This Policy Applies to: ☒ *Family Service Association of San Antonio, Inc.*	**Date Revised** *March 2015* *October 2017* *July 2020*
Name of Policy: *Medicare/Medicaid/Insurance Compliance Plan*	**Date Approved** *May 2015* *December 2017* *August 2020*
Department Areas Impacted: *Behavioral Health Counseling; Outpatient Treatment Services and Medicaid Reimbursable Case Management Services*	**Date Disseminated** *May 2015* *January 2018* *September 2020*
Electronic Storage Location: *Manager's SharePoint page and Quality Assurance SharePoint pages*	**Position Responsible:** *Chief Operating Officer*

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I. Introduction

Family Service Association of San Antonio, Inc. (Family Service)'s mission is to "Empower individuals and families to transform their lives and strengthen their communities". This is accomplished through our Behavioral Health, Outpatient and Intensive Case Management services by providing behavioral, substance abuse outpatient treatment, case management and educational services in a caring environment where children and their families find strength, healing, hope and trust.

Family Service's services are provided to all for whom they are appropriate without regard to race, creed, national origin, or gender. Family Service is dedicated and committed to meeting high ethical standards and compliance with all applicable laws in all activities regarding the delivery of behavioral health services through its licensed staff and licensed facilities. It is our goal that our established Compliance Program will assist the Agency in fulfilling its fundamental vision, mission, and values.

Our organization has adopted this Corporate Compliance Plan to comply with the provisions of The Office of Inspector General of the Department of Health and Human Services. This Policy describes our procedures for detecting and preventing Medicare/Medicaid/Insurance fraud, waste and abuse. As is detailed within this Compliance Plan, it is the duty of all of our direct service providers and agency personnel to comply with the policies as applicable to their individual areas of employment or contracts. This Compliance Plan also advises all of our employees, contractors, vendors and agents of the procedures to be used in reporting non-compliance with such Federal and State laws.

It is the purpose of this plan to organize our resources to resolve payment discrepancies and detect inaccurate billings as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences of any such findings.

Benefits to our Compliance Program

Benefits to our Compliance Program include, but are not limited to the following:

- Demonstrates to the employees and community at large our strong commitment to honesty, responsibility and appropriate conduct.
- Develops a system to encourage employees to report potential problems that may be detrimental to the client and the Agency.
- Develops procedures that allow for a thorough investigation of alleged misconduct.
- Develops procedures for promptly and effectively conducting internal monitoring and auditing which may prevent non-compliance.
- Through early detection and reporting, minimizes the risk to the Agency and, thereby, reduces our exposure to any civil damages or penalties, criminal sanctions or administrative remedies.

II. Corporate Compliance Code of Conduct

In addition to the Agency's general policies and procedures as found in documents such as the Service Delivery Policies Procedures, Professional Practices, Program Policies and Procedures and the Employee Handbook, the following *Compliance Code of Conduct* are addressed specifically for the guidance of the Agency's staff in relation to third-party billable services. They are not intended to prescribe a specific response to every conceivable situation, but they are intended to assist staff in determining an appropriate response as situations arise. Whenever a staff person has a question about an appropriate response in a given situation, he/she should consult his/her supervisor and/or administrator.

1) Family Service will bill only for services actually rendered and shall seek the amount to which it is entitled by third party payer agreements.
2) Family Service does not tolerate billing practices that misrepresent the services actually rendered.
3) 3) Supporting documentation must be prepared for all services rendered including EHR notations, assessments, service plans, etc. Specific funder required documentation (DFPS) and a completed, certified Superbill. Family Service cannot bill a third party payer without the contractually required EHR entries and superbill completed prior to billing.
4) Family Service shall bill private insurance and Medicaid by the principle that if the appropriate and required documentation has not been provided, then the service has not been rendered.
5) All services must be accurately and completely coded and submitted to the appropriate payer in accordance with applicable regulations, laws and contracts and Family Service Policies and Procedures.
6) An accurate and timely billing and documentation structure is critical to ensure that Family Service staff can effectively implement and comply with required policies and procedures.
7) Demonstrated lapses in the documentation and billing systems infrastructure should be remedied in a timely manner at the program level with input from the Compliance Committee whenever possible. The Chief Compliance Officer must approve all proposed remedies in consultation with Agency Executive Leadership.
8) Family Service staff is not to falsify documentation for the purposes of billing.
9) Family Service billing staff is never to assume a service has been provided. They must always verify services by referring to clinical and medical records for documentation, (Electronic Health Record-EHR entries) of the services being billed.
10) If a Family Service employee did not provide a service, they must never sign/initial that the service has been provided.
11) Family Service staff member must never pre or post-date documentation.
12) Family Service staff is not to use white-out in clinical or medical records, or erase any official documentation – always strike a line through the entry; initial and then re-write.
13) Whenever a Family Service staff member is in doubt if a service is being provided, check the Family Service Policies and Procedures governing regulations for that service area, or your direct supervisor and/or administrator.

III. Compliance Officer

Family Service has designated a Compliance Officer who oversees the development and implementation of Family Service's Compliance Program and ensures appropriate handling of instances of suspected or known illegal or unethical conduct. However, in the event that the Chief Compliance Officer is not available, we have designated an alternate contact. The following responsible individuals will receive and coordinate complaints or concerns involving its behavioral health care operations:

Richard Davidson, Chief Compliance Officer
Chief Operating Officer at Family Service
rdavidson@family-service.org
210-299-2412

Alternate Compliance Officer:
Veronica Salgado, Manager
Behavioral Health and Youth Services Manager
vsalgado@family-service.org
210-563-4926

A. Duties of the Compliance Officers:

- Oversee and monitor the implementation of the Compliance Program;
- Maintain the effectiveness of the Compliance Program;
- Establish methods such as conducting periodic audits, developing effective lines of communication on compliance issues and preparing written standards and procedures that reduces Family Service's vulnerability to fraud and abuse;
- Periodically revise the Program in light of changes in the needs of the organization, in the law, policies, and procedures of the government;
- Develop, coordinate and participate in a training program that focuses on the components of the Compliance Program and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent federal and state standards; and that independent contractors, consultants and volunteers who furnish mental health services to Family Service's clients are aware of the requirements of the Compliance Program;
- Ensure that the List of Excluded Individuals and Entities have been checked with respect to all behavioral health employees, and any independent contractors.
- Report on a regular basis to the Executive Leadership, Agency Board of Directors, and the Compliance Committee (Quality Assurance Committee) on the progress of implementation, any investigations and corrective actions.

IV. Communication and Changes in Compliance Manual

The Chief Compliance Officer will distribute in writing via email and hard copies and/or post in SharePoint sites, any modifications of, or amendments to, this Compliance Plan. The Chief Compliance Officer will also provide employees, any contractors, and professional staff members with written explanations of any substantial changes in these policies. If the Chief Compliance Officer determines that written materials are insufficient, in-services will be conducted (please refer to section on Education and Training below).

Employees, contractors, vendors, agents of the agency and professional staff will be provided periodic information about our Corporate Compliance Program, changes in applicable laws or ethical standards that may affect an employee's responsibilities through written memoranda, newsletters, periodic training sessions or other appropriate forms of communication, including the posting of such information on our website or our SharePoint site.

V. Education and Training

The proper education and training of employees is a significant element of an effective compliance program. As such, staff will be expected to participate in appropriate training.

A. Compliance Plan

- All current employees will be provided a copy of the Compliance Plan. The first time they receive the Plan they will be expected to sign a certification stating that they have read and understood the Plan. We will expect all staff to annually certify receipt and review of the Plan through their participation in annual compliance training.

- For new employees, the Compliance Plan will be provided during the orientation process and an educational session will occur at that time with their supervisor. All new employees will be expected to sign a certification stating that they understand and will comply with the Plan.

- For vendors, consultants, contractors and other agents who provide any service where Medicaid/Medicare/Insurance dollars are used; the Compliance Plan and any updates will be on our Family Service website. If they cannot access internet or email, we will provide a hard copy.

B. Federal and State False Claims Act and Whistleblower Protection

- All Family Service behavioral health employees will be provided with posted information regarding Federal and State Whistleblower Protections.

- On-Site Training – An on-site training will be presented annually to all staff participating in Medicare/Medicaid/Insurance billable services. Attendance will be taken as proof of participation. The Human Resources Department will maintain documentation that shows all employees who have completed training for the year. If any staff member is non-compliant, the supervisor will be informed and further non-compliance may result in disciplinary action.

VI. Reporting Requirements

Family Service believes that it is our employees who best know where organizational policy or regulation is not being followed. Therefore, the effectiveness of our Compliance Program depends on the willingness of employees in all parts and at all levels of the organization to step forward, in good faith, with questions and concerns.

We believe strongly that in all of these cases, resolution of the problem behaviors or actions will result in better care for our consumers. Therefore, each person reporting problems or concerns will be contributing positively to the overall quality of the services at Family Service.

If there is suspicion of possible fraud, waste and abuse or other matter related to the Compliance Program, it is the responsibility of the staff who suspects such action to inform the Chief Compliance Officer or Alternate Compliance Officer in directing the issue/concern to resolution. Family Service expects that the first person informed should be the direct supervisor; however, if staff wants to keep general, anonymity they can call and/or email the Chief Compliance Officer or Alternate Compliance Officer. (See procedures for reporting possible non-compliance below.)

All reports of possible fraud, waste and abuse, or other matters related to Medicaid/Medicare/Insurance compliance must be reported to the Chief Compliance Officer and/or Alternate Compliance Officer, of which, both will implement the necessary steps as set forth in the Compliance Program for investigating the matter.

Examples of provider fraud or abuse:

- Billing for services that were not provided.
- Duplicate billing, which occurs when a provider bills Medicaid and also bills private insurance and/or the recipient.
- Upcoding – billing for a comprehensive visit at a higher rate, when a lower rate visit was actually provided.
- Having an unlicensed person perform services that only a licensed professional should render, and bills as if the professional provided the service.
- Billing for more time than actually provided.
- Billing for an office visit when there was none, or adding additional family members' names to bills.

Example of provider waste

- Referring the recipient for more office visits when another appointment is not necessary.

A. Policy

1) Every employee is responsible for doing his/her job in a manner that is ethical and complies with the laws and regulations that govern our work.

2) Every employee is responsible for seeking supervisory assistance if he or she has doubts or is unclear about what the right action is to stay compliant. If the employee does not believe

that their supervisor is correct in their advice, they can go to the service area Director or directly to the Chief Compliance Officer with the question and he/she will investigate and answer the question.

3) Every employee has a duty to Family Service and to our consumers to report actions or behaviors they feel violate the code of conduct, procedure, law or regulation. Any employee that fails to report misconduct or illegal behavior may be subject to disciplinary procedures up to and including, termination.

4) Family Service will encourage employee questions and/or reports by:
    a) taking each report seriously;
    b) investigating each report; and where there is enough information, to determine the extent of the problem and corrective action(s) needed;
    c) making sure that employees who do report: Do not suffer any retaliation by their peers or supervisors for their good faith reports or questions.

5) Family Service ensures that agency staff members have more than one way to report questionable behavior or for asking questions about compliance. This includes giving employees the option of reporting directly to their supervisor or directly to the Chief Compliance Officer.

6) Family Service ensures that agency staff members have the choice of keeping their name confidential in regard to a specific report for as long as the organization can reasonably do so.

7) Family Service has an agreed upon method for determining the status of any staff report and any subsequent investigation where possible.

B. Procedures

How to Report- Employees may report at any time to:

1) CHIEF COMPLIANCE OFFICER: Directly to the Chief Compliance Officer through the hotline number at 1-210-299-2412. This line will be answered only by the Chief Compliance Officer (or his or her designee during vacations and other prolonged absences).

2) VOICE MAIL OR FACE-TO-FACE REPORTS: Voice mail or face-to-face reports to the Chief Compliance Officer or any supervisor who will then report to the Chief Compliance Officer utilizing the reporting form attached at the end of the Compliance Plan.

3) MAIL AND EMAIL: Employees may use mail or email to report problems or concerns. Mail can be directed to the Chief Compliance Officer: Richard Davidson, Chief Operating Officer, Family Service Association of San Antonio, Inc., 702 San Pedro Avenue, San Antonio, Texas 78212 and email can be directed to the Chief Compliance Officer at rdavidson@family-service.org or to their supervisor or area Director who will then notify the Chief Compliance Officer within 24 hours utilizing the reporting from attached at the end of the Compliance Plan. In all cases, the Executive Leadership of Family Service will be given information regarding the possible non-compliance by the Chief Compliance Officer within 24 hours of his notification.

In all cases, supervisors who get employee reports will be required to discuss the report with first the agency's Chief Compliance Officer and then their service area Director.

VII. Enforcement and Discipline

In the event of an investigation or through monitoring and auditing it is determined that fraud, waste or abuse has occurred, or that a staff person or program is violating policies and procedures set forth in the Compliance Plan, there may need to be disciplinary action.

A. Discipline Policy and Actions

All employees are expected to report any breaches of laws, regulations, policies and standards that govern our work as well as the organization's Code of Conduct. Upon receipt of such reports, the matter will be investigated by Family Service.

Additionally, the Agency, through its ongoing monitoring, may determine a breach (as) may have occurred. In either instance, where a breach is confirmed, appropriate actions will be taken by the Agency.

As a result, in order to correct or improve employee performance, Family Service encourages employee counseling as an initial step. However, there may be times (such as an outcome from an investigation determines fraud has taken place) where more severe action is appropriate. In these cases, formal disciplinary actions will range from verbal warnings to termination. When disciplinary action other than a verbal warning is proposed, the Human Resources Office will be contacted and they will coordinate such action.

B. Non-retaliation Policy

To the extent possible, all employee reports will be handled in a manner that protects the confidentiality of the reporter if they request it. However, there may be circumstances in which confidentiality cannot be maintained. Some examples of this include situations where the problem is known to only a very few people or situations in which the government or one of our other payers or funders must be involved. In most cases, they will require the name of the individual who first brought the problem to the attention of the organization. In all cases, however, Family Service is determined that the reporting employee will not suffer from any retaliation for their good faith actions.

It is the responsibility of the Chief Compliance Officer to ensure that those reporting in good faith does not suffer any retaliation for reporting. As such, the following will occur:

1) The Chief Compliance Officer will explain the Agency's Non-retaliation Policy to Each caller or reporter.

2) The Chief Compliance Officer will give the reporter a means for contacting them confidentially to report any actions the reporter believes is retaliatory.

3) The Chief Compliance Officer will investigate any reports of retaliation and will make recommendations to Human Resources and Agency Executive Leadership regarding disciplinary and other corrective actions that should take place, if there is a positive finding.

The Chief Compliance Officer will confidentially contact reporters on a regular basis to inquire about any perceived retaliation.

C. List of Excluded Individuals or Entities

To be in compliance with HIPAA and other Federal and State requirements, providers must check the OIG List of Excluded Individuals and Entities on the OIG website at: *http://www.oig.hhs.gov/fraud/exclusions.html* prior to hiring or contracting with individuals or entities providing services billable to Medicare/Medicaid or Insurance. Persons and entities who are listed on the Federal OIG Exclusion Database must receive reinstatement through the OIG to be eligible for reimbursement through Medicaid.

In addition, Texas has a list of excluded individuals and entities which can be visited at https://oig.hhsc.state.tx.us/oigportal/EXCLUSIONS.aspx.

Family Service has implemented the following policy:

1) Prior to hiring an employee to provide Medicare/Medicaid/Insurance billable services, the Human Resources Department will check both of the websites noted above. Printed proof of "no matches" will be filed in the employee's personnel record;

2) For current employees, vendors or contractors, the websites will be checked annually in September of each year.

All matches will be addressed by the Chief Compliance Officer and appropriate staff. If the person is working for a program where Medicare/Medicaid/Insurance dollars are used, then Human Resources and Executive Leadership (as appropriate) will be involved in decisions about the future of the staff person.

VIII. Monitoring and Auditing

The Agency's Monitoring and Auditing Procedures will uncover activities that could potentially constitute violations of the Compliance Plan or failure to comply with Federal and State law or other types of misconduct. We understand our obligation to investigate any incidents uncovered to determine:

- that a violation has, in fact, occurred;
- that disciplinary action must be taken; and
- corrective actions are put into place as required.

All issues reported to the Chief Compliance Officer will be handled in a consistent fashion so that the integrity of the Plan is maintained, and so employees will have confidence in the workings of compliance investigations.

The Agency has a management hierarchy that is designed to deal with employee misconduct through the normal avenues of supervision. Most day-to-day issues should be handled through this hierarchy. Action from the Chief Compliance Officer is required when systemic problems give rise to misconduct and require system-wide changes to prevent misconduct from occurring in the same fashion in the future.

As part of our effort to implement an effective Compliance Program, Family Service will at least annually conduct routine self-audits of its operations including its billing practices, its written standards, policies and procedures to ascertain problems and weaknesses in its operations and to measure the effectiveness of its Compliance Program.

Procedures for auditing clinical, medical and billing records:

A. Periodic Audit of Coding and Billing Practices
A periodic audit of coding and billing practices to identify whether

- bills are accurately coded and accurately reflect the services provided (as documented in the clinical and medical records);
- documentation is being completed correctly;
- services provided are reasonable and necessary; and
- any incentives for unnecessary services exist.

The above will be accomplished through the use of existing tools and systems such as; clinical and/or billing software, manual billing records, Medicaid Audit Checklists (see below), daily session logs, progress notes and EHR entries, review of billing records with progress notes.

The Alternate Compliance Officer and Evaluation & Data Specialists II will generate reports from our Electronic Health Records database comparing them against a sample of services that have been billed to Medicare/Medicaid/Insurance and check the medical records to determine if there is an appropriate progress note for the billed service.

Leveling
A system of "leveling" clinicians and social workers will be developed. Monthly reviews will be conducted based on the following criteria:

An initial review of client records will be conducted by Data & Evaluation Specialists II and the Alternate Compliance Officer. Once that review has concluded an analysis of the data will determine the level of compliance based on a percentage of compliances met from the Medicaid Audit Checklist. If the compliance is met at 95% or higher for three consecutive months, the staff will be placed in the "A" category. If they are in an 85% - 94% compliance rate, the worker will be put into the "B" category. If 84% or less compliance is noted, the worker will be placed in "C" category.

Category A:
Workers in this category have achieved a 95% or higher compliance rate for three consecutive months. Once placed in this category 10% of their charts will be reviewed on a monthly basis. If the staff member's compliance rate goes below 95%, they will be placed in the "B "category until they show compliance at 95% for three consecutive months.

Category B:
Workers in this category have achieved an 85%-94% compliance rate. They will be subjected to

monthly audits in which 50% of their charts will be audited. They will stay at a "B" until their compliance rate increases to 95% through a corrective action plan and their compliance is maintained for three consecutive months or until 6 months have passed. If 95% compliance is not reached within 6 months, the worker will be placed into category "C" with a timeframe for achieving program compliance.

Category C:
Workers in this category have only achieved an 84% or lower compliance rate. The staff will be required to submit all documentation to their supervisor on a daily basis. The supervisor will review it for completeness and accuracy and will provide the Chief Compliance Officer with weekly updates. The supervisor will be available to provide additional training to the worker, if required, to ensure compliance. This process will take place for 90 days, at which time compliance should reach 95%. At that time, the worker will be placed in Category "B", although they will have expanded evaluation of documentation compliance for the first three months. In this situation, Data & Evaluation Specialist II will audit 100% of their charts monthly for three months. If compliance does not reach 95% within 90 days, further disciplinary action will be taken up to an including termination.

Performance Plans
If further disciplinary action is necessary, then the worker will be placed on a performance plan. The staff will be given a formal memo outlining the details of the plan which includes concerns and future expectations of the worker. The worker will be provided with increased supervision, training, and monitoring. The staff will receive formal written feedback each month and will be reported to their Director. If the necessary improvements are not met within the expected timeframes, then employment could be jeopardized.

Duties of the Alternate Compliance Officer
The duties of the Alternate Compliance Officer in relation to the Medicaid Compliance Analysts consist of, but are not limited to:

- Providing direct supervision including but not limited to reviewing work performance and helping to resolve any issues or conflicts.
- Receiving monthly aggregate reports from the Medicaid Compliance Officer and reviewing the data to level clinicians/workers.
- Provides monthly reports on leveling to Senior Vice President, Human Resources Manager and President/CEO.
  Communicating on a regular basis with program staff on status of findings and corrective actions.
- Participates in Medicaid Quality Improvement Team.

Review of billing practice against Medicaid regulations
Due to changes in Medicare/Medicaid/Insurance regulations, rate changes and operational changes within the agency, it is important for the organization to periodically review its billing practices to ensure that they remain compliant. The Chief Compliance Officer will review written billing procedures and/or meet with billing staff on how billing occurs and what process is being used to ensure compliance. She/he will also address if there has been any changes in

billing practice since the last review. The Chief Compliance Officer will provide any resources to billing staff that may assist in understanding the Medicare/Medicaid/Insurance Regulations that apply to their billing practice. To maintain best practices in the industry, Family Service utilizes a Superbill system from which the billing specialists bills for Medicare/Medicaid and Insurance reimbursements. Family Service only bills from complete and certified Superbills, as well as, determines current Electronic Health Records are in place before billing for the specified service, this includes Electronic Health Records documenting the Assessments, Service Plans and Session Notes. Family Service also only bills according to scheduled provider plan reimbursement amounts to ensure accurate and reasonable tracking of billing and payments.

Pre-Billing Compliance
The Billing Specialist will conduct pre-billing compliance with each billing entry. The Billing Specialist will compare the Electronic Health Record entries comparing progress notes to the Superbill to ensure all dates and types of services match. If an error is cited, the Superbill will be sent back to the Clinical Director with instructions from the Billing Specialist to re-submit when corrections are made. When the Billing Specialist receives and ensures all corrections have been made, the Superbill will be processed for billing. The Billing Specialist will prepare a daily summary report to the Chief Compliance Officer of Superbill and Electronic Health Record comparisons. This summary report will contain the client's name, clinician's name, the error and the Medicare/Medicaid/Insurance number of the client, returning all non-billed Superbills to the Chief Compliance Officer who will return them to the appropriate agency Director for corrections and re-submission.

The Chief Compliance Officer will utilize this report to identify patterns of noncompliance. It may also be used when reporting to the Family Service Executive Leadership and Agency Board of Directors.

B. Medicaid Audit Checklist
All Family Service program areas where Medicare/Medicaid/Insurance billing occurs will utilize the Medicaid Audit Checklist for agency audits. The Medicaid Audit Checklists will include the necessary Medicaid requirement questions associated with the particular service area.

The Medicaid Audit Checklist will only be revised with the approval of the Chief Compliance Officer. Revisions may occur for the following reasons:

- New Medicaid Regulations associated with the designated program area;
- To ensure clarity and consistency of the tool.

C. Methodology for Audits
The Alternate Compliance Officer will use various methods for monitoring and auditing. She/he will use the Medicare/Medicaid/Insurance billing list from the EHR or for programs where manual billing occurs, the client roster will be used. This is critical to ensuring a system of checks and balances and for providing further objectivity to the monitoring and auditing process.

In addition to the Alternate Compliance Officer, Evaluation & Data Specialists will have a method for auditing which will include a review of medical and billing records documenting results.

The Chief Compliance Officer conducts analysis of compliance data and submits reports to program leadership and agency Executive Leadership. She/he also reviews and updates compliance audit tools.

Timeframe
The Alternate Compliance Officer and Data & Evaluation Specialists will conduct audits via the Medicaid Audit Checklist for every program area on a monthly basis in accordance with the Leveling System. In addition to the review of case records, the Alternate Compliance Officer, as noted in Section VIII – A (above), will conduct audits of billed services against progress notes; and billing practices against Medicaid Regulations. The timeframe might be altered depending on any reports of fraud, waste, or abuse that may require investigation. It can also change if we get an unexpected Medicaid audit from the federal or state government.

Finally, it can change depending on risk area, which will be determined through analysis of audits that have been completed or through senior management concerns about specific vulnerabilities.

Sample size
The Alternate Compliance Officer will sample, initially an average, 10% of billable services per audit time period. Sample size will depend on the following factors:

- The number of billable activities for a given period of time;
- Risks and vulnerabilities in any given program area; (Leveling System)
- Number of errors from previous audits.

Record retention
Through compliance activities, the Chief Compliance Officer will receive and generate hard copy, electronic records and information. Audit records will be kept for a period of 7 years based on legal and contractual obligations. Other records maintained or created will be retained or destroyed pursuant to agency record retention policies.

This policy will help the Chief Compliance Officer manage the records of the Compliance Program in a manner that will promote the organization and integrity of the program. In addition, the policy will help protect the anonymity or confidentiality of consumers, employees or others who report problems or concerns to the Chief Compliance Officer or to other staff of the program.

Policy
1) Compliance records management is the responsibility of the Chief Compliance Officer. Records will be kept in a secure location and the confidentiality of consumers, employees and business operations and activities will be protected.

2) Records relating to a specific incident or report and all audit records (with the exception of a summary of activities, findings and corrective actions) related to a specific incident that has been resolved should be destroyed after 7 years.

3) Records relating to the Compliance Program including memoranda, meeting minutes and reports will be retained for a minimum of 7 years in order to maintain a record of Compliance Program activities. These documents can be used by the organization to prove the existence of an active and effective Compliance Program.

Procedures
1) All records of the Chief Compliance Officer will be kept in secure locations. File cabinets will be locked when not in use and any electronic data or records will be protected by passwords or other security features.

2) Any information received via the hotline or any report of a potential problem and the records developed during the investigation of the potential problem will be maintained, at a minimum, until the matter is resolved.

- All records relating to a particular incident or report will be kept together in a locked file cabinet or if in electronic form, secured through the Chief Compliance Officer's password.
- All records related to information received by the Chief Compliance Officer or the hotline relating to an incident or potential problem (in either paper or electronic
- form) will be reviewed every 180 days. The Chief Compliance Officer will make
- the decision to destroy any records or set of records during this review only after
- all issues relating to a specific incident or problem have been resolved.
- Resolution includes the completion of any investigation or inquiry,
- implementation of any disciplinary actions, implementation of any corrective
- action and evaluation of the efficacy of the corrective action plan
- Before destroying records of an investigation, the Chief Compliance Officer will
- prepare a summary of all material activities, lists of interviewees, findings and
- actions taken in light of findings.

3) In addition to records relating to reports, incidents or potential problems, during each review period the Chief Compliance Officer will also assess the need to retain other records (in both paper and electronic form) including correspondence, calendars, diaries, notepads, personal files, telephone message pads, chronological correspondence files and other similar materials.

4) If the Chief Compliance Officer should receive notice of any kind that an investigation is underway, she/he will take immediate steps to secure all relevant documents and/or to cease their destruction until notice that the investigation or any related litigation has concluded.

D. Medicaid Quality Improvement Team

The Agency is committed to developing and operating an "effective" Compliance Program. The organization has, therefore, established the Medicaid Quality Improvement Team (Comprised of the Alternate Compliance Officer, a designated Behavioral Health staff member, Data & Evaluation Specialist II, and the Manger of Human Resources) to assist the Chief Compliance Officer in the development, implementation, oversight and evaluation of the Compliance Program. The Medicaid Quality Improvement Team will be chaired by the Chief Compliance Officer and will meet quarterly.

The role of the Medicaid Quality Improvement Team includes, but is not limited to:

- assessing the impact of current and future Medicaid Regulations on Family Service's day to day operations;
- working with the Chief Compliance Officer and Alternate Compliance Officer to develop any necessary changes for compliance;
- ensuring that Medicaid compliance is occurring throughout the agency;
- recommending solutions to barriers that may exist in the successful implementation of compliance activities;
- addressing issues regarding billing (Medicare/Medicaid and Insurance) that impact our ability to maximize our revenue and make recommendations on how to improve them;
- assessing the success of the Compliance Plan by reviewing compliance-related activities and recommending any needed updates to the Plan;
- addressing any compliance and billing issues that may present a risk to Family Service and make recommendations on how to correct and prevent them from occurring;
- establishing and maintaining an open line of communication with the Central Quality Improvement Committee in order to ensure that recommendations and feedback are implemented in a timely manner.

The Chief Compliance Officer will inform the Medicaid Quality Improvement Team of any allegations and investigations of Medicaid fraud or abuse. However, prior to making a decision to share such information, the Chief Compliance Officer will consult the Agency's Senior Vice President and Manager of Human Resources.

The Medicaid Quality Improvement Team is expected to work with the highest level of confidentiality and members may be sought to provide information that can assist in making a determination on any pending investigations. The Chief Compliance Officer will also provide the Medicaid Quality Improvement Team with reports of any monitoring and auditing findings as necessary. As an advisory committee, the Medicaid Quality Improvement Team may provide feedback on the findings and make recommendations for corrective actions.

IX. Response and Prevention

The goal of our Compliance Program is to prevent and reduce the likelihood of improper conduct. Family Service's response to information concerning possible violations of law or the requirements of the Compliance Program is an essential component of its commitment to compliance.

A. Investigations

Upon receiving a report or other reasonable indication of suspected non-compliance, the Chief Compliance Officer will initiate prompt steps to investigate the conduct in question and determine whether a material violation of applicable law or the requirements of the Compliance Plan has occurred. An investigation will be conducted with one or several of the following:

- In conjunction with the Alternate Compliance Officer, Data & Evaluation Specialist II, and a Human Resources staff member will investigate information about what might have occurred;
- Interviewing of individuals with potential knowledge of the matter;
- Review of the relevant documents;
- Engaging legal counsel, outside auditors or other experts to assist in the Investigation if determined is needed.

Upon receipt of information concerning alleged misconduct, the Chief Compliance Officer will, at a minimum, take the following actions:

1) Notify the President/CEO, Senior Vice President, Manager of Human Resources and the Director of the program area.

2) Ensure that the investigation is initiated as soon as reasonably possible but in any event not more than three business days following receipt of the information. The only exception is if relevant staff is on vacation or ill. The investigation shall include, as applicable, but need not be limited to:

a) Interviews of all persons who may have knowledge of the alleged conduct and a review of the applicable laws, regulations and standards to determine whether or not a violation has occurred.

b) Identification and review of relevant documentation including, where applicable, representative bills or claims submitted to Medicare/Medicaid/Insurance programs, to determine the specific nature and scope of the violation and its frequency, duration and potential financial magnitude.

c) Interviews of persons who appear to play a role in the suspected activity or conduct. The purpose of the interviews is to determine the facts surrounding the conduct, and may include, but shall not be limited to:

- The person's understanding of the applicable laws rules and standards;
- Identification of relevant supervisors or managers;
- Training that the person received;
- The extent to which the person may have acted knowingly or with reckless disregard or intentional indifference of applicable laws.

d) Written transcript of interviews to be signed by the interviewer and

interviewee attesting that everyone as written is correct.

e) Preparation of a summary reports that (1) defines the nature of the alleged misconduct, (2) summarizes the investigation process, (3) identifies any person who is believed to have acted deliberately or with reckless disregard or intentional indifference of applicable laws, (4) assesses the nature and extent of potential civil or canal liability and (5) where applicable, estimates the extent of any resulting overpayment by the government.

3) Establish a due date for summary report or otherwise ensure that the investigation is completed in a reasonable and timely fashion and the appropriate disciplinary or corrective action is taken if warranted.

B. Corrective Action Plans and Implementation Reviews

Investigations
In the event the investigation identifies employee misconduct or suspected criminal activity, Family Service will undertake the following steps:

1) Immediately cease the offending practice. If the conduct involves the improper submission of claims for payment, we will immediately cease all billing potentially affected by the offending practitioners.

2) Consult internally and externally, if deemed practicable, to determine whether voluntary reporting of the identified misconduct to the appropriate governmental or private authority is warranted.

3) If applicable, calculate and repay any duplicate or improper payments made by a Federal, state government or private insurance program as a result of the misconduct.

4) When appropriate, handle any over payments through the administrative billing process by informing the billing staff and making appropriate adjustments via software used for billing.

5) Ensuring that any investigation and overpayment is finalized no later than 60 days after it was first identified. This ensures compliance with Federal and State laws.

6) We will initiate disciplinary action as noted in “Section VII – Enforcement and Discipline” of this Compliance Plan.

7) Promptly undertake appropriate training and education to prevent a recurrence of the misconduct.

8) Conduct a review of applicable Family Service Policies and Procedures to determine whether revisions or the development of new policies and/or procedures are needed to

minimize future risk of noncompliance.

9) Conduct, as appropriate, follow-up monitoring an audit to ensure effective resolution of the offending practice.

Audit Findings

Family Service will use the Medicaid Audit Checklist and reviews of billed services against Electronic Health Care entries for assessment, service plans and case notes as well as a comparison to the client file documentation as our primary tools for determining compliance.

The following will be the process for reporting audit findings:

1) The Chief Compliance Officer will provide a report to President/CEO, Senior Vice President the Medicaid Quality Improvement Team and appropriate Directors at least twice annually that includes charts and narrative to show agency levels of compliance in billing versus progress notes, service plans, service plan reviews, assessments, client adherence rates and quality measure outcomes as well as staff/client utilization reviews;

2) The Chief Compliance Officer will provide to the appropriate Directors of each service area specific details from the Medicaid Audit Checklist and reviews of billed services against Electronic Health Records and Client Records so that the appropriate staff has the opportunity to correct errors. This will provide billing staff the opportunity to make adjustments where errors in billing may have occurred. Errors may only be corrected as long as they are in compliance with Family Service's Policies and Procedures and within the allowable federal, state and private insurer regulations;

3) If applicable, Family Service will calculate and repay any duplicate or improper payments made by a federal, state government or private insurer program as a result of the non-compliance;

4) The Chief Compliance Officer will ensure that any repayment is done no later than 60 days after the audit findings;

5) The Chief Compliance Officer will request that a corrective action plan which details steps the program/service area will take in preventing similar non-compliance activities from occurring in the future; (Appendix H: Sample of a Corrective Action Plan)

6) The Alternate Compliance Officer or the appropriate program Director will complete corrective action reports and provide them to the Chief Compliance Officer for review and approval.

7) The Corporate Compliance Coordinator will work with service area staff to ensure corrective action plans are completed and monitoring of the Corrective Action Plan will occur through their direct supervisor.

8) In the event that the non-compliance occurs in Family Service's billing practice, the Chief Compliance Officer will create a report that explains the current practice, why it is non-compliant and what the practice should be moving forward. Such reports will be provided to the President/CEO, Senior Vice President, appropriate Director, billing staff and members of the Medicaid Quality Improvement Team.

9) Conduct, as appropriate, follow-up monitoring an audit to ensure effective resolution of non-compliance findings;

10) It will be the responsibility of the Director of each service area, through prompting by the Chief Compliance Officer, to address implementation of correction action activities and/or other implemented changes that minimize risk and address non-compliance.

C. Reporting to the President/CEO and Board of Directors

The Chief Compliance Officer will report investigations to the President/CEO within 1 – 2 days of having received a possible fraud, waste or abuse allegation. The President/CEO will determine how to report it to the Board of Directors.

Through verbal reporting, the President/CEO will immediately be aware of the outcome of any investigations. However, a formal report, as noted previously, will also be provided to the President/CEO.

At least annually, the Chief Compliance Officer will provide a report to the Board of Directors, which includes all investigations and their status. She/he will also provide to them the audit findings from any reviews that have taken place throughout the year, as well as corrective actions that have been implemented.

X. Outside Legal Counsel

Outside legal counsel is available to assist the President/CEO, Board of Directors, Chief Compliance Officer as needed to identify and interpret federal and state laws and regulations in the Corporate Compliance Plan.

Outside legal counsel may be notified at the discretion of the President/ CEO of incidents that has a reasonable cause to support the assertion of non-compliance at which time the Chief Compliance Officer will be responsible for facilitating an investigation. The results of the investigation will be used by legal counsel to provide legal advice to the President/CEO of Family Service Association of San Antonio, Inc.

XI. Assessing Effectiveness of Compliance Program

Every January, Family Service is expected to certify to the Office of Inspector General that we have an "effective compliance program" in place. In order for us to certify to our effectiveness Family Servicer has used various tools to assist providers in this process. We use a Self-Assessment Tool, which basically addresses all of the required elements that are supposed to be in our Compliance Plan and whether we are or have implemented them throughout the

agency. The assessment tool is completed yearly by the Chief Compliance Officer and the findings are shared with the Medicaid Quality Improvement Team, Quality Assurance Committee, Directors and Executive Leadership. The outcome of this assessment will be used to update our Plan and implement new systems that address any deficiencies in our compliance program.

XII. Conclusion

The Corporate Compliance Plan has been prepared to outline the broad principles of legal and ethical business conduct embraced by Family Service. It is not a complete list of legal or ethical questions you might face in the course of business. Therefore, this plan must be used together with your common sense and good judgment.

If you are in doubt or have a specific question, you should contact your supervisor or the Agency Chief Compliance Officer.

Acknowledgment of Receipt

Family Service Association of San Antonio, Inc.
Medicare/Medicaid/Insurance Compliance Plan

I have received, read and understand the Family Service Medicare/Medicaid/Insurance Compliance Plan and I will uphold and abide by all policies set forth in this

Name of Employee, Organization, or vendor:

_____

This is to certify that _____ (organization/person name) has received and understands my/our responsibility to ensuring compliance with Family Service's Medicare/Medicaid/Insurance Corporate Compliance Plan.

_____ _____

Signature of service provider **NPI #**

_____

Date of signature

COMPLIANCE PLAN ANNUAL ASSESSMENT FORM

Agency: Family Service Association of San Antonio, Inc.

Person Completing Assessment: _

Title of Person Completing Assessment: _

Date Assessment Completed: _

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required ***Include specific citations to the documents and text that supports any "Yes" response***
	Element 1: Written policies and procedures			
1.1	Do you have written policies and procedures that describe compliance expectations in a code of conduct or code of ethics?			
1.2	Have you implemented the operation of the compliance program?			
1.3	Do you have written policies and procedures that provide guidance to *employees* on dealing with potential compliance issues?			
1.4	Do you have written policies and procedures that provide guidance on how to communicate compliance issues to appropriate compliance personnel?			
1.5	Do you have written policies and procedures that provide guidance on how potential compliance problems are investigated and resolved?			

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*

Element 2: Designate an employee vested with responsibility

2.1	Has a designated employee been vested with responsibility for the day-to-day operation of the compliance program?			
2.2	Are the designated employee's duties related solely to compliance?			
2.3	If the designated employee's compliance duties are combined with other duties, are the compliance responsibilities satisfactorily carried out?			
2.4	Does the designated employee report directly to the entity's chief executive or other senior administrator?			
2.5	Does the designated employee periodically report directly to the governing body on the activities of the compliance program?			

Element 3: Training and education

3.1	Is training and education provided to *all affected employees* on compliance issues, expectations and the compliance program operation?			
3.2	Is training and education provided to *all affected persons associated with the provider* on compliance issues, expectations and the			

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*
	compliance program operation?			
3.3	Is training and education provided to *all executives* on compliance issues, expectations and the compliance program operation?			
3.4	Is training and education provided to *all governing body members* on compliance issues, expectations and the compliance program operation?			
3.5	Does the compliance training occur periodically?			
3.6	Is compliance training part of the orientation for *new employees*?			
3.7	Is compliance training part of the orientation for *appointees or associates*?			
3.8	Is compliance training part of the orientation for *executives?*			
3.9	Is compliance training part of the orientation for *governing body members*?			

Element 4: Communication lines to the responsible compliance position

4.1	Are there lines of communication to the designated employee that are accessible to *all employees* to allow compliance issues to be reported?			
4.2	Are there lines of communication to the designated employee that are accessible to *all persons*			

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*
	associated with the provider to allow compliance issues to be reported?			
4.3	Are there lines of communication to the designated employee that are accessible to *all executives* to allow compliance issues to be reported?			
4.4	Are there lines of communication to the designated employee that are accessible to *all governing body members* to allow compliance issues to be reported?			
4.5	Is there a method in place for *confidential* good faith reporting of potential compliance issues?			

Element 5: Disciplinary policies to encourage good faith participation

5.2	Are there policies in effect that articulate expectations for reporting compliance issues for all affected individuals?			
5.3	Are there policies in effect that articulate expectations for assisting in the resolution of compliance issues for all affected individuals?			
5.4	Is there a policy in effect that outlines sanctions for failing to report suspected problems for all affected individuals?			
5.5	Is there a policy in effect that outlines sanctions for participating in non-			

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*
	compliant behavior for all affected individuals?			
5.6	Is there a policy in effect that outlines sanctions for encouraging, directing, facilitating or permitting non-compliant behavior for all affected individuals?			
5.7	Are all compliance-related disciplinary policies fairly and firmly enforced?			

Element 6: A system for routine identification of compliance risk areas

6.1	Do you have a system in place for routine identification of compliance risk areas specific to your provider type?			
6.2	Do you have a system in place for self-evaluation of the risk areas identified in internal audits and as appropriate external audits?			
6.3	Do you have a system in place for evaluation of potential or actual non-compliance as a result of self-evaluations and audits identified?			

Element 7: A system for responding to compliance issues

7.1	Is there a system in place for responding to compliance issues as they are raised?			
7.2	Is there a system in place for investigating potential compliance problems?			
7.3	Is there a system in place for responding to compliance problems as identified in the			

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*
	course of self-evaluations and audits?			
7.4	Is there a system in place for correcting compliance problems promptly and thoroughly?			
7.5	Is there a system in place for implementing procedures, policies and systems as necessary to reduce the potential for recurrence?			
7.6	Is there a system in place for identifying and reporting compliance issues to the Office of Inspector General?			
7.7	Is there a system in place for refunding overpayments?			

Element 8: A policy of non-intimidation and non-retaliation

8.1	Is there a policy of *non-intimidation* for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions?			

FAMILY SERVICE
Medicare/Medicaid/Insurance Complaint or Fraud Report

If you have a concern about an instance or pattern of possible Medicare/Medicaid/Insurance Waste, Fraud or a complaint related to the provision of these services, we would definitely like to hear from you. In stating your concern below, please be as specific as possible. Be sure to clearly identify the problem and the parties involved. Your Complaint or concern will be fully investigated and you will be communicated regularly to ensure that you are protected from any form of retaliation. Thank You!

Reporters Name (printed): _____

Reporters Signature: _____ Date: _____

Address:_____

Telephone: (Work) _____ (Home) _____

Please Mail this form or email the form or you may report by phone to the following:

Richard Davidson, Chief Compliance Officer
Family Service Association of San Antonio, Inc.
702 San Pedro
San Antonio, Texas 78212
(210) 299-2412
rdavidson@family-service.org

Medicaid Audit Checklist

The following audit checklist was derived from Texas Medicaid Provider Procedures Manual dated March 2016.

PROVIDER NAME:	**AUDIT DATE:**
PROVIDER #:	**NAME & ACCT. #:**
CONTROL #:	**SERVICE TYPE:**
MEDICAID #:	**PROCEDURE CODE:**
DOB/AGE:	**SERVICE DATE:**
RECORD #:	**UNITS PAID:**

RATING CODES:	0 = No 2 = partially met 4 = Yes	6 = No service/not 7 = Unable to identify service provider	8 = Rpt'd 9 = NA	RATING
AUTHORIZATION/PERSON CENTERED PLAN (Use rating of "4" or "0" for Q 1-3				
1.	Is an authorization in place covering dates of service?			
2.	Is there a valid service order 'Superbill' for the service billed? If NO, list dates of missing Superbills: _____, _____, _____, _____.			
3.	Are the dates of service covered by a valid Provider? If NO, list dates: _____, _____, _____.			
SERVICE DOCUMENTATION (Use Likert Scale Scoring Instructions) (Use rating of "4", "2" or "0" for Q 4-9 and "4" or "0" for Q 10 or ratings of 6, 8, or 9 as applicable)				
4.1	Initial assessment contains a chronological psychiatric, medical and substance use history with time frames of prior treatment and the outcomes.			
4.2	Initial assessment contains a social and family history.			
4.3	Initial assessment contains an educational and occupational history.			
4.4	Initial assessment contains a narrative description of the assessment.			
4.5	Initial assessment contains background, symptoms, and impression..			
4.6	A description of why treatment is being sought at the present time.			
4.7	A mental status examination, which validates a diagnosis as listed in the current edition of the DSM.			
4.8	A description of any existing psychosocial or environmental problems.			
4.9	A description of the current level of social and occupational or educational functioning.			
5.1	Treatment Plan contains a description of the primary focus of the treatment.			
5.2	Treatment Plan contains clearly defined discharge goals that indicate treatment can be successfully accomplished.			
5.3	Treatment Plan contains the expected number of sessions it will take to reach the discharge goals, and standards of practice for the client's diagnosis.			
5.4	Treatment Plan contains information that family therapy services are appropriately planned unless there are valid clinical contraindications.			
6.1	Session notes contain session beginning and ending times.			
6.2	Session notes contain a current DSM diagnosis.			
6.3	Session notes contain behavioral observations during the session.			
6.4	Session notes contain a narrative description of the counseling session.			
6.5	Session notes identify treatment plan goal(s) worked on in counseling.			
6.6	Session notes reflect assessment of progress toward goal(s).			
6.7	Session notes are individualized per person.			
7.1	Discharge plan reflects concluding the client's treatment based on an assessment of the client's progress in meeting the discharge goals.			
7.2	Discharge plan identifies the client's aftercare needs that include a plan for transition if required.			
8.	Other noted discrepancies:			

COMMENTS:

AUDITOR NAME:	**AUDITOR SIGNATURE:**

Family Service Association of San Antonio, Inc.
File Audit Summary Notes

☐ **Medicare/Medicaid/Insurance Compliance Review**

Case File Name or Number:_____
Direct Service Employee: _____
Department/Project:
_____

Date_____ ☐ **Compliant** ☐ **Not Compliant**

Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Actions	Who	By When

Auditor Name & Signature_____ Date_____
Direct Service Provider Signature_____ Date_____
Supervisor Signature_____ Date_____

Type of Report ☒ *Medicare/Medicaid/Insurance Audit Report*	**Date Disseminated**
Compiled:	
Agency Policy that Requires this Information: *Medicare/Medicaid/Insurance Compliance Plan*	**Month:**

Quality Audit Review –Medicare/Medicaid/Insurance Billing

Function	Month	Month	Month
Billing Entries			
Billing Entries Verified			
Double Billed			
Triple Billed			
No Shows Billed			
Visits Not Billed			
Accuracy Rate			

Clinician/Case Management-Medicare/Medicaid/Insurance Billing

Staff Member	Compliance %	Level	Corrective Action
Average Accuracy Rate			

Corrective Action Plan			
Contractor Name: Family Service Association of San Antonio, Inc.	**NPI #:**		**Date:**
Audit Findings	**Statement of the problem:** .		
Proposed Action Steps	**Timeline for each step**	**Person Responsible - Implementation**	**Person Responsible - Oversight**

Additional response for this finding/issue: