

**CHALLENGE INDUSTRIES, INC.**  
**EXPECTATIONS AND GUIDELINES FOR MEDICAID COMPLIANCE**

**Responsible Parties**

All Challenge staff, interns/volunteers, managers, and administrators involved with any aspect of Medicaid Services and all Board Members are expected to be knowledgeable and comply with Challenge's policies and procedures regarding provision, documentation and billing of Medicaid funded services.

**Components of Medicaid Compliance:**

Dependent on the scope and responsibilities of the position, staff, interns/volunteers, managers and administrators are responsible for:

- Providing services in accordance with funding agency and Challenge requirements
- Completing accurate and timely required documentation that substantiates provision of services
- Submitting accurate billing only for services that meet service standards and for which there is complete and timely documentation
- Communicating with one's direct supervisor or other appropriate administrator about any issues with paperwork being out of compliance
- Refraining from submitting or altering documentation for services that have not been provided or do not meet Challenge's guidelines for contemporaneous documentation
- Cooperating with Challenge's quality assurance program through timely completion of all QA checklists and other tools and timely follow-up results of file reviews and other internal audit procedures
- Mandatory reporting of suspected fraud or other compliance issues (see below)

In addition to items contained in this document, Challenge staff, interns/volunteers, managers, and administrators involved with any aspect of Medicaid Services and all Board Members are responsible for adherence to all policies and procedures detailed in the Challenge Policy and Procedures on Assuring Provision, Documentation and Billing of OMRDD HCBS Waiver and Mirrored (Non-Waiver) Services.

**Additional Services Staff Guidelines:**

In addition to information contained in this document, all Services staff will receive and sign a Services Documentation Agreement on a yearly basis that provides specific timelines and procedures for completion of documentation. The guidelines, and consequences for not meeting them, reflect the risk of serious repercussions for the agency as a whole when we are out of compliance with documentation that confirms the services we are paid for have been provided, and that the documentation meets or exceeds standards and format established by each specific funder.

**Reporting Suspected Medicaid Fraud:**

All staff, interns/volunteers, managers, administrators and Board Members are required to report suspected Medicaid or other fraud or other compliance problems. Failure to report suspected problems, assisting or participating in fraud or other non-compliant behavior, and/or encouraging, directing, permitting or facilitating such activities (whether actively or passively)

will result in disciplinary action, up to and including termination. Suspected fraud or other compliance problems should be reported to his or her immediate supervisor, unless the immediate supervisor is suspected of being involved in the wrong-doing. In that case, the report should be made to the next higher level supervisor not suspected of being involved. If the supervisor is not available, the report should be made to the next higher-level supervisor. If the suspected violation is on an organization-wide level or by top management, the report of wrong doing should be made to the President of the Board of Directors. Report of suspected fraud or other compliance problems can also be made anonymously to the Director of Program Development and Quality Assurance or Challenge President by mail or placed in a sealed envelope in their respective mailbox.

### **Investigation of Suspected Medicaid Fraud**

All reports of suspected Medicaid fraud or other major non-compliance activities will be investigated by the Director of Program Development and Quality Assurance who serves as Challenge's Compliance Officer. The results of the investigation will be reviewed by the Senior Management Group consisting of the President, Vice President/Director of Finances, and Director of Services who will jointly determine what follow-up actions are required including personnel action, voiding billing and returning overpayments, and reporting to the New York State Office of the Medicaid Inspector General, Office of Mental Retardation and Developmental Disabilities, and other state or federal agencies. This group will also discuss and recommend changes in policies and procedures to reduce the potential for reoccurrences of this or other compliance issues. The President will also keep the Board of Directors informed of reports and investigations of suspected Medicaid fraud or other major non-compliance activities.