Fraud: Alan White, Division of Healthcare Access and Accountability, (608) 266-7436

Medical Mediation Panels
Randy Sproule, Director
110 East Main Street, Suite 710
Madison, WI 53703-3356
Phone: (608) 266-7711
Fax: (608) 261-2352

Additional resources may be found through the nearest county Aging and Disability Resource Center. A Directory is found at: <http://dhs.wisconsin.gov/LTCare/Generalinfo/adrcontactlist.pdf>

ATTACHMENT 3: PACKET CHECKLIST AND SURVEY RECORD FORMS

Hospital, F62516, Hospital Survey Packet Checklist: Checklist of forms and documents for each category of hospital survey, i.e., accredited federal random sample, non-accredited T-18 full survey; accredited hospital federal complaint validation, non-accredited T-18 hospital complaint; accredited hospital validation verification visit; non-accredited T-18 validation visit; federal EMTALA, HFS 124 only initial, HFS 124 only verification visit, HFS 124 only complaint.

Hospital, F62068, Health and Life Safety Code Survey Record: History of survey actions and reviews. Includes survey type, COPs out, existing and initial waivers, IJ status, SOD information, dates of data entry.

HH & Hospice Survey Packet Checklist, F62314: Checklist of forms and documents for HH recertification surveys, home visits, verification visits, and complaint investigations; and checklist of forms and documents for hospice recertification surveys, verification visits, and complaint investigations.

HH & Hospice, F62278, Home Health or Hospice Survey Record: History of survey actions and reviews, including tracking for HH Master Survey Schedule and recommendations for type and timing of verification visits.

Swingbed, CORF, and OPT, F62632, Survey Packet Checklist: Checklist of forms and documents for each provider type, including verification visits.

CAH, ESRD, ASC, and RHC, F62631, Survey Packet Checklist: Checklist of forms and documents for each provider type, including verification visits.

ATTACHMENT 4: CLOSING OF COMPLAINTS

Provider & Survey Type	ACTS Closure	Notes
State only investigation completed	Hospital/Other OOA	
State only no investigation	BHS Complaint Coordinator	
Deemed investigation completed	CMS	See page 14 of ROV ACTS Hospital Complaint Incident Processing Guide
Deemed no investigation	BHS Complaint Coordinator	
Non-accredited investigation completed	BTLE ODIE/OSCAR DE OOA	See page 13 of ROV ACTS Hospital Complaint Incident Processing Guide
Non-accredited no investigation	BHS Complaint Coordinator	
State only investigation completed	HHA/Hospice OOA	
State only no investigation	BHS Complaint Coordinator	
Deemed investigation completed	CMS	To parallel hospital procedures in ROV ACTS Hospital Complaint Incident Processing Guide see page 13
Deemed no investigation	BHS Complaint Coordinator	
Non-deemed no investigation	BHS Complaint Coordinator	
Non-deemed investigation completed	BTLE ODIE/OSCAR DE OOA	
No investigation required	BHS Complaint Coordinator	
Investigation completed	BTLE ODIE/OSCAR DE OOA	

ATTACHMENT 5: ACTS--DATA ENTRY TIMELINES

With respect to complaints and self-reported incidents, state agencies are required to enter the following intakes into ACTS:

- Complaints that allege noncompliance with the Federal condition(s) of participation (COPs), condition(s) for coverage (CFCs), or requirement(s) for participation (RFPs).
- Incidents that lead to an onsite survey of the Federal COPs, CFCs, or RFPs.

Unless there are extenuating circumstances, the following table describes the general timeframes in which SAs must enter data:

Timeframe in which to enter data	Required ACTS fields to which the timeframes apply
Within 5 working days of the date the intake is triaged (Received End date)	Intake Type Intake Subtype Complainant Name Source Received Start Date Received End Date Complaint Priority Investigate within X Days Investigation Due By Allegation Category
If the intake is linked to an onsite survey - Within 15 working days of the survey exit date.	Allegation Findings Category Allegation Findings Subcategory Whether the Intake is Linked to a Survey Whether the Allegation is Linked to a Deficiency
If an onsite survey is conducted - Within 30 working days of the survey exit date.	Intakes linked to an onsite survey Investigated by Investigation Completed Notifications: Type, Party, Method, Notification Date Proposed Action Proposed Action Date Reason Closed Date Closed
If an onsite survey is not conducted - Within 30 working days of the date the intake is received (Received End date).	Notifications: Type, Party, Method, Notification Date Proposed Action Proposed Action Date Reason Closed Date Closed

ATTACHMENT 5: ACTS-EMTALA--DATA ENTRY TIMELINES

SAs are required to enter all intakes that allege a violation with EMTALA. Unless there are extenuating circumstances, the following table describes the general timeframes in which SAs must enter data:

Timeframe in which to enter data	ACTS fields to which the timeframes apply
Immediately (Within 2 working days of the Received Start date).	Intake Type Intake Subtype Complainant Name Source Received Start Date Received End Date Allegation Category EMTALA Request for RO Approval Checkbox EMTALA Request for RO Approval Date
If an alleged EMTALA violation is found - Within 10 working days of the survey exit date.	Allegation Findings Category Allegation Findings Subcategory Whether the Intake is Linked to a Survey Whether the Allegation is Linked to a Deficiency, if applicable
If no alleged EMTALA violation is found - Within 15 working days of the survey exit date.	Allegation Findings Category Allegation Findings Subcategory Whether the Intake is Linked to a Survey Whether the Allegation is Linked to a Deficiency, if applicable

ATTACHMENT 6: ACTS REQUIRED INTAKE FIELDS

TAB	FIELD(s)	DEFINITION
Intake	Intake Type	<p>1) Complaint - A complaint is a report made to the SA or RO by anyone other than the administrator or authorized official for a provider or supplier that alleges noncompliance with Federal and/or State laws and regulations.</p> <p>2) Incident - An incident is an official notification to the SA or RO from a self-reporting provider or supplier (i.e., the administrator or authorized official for the provider or supplier).</p>
	Intake Subtype (for Complaints)	<p>Federal COPs, CFCs, RFPs, EMTALA: The allegation relates to noncompliance with the Federal condition(s) of participation (COPs), condition(s) for coverage (CFCs), requirement(s) for participation (RFPs), or EMTALA requirement(s). This would include allegations of noncompliance with Federal requirements only or both Federal and State requirements. (SAs and ROs are required to enter these cases into ACTS.)</p> <p>State-only, licensure: The allegation is related to noncompliance with State licensure requirements only. (SAs have the option to enter these cases into ACTS.)</p> <p>No State or Federal provider compliance issue involved: The allegation does not relate to noncompliance with Federal or State survey and certification requirements. (SAs have the option to enter these cases into ACTS.)</p>
	Intake Subtype (for Incidents)	<p>Federally required, entity-reported: A provider or supplier is required by Federal law, regulation, or policy to report this type of incident, which includes the following: 42 C.F.R. §482.13(f)- Standard: Seclusion and restraint for behavior management. The hospital must report to CMS any death that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion. (SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.)</p> <p>State-required, may result in Federal noncompliance, entity-reported: A provider or supplier is required by State law, regulation, or policy to report this type of incident to the SA. This type of incident may result in noncompliance with a Federal condition(s) of participation, condition(s) for coverage, requirement(s) for participation, or EMTALA requirement(s). For incidents of this type, the SA must follow CMS policies and procedures to investigate Medicare/Medicaid complaints, no matter the source of information. (SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.)</p> <p>State-required, all other, entity-reported: A provider or supplier is required by State law, regulation, or policy to report this type of incident to the SA. This type of incident does not imply noncompliance with Federal conditions or requirements. (SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.)</p> <p>Reported by other agencies: As defined by the State.</p> <p>None of the above: A provider or supplier is not required by Federal or State laws, regulations, or policies to report this type of incident. (SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.)</p>

ATTACHMENT 7: DQA COLLABORATION WITH ESRD NETWORK #11

To implement the Agreement for Collaboration between Renal Network of the Upper Midwest, INC (ESRD Network #11) and Wisconsin Department of Health Services, finalized 6/15/04, the Division of Quality Assurance will undertake the following measures:

1. BTLE staff will forward to the Network #11 Director of Quality Improvement and Consumer Services copies of all Statements of Deficiency from recertification and complaint surveys. BTLE will also forward facility plans of correction for incidents voluntarily sent by the facility. BTLE will keep documentation of accomplishment of these tasks.
2. BHS supervisor will notify the Network by phone of any findings of Immediate Jeopardy. This notification will be followed up by an e-mail. The e-mail will cc'd to the BHS supervisor, and saved in the Outlook shared folder titled "Network 11" for purpose of documentation.
3. BHS will consult any information provided by the Network, including facility rankings, in the development of the annual recertification schedule. Documentation will be in the form of a column reflecting Network rankings on the annual recertification schedule.
4. The BHS complaint coordinator will send an e-mail with the substance of all complaint allegations scheduled for investigation under Medicare certification regulations to the Network. These e-mails will be saved in a Outlook Shared Folder entitled "Network 11" for purpose of documentation.
5. The BHS complaint coordinator will refer complaints received that do not represent a violation of Medicare regulations to Network #11. These referrals will be documented in the BHS Uninvestigated Complaints log.
6. As many BHS ESRD surveyors as practically possible will attend the Network's annual meeting and Network educational offerings. DQA training coordinator's files will document these attendances.
7. Informal phone contacts between ESRD surveyors and Network staff will continue as is past practice. Surveyors will summarize these phone calls in an e-mail to the Complaint Coordinator to save in the Outlook Shared Folder entitled "Network 11"