Finger Lakes Area Counseling and Recovery Agency, Inc.

(FLACRA)

Corporate Compliance Program Manual

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I. COMPLIANCE POLICY STATEMENT

The Finger Lakes Area Counseling and Recovery Agency, Inc. (FLACRA) is dedicated to maintaining quality and integrity in all aspects of our operations. Accordingly, FLACRA is committed to conformance with high ethical standards and compliance with all governing laws and regulations not only in the delivery of Addiction Services but in business affairs and dealings with employees, administrative staff, physicians, agents, payers, and the communities it serves. It is the personal responsibility of all who are associated with FLACRA to honor this commitment in accordance with the terms of the FLACRA Canon of Ethical Principles and Code of Ethics, related policies and procedures, and standards developed by FLACRA in connection with the Corporate Compliance Program.

II. PURPOSE OF COMPLIANCE PROGRAM

The FLACRA Corporate Compliance Program (the "Program") is intended to provide reasonable assurance that FLACRA:

1. Complies with all federal, state, and local laws and regulations that are applicable to its operations;
2. Satisfies the conditions of participation in the programs funded by the state and federal government and the terms of its other contractual arrangements;
3. Deters, detects, and appropriately responds to criminal conduct or other forms of misconduct by trustees, officers, employees, medical staff, agents, and contractors;
4. Promotes self-auditing and self-policing, and provides for, in appropriate circumstances, voluntary disclosure of violations of laws and regulations; and
5. Establishes, monitors, and enforces high professional and ethical standards.

III. SCOPE OF COMPLIANCE PROGRAM

The provisions of the Program apply to all clinical, business, and legal activities performed by FLACRA employees, board members, agents, and contractors. The expectations regarding compliance with the Program are as follows:

1. Comply with FLACRA's Mission Statement, values, Canon of Ethical Principles and Code of Ethics;
2. Familiarize themselves with the purpose of the Program;
3. Perform their jobs in a manner which demonstrates commitment to compliance with all applicable laws and regulations;
4. Report known or suspected compliance issues to the Chief Quality Officer or his/her designee and investigate or participate in investigations to the point of resolution of an alleged violation. Anonymous reports may be made by completion of Quality Assurance Complaint Form found in each program in the main client lobby and staff break room area and forwarded by interoffice mail or formal post to:

Chief Quality Officer
28 East Main Street
Clifton Springs NY 14432

5. Other forms of reporting are equally encouraged, such as phone calls or email directly to the Chief Quality Officer. For all reporting, confidentiality will be upheld to the highest extent possible.

6. Strive to prevent errors and provide suggestions to reduce the likelihood of errors.

IV. COMPLIANCE PROGRAM ELEMENTS

1. Ethical Principles for Professionals at FLACRA and Board Member Code of Ethics - development and distribution of these documents, as well as the development and distribution of policies and procedures that further promote FLACRA's commitment to compliance. Such policies should be considered an integral part of this Program;
2. Chief Quality Officer and Compliance Committee as well as Quality Assurance/Safety Committee and Quality Improvement Committee – functions to facilitate the advance of skills and abilities of staff;
3. Program Performance and Evaluation Committee – Board of Director Committee level meeting that reviews and analyzes program quality and effectiveness through data, statistics and other performance measures to ensure the organizational programs are providing high quality treatment and services.
4. Education and Training Program Development and Implementation – to provide general compliance information to the broad-based service member populations as well as focused technical training of those functional areas that have a greater degree of compliance exposure;
5. Sanction or Disciplinary Action Enforcement – the enforcement of appropriate sanctions or disciplinary actions against employees, board members, physicians, or on-site agents or contractors who violate compliance policies, applicable laws and/or regulations;
6. Monitoring – the performance of audits and risk assessments to identify problems and conduct ongoing compliance monitoring of identified problem areas; and
7. Investigation and Remediation – the investigation and remediation of identified systemic problems and the development of appropriate corrective actions plans to remediate such problems.

This Program establishes a framework for legal and ethical compliance by service members. The Program is a living document and all members of FLACRA are encouraged to suggest changes or additions to the Program.

V. ETHICAL PRINCIPLES AND BOARD MEMBER CODE OF CONDUCT

The Ethical Principles for Professionals and the Board Member Code of Ethics provides the guiding standards for service member actions. Although these cannot cover every situation in the daily conduct of FLACRA's many varied activities nor substitute for common sense, individual judgment or personal integrity it is the duty of each service member to adhere, without exception, to the principles set forth herein.

1. Comply With All Applicable Laws

It is the duty of service members to uphold all applicable laws and regulations. All service members must be aware of the legal requirements and restrictions applicable to their respective positions and duties. FLACRA expects each of its service members to refrain from engaging in activity which may jeopardize the tax exempt status of the organization, including inappropriate lobbying and political activities.

FLACRA shall implement programs necessary to further such awareness and to monitor and promote compliance with such laws and regulations.
Questions about the legality or propriety of any actions undertaken by or on behalf of FLACRA should be referred immediately to one's supervisor, Program Director, or the FLACRA Chief Quality Officer. The Quality Assurance/Safety Committee will also serve as a reporting method.

2. Conduct Affairs in Accordance with the Highest Ethical Standards

Service members shall conduct all activities in accordance with the highest ethical standards of the community and their respective professions at all times and in a manner which shall uphold FLACRA's reputation and standing. No service member shall make false or misleading statements to any client, person or entity doing business with FLACRA.

3. Avoid Conflicts of Interest

FLACRA is a non-profit organization dedicated to the provision of addiction services. All members of the FLACRA community must faithfully conduct their duties, in their assigned roles and tasks, for the purpose, benefit, and interest of FLACRA and those whom it serves.
All FLACRA community members have a duty to avoid conflicts with the interests of the agency and may not use their positions and affiliations with FLACRA for personal benefit. Members of the FLACRA community must consider and avoid not only actual conflicts but also the appearance of conflicts of interest. Any potential conflict of interest must be disclosed to FLACRA.

4. Strive to Attain the Highest Standards for All Aspects of Patient Care

All members of the FLACRA community must support the FLACRA mission to provide health services of the highest quality that respond to the needs of our clients, their families, and the community as a whole. The care provided must be reasonable and necessary to the care of each client, as appropriate to the situation, and such care must be provided by properly qualified individuals. All such care must be properly documented as required by law and regulations, payer requirements and professional standards.

5. Provide Equal Opportunity and Shall Respect the Dignity of All Members of FLACRA

FLACRA is committed to providing addiction services for all persons, without regard to race, color, nationality or ethnic origin, religion, gender, sexual orientation, disability or veteran's status. FLACRA is committed to maintaining an environment that respects the dignity of each individual in the community. Therefore, discrimination in any form or context will not be tolerated. FLACRA's Employee Handbook clearly references agency and member obligations and employee benefits that relate to this Compliance Program.

6. Maintain the Appropriate Levels of Confidentiality for Information and Documents

Members of the FLACRA community have access to a variety of sensitive and proprietary information, the confidentiality of which must be protected. All service members must adhere to the appropriate laws, regulations, policies and procedures to ensure that confidential information is properly maintained and inappropriate or unauthorized release is prevented. FLACRA and its

community members shall create and keep records and documentation that conform to legal, professional, and ethical standards.

7. Maintain a Relationship of Integrity with Each Payer Source

Service members shall ensure that all requests for payment for all services are (i) reasonable, necessary and appropriate; (ii) provided by properly qualified persons, and (iii) the claims for such services are billed in the correct amount and supported by appropriate documentation. Related details, policies and procedures are contained in this program and the agency Finance Policy and Procedure Manual.

8. Conduct All Business With Honesty and Integrity

All business practices of FLACRA must be conducted with honesty and integrity and in a manner that promotes a positive and professional reputation with clients, payers, vendors, regulatory agencies and other providers. All service members must:

- adhere to proper business practices and federal and state fraud, abuse, and referral prohibitions in dealing with vendors and referral sources;
- conduct business transactions free from offers or solicitation of gifts, favors or other improper inducements;
- conform to all applicable antitrust laws and regulations, and ensure that FLACRA does not violate laws and regulations with respect to (i) pricing or other sale terms or conditions, (ii) improper sharing of competitive information, (iii) the allocation of territories or (iv) the impermissible exclusion of others from economic activities;
- maintain and protect the property and assets of FLACRA including intellectual property and proprietary information, controlled substances and pharmaceuticals, equipment and supplies, and funds of FLACRA, and refrain from converting FLACRA assets to personal use;
- maintain the confidentiality of proprietary information belonging to other persons or entities doing business with FLACRA; and
- prepare accurate financial reports, accounting records, research reports, expense accounts, time sheets, and other documents so that they completely and accurately represent the relevant facts and true nature of all FLACRA business transactions.

All of these business practices are detailed in the agency Finance Policy and Procedure Manual.

9. Have Proper Regard for Safety

FLACRA shall provide a workplace that conforms to regulations regarding occupational health and safety. FLACRA is committed to proper maintenance of the earth's environment; therefore, all medical waste, hazardous waste and other products shall be used and disposed of in accordance with all applicable environmental laws and regulations. The Quality Assurance/Safety Committee is part of such activities.

10. The Ethical Principles for Professionals and the Board Member Code of Ethics Shall be Integral to the Operation of FLACRA and the Activities of the Community

These exist for the benefit of the FLACRA community. It is a dynamic document that will change through the contributions of service members. All members of the FLACRA community are

encouraged to suggest changes or additions. These must be incorporated into the daily activities of the members of the FLACRA community.

The above does not limit specific policies and procedures of FLACRA. Service members must perform their duties in accordance with such policies and procedures.
Officers, managers and supervisors of FLACRA have a special duty to adhere to the principles set forth, to support other service members in their adherence, to recognize and detect violations and to enforce the standards set forth in support of the Ethical Principles for Professionals and Board Member Code of Ethics.

Any failure to report suspected illegal or improper conduct, participating in non-compliant behavior, or encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior is a violation of the Compliance Plan and may subject the individual to discipline. Compliance is extremely important because the failure to abide by these laws and regulations can lead to civil and/or criminal violations, serious financial consequences such as significant fines and penalties, and/or criminal sanctions for individuals and organizations.

No retaliation or adverse action will be taken against an individual as a result of submitting a good faith report of suspected irregular activities. Any individual who is found to have harassed or to have taken any adverse action against an individual, who submitted a report, participated in an investigation or assisted with remedial action may be subject to discipline, including immediate discharge. All relevant Labor Laws will be followed.

Alleged violations will be investigated by persons designated by, and pursuant to procedures established by FLACRA.

Disciplinary action for violations shall be enforced through the disciplinary policies and procedures of the agency. Disciplinary actions will be determined on a case-by-case basis and may include dismissal from employment or other association with the Agency. FLACRA will cooperate with law enforcement authorities in connection with the investigation and prosecution of any service member who violates a law governing the activities of FLACRA.

VI. CHIEF QUALITY OFFICER

The Chief Quality Officer (CQO) reports to the Executive Director and the FLACRA Board of Directors. The CQO's primary responsibilities include:

- Overseeing and monitoring the implementation of the FLACRA Compliance Program.

The CQO will work with the Corporate Compliance Committee (Executive Committee) and appropriate FLACRA Program Directors to develop Compliance Plan details which at a minimum will:

- ✓ develop and implement audit and monitoring policies and procedures.
- ✓ plan timetables for educational and training programs relating to legal and regulatory areas
- ✓ plan timetables for implementation of departmental compliance policies and procedures where appropriate
- ✓ plan timetables for continued monitoring of areas under corrective action based on prior compliance assessments;

- reporting as necessary to the FLACRA Board on the progress of Compliance Program implementation. Included in such report will be statistics and narrative compliance summaries, new compliance issues noted, plans for investigation, status of previously initiated investigations, timing and adequacy of corrective action plans implemented, and designs for ongoing and future monitoring;
- assisting FLACRA members and other staff in establishing methods to improve their efficiency and quality services, and to reduce FLACRA's vulnerability to fraud, abuse, and waste;
- obtaining from FLACRA's Board and Executive Director the required commitment of resources to carry out review and monitoring activities identified;
- periodically revising the Compliance Program in light of changes in the needs of the organization, and in the laws, policies, and procedures of government and private payer health plans;
- developing, coordinating, and participating in a multifaceted education and training program that focuses on the elements of the Compliance Program, and ensures that all appropriate staff and management are knowledgeable of, and comply with, pertinent federal and state standards;
- ensuring through coordination with other FLACRA staff that independent contractors and agents who furnish service to FLACRA are aware of the applicable requirements of the FLACRA Compliance Program with respect to coding, billing, and marketing;
- assisting FLACRA Finance and Administrative Services Department Staff by coordinating internal compliance review and monitoring activities;
- independently investigating and acting on matters related to compliance, including the design and coordination of internal investigations that respond to reports of problems or suspected violations, and any resulting corrective action. The CQO and his/her designee have authority to review all documents and other information that are relevant to compliance activities;
- ensuring coordination between Quality Assurance, and Quality Improvement activities and this Compliance Program;
- ensuring that required certifications related to this Plan are filed with the New York State Office of the Medicaid Inspector General; and
- responding, in conjunction with legal counsel, to external agency requests regarding compliance issues.

VII. CORPORATE COMPLIANCE COMMITTEE

The Corporate Compliance Committee shall be comprised of the Executive Team which includes the Executive Director, the Director of Finance, Chief Quality Officer and the Chief Operating Officer. These members have broad backgrounds and experience levels and expertise in operations, billing, monitoring quality, service delivery, and legal/regulatory compliance.

The Compliance Committee is responsible for the development, implementation, and monitoring of the FLACRA Compliance Program. The Compliance Committee's functions include:

- monitoring changes in the addiction services environment, including regulatory changes with which FLACRA must comply, and identifying the impact of such changes on specific risk areas;
- recommending the revision of policies and procedures, as needed, so that such policies support the Values, Mission and Ethical Principles and Codes; and

- monitoring, through summary reports, the types of compliance issues and concerns related to compliance

VIII. EDUCATION AND TRAINING

1. All service members and the Board of Directors will be introduced to and trained in the Program, the Ethical Principles and Code of Ethics, and organization compliance policies and procedures. Such training will reinforce the need for strict compliance with the law and will advise employees that any failure to comply will be documented on the employees' performance evaluation, as applicable, and may result in disciplinary action.
2. New employees and others associated with the Agency will sign the Canon of Ethical Principles Statement and new Board members the Code of Ethics.
3. Focused in-service training will be provided regularly to employees involved in treatment and in billing government and private payer programs.
4. Attendance at all training programs is mandatory and will be monitored and properly documented.

Training materials and a system to document that such training has occurred will be developed by the Compliance Committee.

IX. COMPLIANCE COMMUNICATION

1. Direct Access to the Compliance Officer and Compliance Committee

FLACRA recognizes that an open line of communication between the Compliance Committee, the CQO and service members is critical to the success of the Program.

Service members, who, in good faith, report possible compliance violation, participate in remedial action or assist in an investigation will not be subjected to retaliation or harassment as a result of these activities. Retribution related to these activities is prohibited and anyone who engages in such prohibited activity will be subject to disciplinary action. Concerns about possible retaliation or harassment should be reported to the CQO or his/her designee. All such communications will be kept as confidential as possible but there may be times when the reporting individual's identity may become known or may have to be revealed if governmental authorities become involved. The CQO will seek advice and guidance directly from legal counsel to assist in the investigation of fraud and abuse reports concerning members of the FLACRA Community who may have participated in illegal conduct or committed other malfeasance.

2. Organizational Structure

The organizational structure at FLACRA lends itself to excellence in compliance. There are 3 Executive Team members that comprise the Corporate Compliance Committee; the Executive Director, the Director of Finance and the Chief Quality Officer.

The Quality Assurance/Safety Committee which reviews Incident Reports, Quality Assurance complaints and conducts Utilization Review is made up of the Program managers representing all areas of service, the Compliance Officer, Quality Assurance Manager and Director, a Peer, a Consumer and a Family member.   Minutes of these activities are provided to the Executive Director the Compliance Committee and summary reports are made to the Board of Directors.

3. New Employee Policy

For all new employees, FLACRA will conduct a reference check as part of the hiring process. All FLACRA job applications shall require the applicant to disclose any exclusion action, as enumerated in 42 U.S.C. 1320a-7(a)&(b), and/or any criminal conviction as defined by 42 U.S.C. 1320a-7(i). The following websites will be queried with respect to potential employees, independent contractors, volunteers and Board Members:

a) General services administration: list of parties excluded from Federal programs. The URL address is https://www.epls.gov/epls/search.do

b) CASAC Verification. The URL address is www.oasas.state.ny.us/credentialingverification/verification/home.cfm

c) HHS/OIG cumulative sanction report. The URL address is http://exclusions.oig.hhs.gov/

d) NYS Medicaid Fraud Database. The URL address is http://www.omig.ny.gov/search-exclusions

e) Licensure and disciplinary record with NYS Office of Professional Medical Conduct (Physicians, Physician Assistants) The URL address is http://www.op.nysed.gov/opsearches.htm

f) New York State Justice Center. The URL address is https://www.justicecenter.ny.gov/SEL/

All staff will have the appropriate credentials and training to perform services. Appropriate and thorough licensing checks and credentialing will occur. References will be checked and verification of educational qualifications performed prior to employment or other association with FLACRA. These checks will be thoroughly documented in the personnel file.

4. Communications with Government Agencies

FLACRA shall document and retain records of all requests for information regarding payment policy from a government agency and all written or oral responses received. Such records are critical if FLACRA intends to rely on such responses to guide them in future decision, actions, or claim reimbursement requests or appeals, while further underscoring FLACRA's commitment to compliance with the law.
It is FLACRA's policy to cooperate with and properly respond to all government inquiries and investigations. Any individual who receives a search warrant, subpoena, or other demand or request for investigation or documentation, or is approached by a federal or state regulatory or prosecutorial agency, should attempt to identify the investigator, if any, and immediately notify their supervisor, the Compliance Officer and the Executive Director. The Compliance Officer, in consultation, as necessary, with legal counsel, will coordinate any response to warrants, subpoenas, inquiries and investigations by regulatory and prosecutorial agencies. The response to any warrant, subpoena, investigation or inquiry must be complete and accurate. No individual associated with FLACRA shall alter, delete or revise any material from any computer, word processor, disk or tape, nor shall any person revise, destroy or alter any written documentation once such inquiry has been commenced. If a document is required to be retained, it must be preserved in its original form.

5. Record Retention

FLACRA is committed to complying with the records and documentation requirements under federal or state law and to the maintenance and retention of records and documentation necessary to confirm the effectiveness of FLACRA's Compliance Program.
Such documentation includes but is not limited to monitoring and audit reports, minutes of Compliance Committee meetings, educational presentation overviews, handouts, and attendance sheets, and documentation of ongoing auditing and monitoring efforts.

X. INVESTIGATIONS

The CQO or his/her designee will:

- promptly initiate an investigation of a potential compliance issues to make a case-by-case determination as to whether a violation has occurred. The CQO will either personally conduct the investigation or refer the complaint to a more appropriate area either within FLACRA services or outside, such as internal or outside legal counsel, auditors or addiction services consultants with needed expertise. The CQO may request assistance in the investigation from the person or persons who filed a complaint, other personnel or external sources, as appropriate;
- request legal counsel to participate in the investigation and provide legal advice in any such matter, as appropriate. In any investigation involving legal counsel, the fact gathering is to be conducted under counsel's direction and control. All members of FLACRA are obligated to cooperate in such investigation.
- prepare a report of each investigation which will include documentation of the issue and, as appropriate, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, the results of the investigation, any disciplinary action, and the corrective action implemented to prevent recurrence. Reports of each investigation and the status of the corrective action will be presented to the Executive Committee and the Board of Directors on a quarterly basis, or as necessary.
- work with relevant areas within FLACRA to ensure return of discovered overpayments to the relevant government programs.
- report, where required, violation of criminal, civil or administrative law to the appropriate federal and/or state authority within a reasonable time period after determining that there is credible evidence of such violation.

XI. AUDITING AND MONITORING

FLACRA is and can be audited or investigated by a variety of reviewers including but not limited to the following:

- Independent Auditors
- Office of Medicaid Inspector General
- Insurers
- Other payers
- OASAS – fiscal and/or regulatory compliance
- New York State Office of the Attorney General Medicaid Fraud Control Unit
- United States Department of Health and Human Services Office of the Inspector General

- United States Department of Justice
- Other State Agencies under contract with FLACRA
- Office of Civil Rights
- New York State Justice Center
- County and Federal Agencies under contract with FLACRA
    - United Ways
    - Health Departments
    - Local Fire Departments
    - Veterans Administration
    - More

Reports or finding issued by any of the above or other external reviews are responded to as necessary as part of FLACRA's Compliance Program.

Monitoring and audit techniques are in place to:

- focus on areas within FLACRA that have potential exposure to government enforcement actions including but not limited to OASAS and the Office of Inspector General. Risk areas are listed below.
- benchmark quality and assure continued quality improvement providing operational snapshots from a compliance perspective that identify the need for further study, improvement or investigation.
- trigger subsequent reviews to ensure corrective actions have been effectively and completely implemented.

From the 2009-2010 Work Plan of the Office of the Medicaid Inspector General (OMIG), "The OMIG will review Medicaid payments for outpatient chemical dependence services to determine if providers claimed reimbursement in accordance with 14 NYCRR § 822. Medicaid reimbursement is available for outpatient chemical dependence services provided in hospital-based or freestanding clinics. The OMIG will conduct reviews of providers that receive the largest amounts of Medicaid reimbursement for these services. Prior OMIG audits identified significant non-compliance with regulations, such as missing treatment plans and missing signatures on treatment plans. The OMIG also identified significant non-compliance with regulations limiting the number of participants for outpatient group therapy services. Additionally, the OMIG will focus on the medical necessity of services rendered to Medicaid recipients and will also consider if the services were clinically excessive. The OMIG will also conduct audits or investigations of OASAS providers who are found to be providing excessive services through OASAS reviews and are referred to the OMIG by OASAS."

Risk Areas include:

1. Provision of free or below fair market value services to referral sources.

2. Failure to maintain records required for Medicaid for six years following the date of payment or failure to comply with other payer requirements.

3. Failure to check Medicaid or other appropriate payer eligibility.

4. Failure to submit bills within 90 days or as required by the appropriate payer.

5. Billing for services not provided.

6. Employing or contracting with those excluded from the Medicare and/or Medicaid programs.

7. Failure to bill a primary insurer where one exists.

8. Failure to disclose changes in ownership or control or a change of managing employees as required by the Medicaid regulations.

9. Failure to receive approvals for changes in programming where required, such as space alterations.

10. Failure to hire appropriately credentialed staff and ensure such credentials are maintained.

11. Failure to file any required Consolidated Fiscal Report.

12. Other than where a limited exception applies, billing for 822 Outpatient Services and 819 Intensive Residential Rehabilitation Services for the same day.

13. Failure to comply with the leasing requirements of the New York State Office of Alcoholism and Substance Abuse Services.

14. Submitting false claims or statements.

15. Illegally discriminating in the furnishing of services based upon the participant's race, color, national origin, religion, sex, sexual orientation, age, physical or mental disability, HIV and AIDS status, pregnancy, or past involvement with substance abuse or the criminal justice system, prior treatment history, referral source, maintenance on methadone or other medication prescribed and monitored by a physician, physician's assistant or nurse practitioner, or lack of cooperation by significant others in the treatment process.

16. Failure to complete a signed admission assessment within 3 visits to the service

17. Failure to demonstrate medical necessity for each admission based on current DSM V substance abuse or dependence criteria with supporting evidence of criteria

18. Failure of participants to meet admission criteria or failure to document such admission criteria.

19. Failure to complete an appropriate level of care determination with appropriate signatures and in the appropriate timeframe.

20. Failure to complete an appropriate, signed comprehensive evaluation in the appropriate timeframe.

21. Failure to complete an appropriate medical assessment and physical evaluation, where required, in the appropriate timeframe.

22. Failure to complete and document the discharge planning process as required by regulation.

23. Failure to provide appropriate individual counseling (for example, for each individual Medicaid participant, at least one out of every ten counseling sessions must be an individual counseling session of at least one half hour in duration with the individual participant's primary counselor, unless a different frequency or intensity is otherwise determined, with supporting documentation, by the multidisciplinary team).

24. Having too many persons in a group counseling session.

25. Failure to complete the treatment plan with all required elements within 45 days of admission to the program.

26. Failure to create and maintain an attendance note documenting the date, type and duration of the service provided.

27. Failure to complete and maintain progress notes with appropriate frequency. If progress notes are written after every session then no session notes are necessary but progress notes shall specify the duration of every visit. Progress notes must be written, signed and dated by the clinical staff providing the service; provide a chronology of the participant's progress related to the goals established in the treatment plan; be sufficient to delineate the course and results of treatment; indicate the participant's participation in all significant services that are provided; and fully document in the individual participant or significant other's treatment record the content and/or outcome of all visits.

28. Failure to review the treatment plan, once established, at least every ninety calendar days by the responsible clinical staff member in consultation with the participant, and/or failure to have such review reviewed, signed and dated by a member of the multi-disciplinary team. Failure to record all of the names of the reviewing individuals in the treatment plan. Failure to ensure that every fourth such ninety calendar day review includes an update of the comprehensive evaluation. Failure to complete a summary of the participant's progress in each of the specified treatment plan goals in the participant's record as part of the treatment plan review.

29. Failure to include, where required, a physician's signature on the treatment plan.

30. Failure to maintain individual records for each participant who is admitted and provided services. These participant records must include, at a minimum, the following:
    - a notation that the participant received at admission a copy of the Agency's rules and regulations, including participant's rights and a summary of the federal confidentiality requirements, that such rules and regulations were discussed with the participant, and that the participant indicated that he/she understood them;
    - the source of referral;
    - documentation that the participant met the admission and retention criteria;
    - if the participant is a minor being treated without parental consent, that the provisions of Mental Hygiene Law Section 22.11 have been met;

- documentation of the comprehensive evaluation, including results of the participant's physical examination, if applicable;
- the individual treatment plan, and all reviews and updates thereto;
- documentation of recommendations, referrals and services provided for the participant's general health or for other special needs, including coordination with other agencies, as included in the individual treatment plan, and notes on the participant's progress with such other agencies, as well as other incoming and outgoing correspondence about the participant;
- results of any toxicology, breath testing, and any other testing performed;
- discharge plan and summary, including the circumstances of the discharge;
- documentation of contacts with a participant's family and/or significant other(s);
- signed releases of consent for information, if any; and
- progress notes.

31. Failure to provide appropriate training to staff.

32. Failure to have a qualified health professional designated as the clinical director. Such person shall have at least three years of full-time clinical work experience in the chemical dependence field, at least one year of which must be supervisory, prior to appointment as clinical director.

33. Failure of the governing authority to designate a physician to be the medical director.

34. Failure to have appropriate physician, registered physician's assistant or nurse practitioner onsite coverage.

35. Failure to have the requisite number of full-time equivalent primary counselors or primary therapists.

36. Failure to have the correct ratio of qualified health professionals on the clinical staff.

37. Failure to have the requisite CASAC and fulltime professionals. Policies and procedures must exist that ensure the continuity of care, including regular participation of full-time and part-time direct care staff in clinical supervision, case conference, in service training and staff meetings.

38. Failure to maintain case record entries in the electronic record.

39. Failure to ensure documentation is legible.

40. Billing for more than one same service Medicaid visit per day, per participant or significant other, regardless of the number or types of outpatient services. A participant or significant other shall mean an individual who is either admitted to an outpatient service or an individual being admitted or assessed to determine that individual's need for outpatient services. A visit means any distinct and separate occasion of outpatient service (occasion of service) provided on-site by an OASAS licensed provider to any participant, or significant other, which would be reimbursable by Medicaid if the participant or significant other were Medicaid eligible.

41. Billing for a visit that does not meet the following requirements:
    - each occasion of service must be a face-to-face contact between a participant or a significant other and treatment staff, which takes place at the certified site;
    - each occasion of service must be an appropriate outpatient service; and
    - each occasion of service must last at least 25 minutes to bill for a brief visit and 45 minutes to bill for a normative visit.

42. Failure to document the content, outcome and results of services for all visits in the individual participant or significant other's treatment record.

43. Failure to maintain all individual and group notes in each individual's record.

44. Failure to ensure that treatment plans and case records are active documents and show progress. Notes in a participant chart must be related to the goals and objectives stated in the individual's treatment plan. If progress is not occurring in a certain area, the record must note what is being done to address the problem. For example, a note such as . . . "participant attended group and participated" . . . is not active since it does not identify progress in treatment.

45. Failure to ensure that entries in case records minimize jargon and refrain from generalities.

46. Ensuring that where a program refers a participant to another treatment program (even when that program is operated by the same service provider), staff thoroughly document the need for the referred services in the case record. The minimum elements of this documentation include: **Assessment by Counselor or Other Appropriate Clinical Staff** -- to include a DSM V diagnosis, if DSM procedures are employed by the referring provider; **Interdisciplinary Case Conference** -- to review the assessment and determine and document if the individual's needs exceed the ability of the program/component to meet them. The documentation must clearly indicate that: (i) the referring program is performing all of the services for which it is billing and which are required components under the OASAS license; and (ii) there is a need for the services which are being prescribed, but the referring program, itself, is unable to meet that need; **Evidence of Physician Review and Approval, including Signature by Program Physician** -- to be placed in the case record; and **Consent for Release of Information** -- to be signed by the participant, prior to referral to another service provider, and placed in the case record.

47. Failing to provide services at a licensed site.

48. Inappropriate billing of acupuncture services.

49. Billing for the following services as if they appropriately constituted a threshold visit eligible for reimbursement:
    - nutrition services;
    - educational and/or vocational services;
    - recreational/or social activity services;
    - urinalysis services;
    - group meetings, workshops or seminars which are primarily informational or organizational;

- acupuncture; or
- services that are not appropriately provided.

50. Failure to ensure that services are approved by the medical director or another physician employed by the Agency, recorded in the initial treatment plan of the participant or significant other, and subject to utilization review procedures.

51. Failure to ensure that there are no more than three visits per participant and/or significant other prior to admission to an outpatient service.

52. Failure to ensure that each occasion of service is documented as a covered Medicaid service in accordance with the following:
    - the service must meet the standards established by Medicaid;
    - the service must be documented in the participant's record as required by Medicaid;
    - the service must be provided by staff as required by Medicaid; and
    - the service must not provide services in excess of the clinical needs of the participants.

53. Providing services in excess of the clinical needs of its participants, such as
    - admitting individuals that present minimal or questionable need for chemical dependence services;
    - applying static treatment schedules to its participants;
    - imposing mandatory make-up sessions on participants for unexcused missed sessions;
    - retaining participants in treatment despite participant attainment of treatment plan goals and/or sustained abstinence;
    - continuing treatment to participants despite their lack of progress and/or ongoing chemical abuse over time and failing to transfer/refer such individuals to the most appropriate level of care;
    - developing non-individualized/generic treatment plans and/or generic treatment progress notes;
    - failing to develop adequate recovery or discharge plans for participants;
    - failing to collaborate with or refer participants to other service providers for other services needed by the participant;
    - failing to provide individualized counseling to participants; and
    - providing financial or other incentives to participants and/or staff that promote increased services regardless of the actual needs of participants.

54. Failure to notify Medicaid in writing of any change in Correspondence, Pay-To or Service Address.

XII. CORRECTIVE ACTION PLANS & SANCTIONS

When a compliance or performance issue that has been identified requires remedial action, the appropriate department or administrative personnel responsible for the activity should develop a corrective action plan which specifies the tasks to be complete, completions dates, and responsible parties. In developing such a plan, the responsible personnel will obtain advice and guidance from the CQO, the Compliance Committee, legal counsel, and other appropriate personnel, as necessary.

Each corrective action plan must be approved by the CQO or Compliance Committee. Reports will be provided on

i. all compliance issues noted for which corrective actions have not been implemented;
ii. corrective action plans that have not met approval from an adequacy or timing standpoint; or
iii. corrective action plans that are not subsequently implemented in accordance with the approved plan in terms of substance or timing.

A corrective action plan should ensure that the specific issue is addressed and that similar problems will not occur in other areas or departments, to the extent possible. Corrective action plans may require that compliance issues be handled in a designated way, that relevant training takes place, that restrictions be imposed on particular employees, or that the matter is disclosed externally, including under relevant self-disclosure protocols upon the advice of counsel. Other actions may include repayment of claims to the appropriate payer or the revision of the Compliance Plan or creation of additional policies and procedures. Sanctions or discipline, in accordance with the standard disciplinary policies and procedures of FLACRA may also be recommended.

If it appears that certain individuals have exhibited a propensity to engage in practices that raise compliance or competence concerns, the corrective action plan should identify actions that will be taken to prevent such individuals from exercising substantial discretion in that area.

XIII. GENERAL COMPLIANCE POLICY – TREATMENT SERVICES

It is the policy of the Finger Lakes Area Counseling and Recovery Agency, Inc. (FLACRA) Treatment Services to assure compliance with high ethical standards and compliance with all governing laws and regulations in the delivery of services. This includes but is not limited to NYS Office of Alcoholism and Substance Abuse Services (OASAS) regulations, all regulations governing services provided under Medicaid, other local, state and federal authorities and other payers.

The FLACRA treatment services staff must carry out all necessary and appropriate components of the Corporate Compliance Program. Most significantly the Chief Quality Officer is the Chief Quality Officer (CQO) answering to the Executive Director (a member of the Compliance Committee).

The scope of the Treatment Services Policies, Procedures, audits and monitoring reports related to compliance include but are not limited to:

- OASAS Regulatory Compliance Self Assessment Site Reviews
- Continuous/Closed Chart Audit – Summary Chart Audit Reporting
- Quality Chart Audits
- Proactive Spreadsheet
- Quarterly Target Reporting
- The Quality Improvement Program
- Utilization Review
- Treatment Plan Review
- Clinical Recordkeeping
- Clients Rights
- Confidentiality
- Staff Development
- Admission Assessment, Treatment and Level of Care Determination

- Medical Necessity
- Admission, Length of Stay and Discharge Criteria
- Client Engagement and Re-engagement
- Comprehensive Evaluation
- Treatment Planning and Review
- Discharge Planning
- Program Effectiveness Surveys
- Quality Assurance/Safety Committee Reviews
- Incident Report Reviews
- OASAS Workscope Reviews
- Facility/Safety Inspections
- More

XIV. GENERAL COMPLIANCE POLICY – FINANCE AND ADMINISTRATIVE SERVICES

FLACRA is a 501(C) (3) Not for Profit Corporation with a Tax ID #16-1013292. The Finance and Administrative Services Department is responsible for the business affairs of the agency including but not limited to Patient Accounts (billing). These functions are part of the agency overall Corporate Compliance program. The policies, procedures and practices are compliant with all local, state and federal governing authorities including but not limited to the New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS) Fiscal Policy and Regulation, the Medicaid Management Information System Regulations, and the requirements of other insurers and payers. The policies, procedures and practices are consistent with Generally Accepted Accounting Principles (GAAP). External review/audit includes but is not limited to OASAS, an annual Independent CPA Audit and audits by other regulators, payers and insurers.

Internally, FLACRA has 2 sophisticated comprehensive software systems that assist in assuring checks and balances in business affairs. These are Fund EZ for the overall account and 10e11 for Patient Accounts. These systems help ensure compliance with internal and external regulations, policies and procedures. Specifically, this relates to accuracy and correctness and includes extensive reports reviewed on a regular basis.

All the above is part of the Corporate Compliance Program. The Director of Finance and Administrative Services oversees these functions and more significantly is part of the Compliance Committee.

Audit reports are presented to the Compliance Committee for review. Consistent with the Compliance Program, these serve to identify areas for improvement and where necessary follow the order of Compliance review all the way to sanction.

A variety of routine reports includes service billing and finance reports. The 10e11 System has been assures a variety of other checks and balances especially for Medicaid billing.

The Finance and Administrative Services Department functions are not limited to billing compliance and are articulated in the larger FLACRA Finance Policy and Procedure Manual. In addition, the Department is responsible for the agency properties and facilities. This includes but is not limited to

ownerships, leases, property management and related to compliance has its own set of facility audit procedures aimed at assuring safety and compliance with such regulations.

The Department also oversees Human Resources and has policies, procedures and audit protocols to assure compliance with labor laws and assurance that functions and services are provided in accordance with regulations by properly qualified persons.

As indicated, a variety of audits and reports are provided for compliance related review. As indicated and as should be, Finance policies and procedures that "cross over" to client records review further assure compliance. Policies, procedures, audit and monitoring reports include but are not limited to the following:

- Monthly finance reports to the Board
- Outpatient unposted dates of service reports
- Residential payment exception reports
- Payroll policy, procedure, audit and reports
- Purchase/requisition policy, procedure, audit and reports
- Other finance policies and procedures contained in Finance Policy Manual
- Non-duplicative service billing audits and report
- Service start date billing audit and report
- Length of service billing audit and report
- Post discharge non-billing audit and report
- Group therapy service coding audit and report
- Group therapy size audit and report
- Patient ID concurrence audit and report
- Service rendered/not rendered audit and report
- Accounts receivable, policy and procedure audit and report
- Paper claims to insurance carriers review policy, procedure, audit and report
- Food stamp policy, procedure, review audit and report
- More

XV. SUMMARY

FLACRA's commitment to excellence and integrity means more than just doing the best job possible. It is our commitment to **DO THE RIGHT THING.** Our success and future depend on it.

Addendum A

CANON OF ETHICAL PRINCIPLES FOR STAFF AT FLACRA

1. To believe in the dignity and worth of all human beings. Pledge to provide service for the welfare and betterment of all members of society.
2. To recognize the right to humane treatment of the suffering directly or the indirectly from alcoholism and substance abuse.
3. To promote and assist in the recovery of all persons served by providing the highest quality of care.
4. To maintain professional relationships with all persons served, assisting them to help themselves and referring them promptly to the other programs or individuals, when this is the person's best interest.
5. To respect the rights, views and positions of other alcoholism/substance abuse counselors and allied professionals.
6. To respect institutional policies and procedures, consistent with professional standards, to cooperate with agency management in the organization with which I am associated.
7. To contribute my ideas and findings to the general body of knowledge concerning alcoholism/substance abuse counseling and to circulate those ideas and findings through appropriate professional channels.
8. To regularly evaluate my own professional strengths, limitations, biases and levels of effectiveness, striving for self-improvement and seeking professional development through further education and training.
9. To respect the unique characteristics of the counseling relationship which demand that sound, non-exploitive interpersonal transactions between myself and persons served are essential to efficacious treatment.
10. To refrain from undertaking any activity where my personal conduct, including the abuse of alcohol and other mood-altering drugs is likely to result in inferior professional services, denigrate the profession in general, or constitute a violation of law.
11. To avoid claiming directly, or implying, professional qualification that exceed those I have actually obtained, accepting that professional competency in one field should not be used as an implication of competency in an unrelated field.
12. To follow the Corporate Compliance Plan. To report to my Supervisor, Executive Staff, or the Chief Quality Officer any violations of which I become aware.
13. Must practice objectivity and integrity; maintain the highest standards in the services offered; respect the values, attitudes and opinions of others; and provide services only in an appropriate professional relationship.
14. Must not discriminate in work-related activities based on race, religion, age, gender, disabilities, ethnicity, national origins, sexual orientation, economic condition or any other basis proscribed by law.
15. Must respect the integrity and protect the welfare of the person or group with whom the employee is working.
16. Must embrace, as a primary obligation, the duty of protecting the privacy of patients and must not disclose confidential information or records under his/her control in strict accordance with federal, state and local laws.

17. Must not engage in relationships with patients, former patients or their significant others in which there is a risk of exploitation or potential harm to the patient.
18. Must not engage in any sexual activity with current or former patients or their significant others.
19. Must not knowingly engage in behavior that is harassing or demeaning, including, but not limited to, sexual harassment.
20. Must not exploit patients or others over whom they have a position of authority.
21. Must treat colleagues and other professionals with respect, courtesy and fairness and cooperate in order to serve the best interests of their patients.
22. Must notify appropriate authorities, including FLACRA and OASAS, when they have direct knowledge of a colleague's impairment or misconduct which interferes with treatment effectiveness and potentially places patients and others at risk.
23. Is expected to recognize the effects of their own impairment on professional performance and must not provide services that create conflict of interest or impair work performance and clinical judgment.
24. Must cooperate with investigations, proceedings, and requirements of OASAS or other authorities that have jurisdiction over those charged with a violation.
25. Must not participate in the filing of ethics complaints that are frivolous or have a purpose other than to protect the public.
26. Must assure that financial practices are in accord with professional standards that safeguard the best interests of the patient, the counselor and the profession.
27. Must take reasonable steps to ensure that documentation in records is accurate, sufficient and timely thereby ensuring appropriateness and continuity of services provided to patients.
28. Must uphold the legal and accepted moral codes which pertain to professional conduct.
29. Must acknowledge the limits of present knowledge in public statements concerning alcoholism and substance abuse. Must report fairly and accurately the appropriate information, and must acknowledge and document materials and techniques used.
30. Must assign credit to all who have contributed to the published material and for the work upon which publication is based.
31. Must adopt a personal and professional stance which promotes the well-being of the recovery community.

Personal Statement

As an employee of FLACRA, I shall strive, at all times to maintain the highest standards in all the services I provide, valuing competency and integrity over expediency or temporary services. I shall recognize the limits of my ability, providing services only in those areas where my training and experiences meet recognized professional standards. I shall always recognize that I have assumed a serious social and professional responsibility due to the intimate nature of my work which significantly touches upon the lives of other human beings.

I HAVE READ THIS ENTIRE CANON OF ETHICAL PRINCIPLES DOCUMENT AND

I AGREE TO ABIDE BY ALL THE STATED PRINCIPLES THEREIN

___________________________________ ___________________________________

PRINT FULL NAME SIGNATURE

DATE______________________

These principles should be considered to be in effect six (6) months beyond the termination of employment with FLACRA and/or the conclusion of a therapeutic relationship with the clients where applicable. Maintaining confidentiality is indefinite as part of your professional obligation.