Topic: Classification of situations reported to the compliance office and completion of subsequent investigations	**Department:** Entire agency
Original effective date: 5/17/11	**Last revision date:** 11/26/19
Owner: VP for Quality and Compliance	**Frequency of reviews:** Annual
Internal/Regulatory Reference(s) (all that apply): Federal sentencing guidelines 8.B.2.1(b)(7); 18 NYCRR 531.3(c)(7); NYS Social Security Law 636-d(2)(g)	
Related documents/Links:	

Policy: It is the policy of The Arc of Monroe that business, administrative and support functions promote personal and organizational outcomes.

Additional Information:

Classification of Concerns:

The Arc knows that it's important to deal with compliance concerns in a consistent way. This policy will make it clear when something would be a compliance concern and when a program can handle it on their own.

For the most part, the following would not be considered a compliance concern:

- Allegations of abuse or neglect. Please google 14 NYCRR parts 624 or 625 for more information.
- HR issues. This would be things like staff not getting along or other things that have to do with employment.
- Things that have to do with how programs are organized or run.

The only time one of these would be a compliance case is if it met one of the conditions listed below.

The following would be a compliance case (these are just examples; this isn't every possible scenario):

- When someone fakes agency documentation on purpose. This would be any documentation: service documentation, time records, applications, fire drill records, overnight check sheets, expense/mileage sheets, etc.
- When someone commits fraud
- If a non-manager reports to the compliance officer that:
    - A program has overbilled for services. Overbilling means billing for services that weren't provide or billing for more services than were really provided.
    - False documentation is happening
- If a program has received government money they shouldn't have gotten and refuse to pay it back.
- If an audit by the VP for Quality and Compliance finds that the program needs to pay money back.
- If The Arc sends protected health information (PHI) to someone outside The Arc who shouldn't have gotten it. Please see HIPAA policies for more information on PHI.
- Anytime an Arc employee looks at PHI that they shouldn't see and they do it on purpose.

- Anytime an Arc employee tries to use PHI to cause harm to someone else.
- If the HITECH risk assessment shows that a breach happened. Please see HIPAA policies for more information on the HITECH rule.
- If the compliance officer thinks a case should be opened.

We will not open a case if a program finds something through their usual work. This is true even if they have to pay money back. That's just part of running a program. Also, we won't open a case if quality staff other than the compliance officer finds something. This is true even if they find it while they're doing an audit for a program.

We will open a non-reportable case if:

- We were pretty sure we were going to have a compliance case but we find out that it wasn't that serious. Opening a non-reportable case lets us keep track of things like this.
- One Arc program sends PHI to another Arc program that shouldn't have gotten it. As long as it's not a breach according to the HITECH law, it can stay a non-reportable case.

Please see the policy on non-compliance detection and response for more information.

Investigations:

To do a compliance investigation, the compliance officer will look at what the concern is and then figure out the best way to investigate. Investigations may be done by trained agency staff. They may also be done by agency management, under the direction of the compliance officer. The goal is to find out if what was reported really happened or not. Compliance investigations might include:

- Interviews
- Documentation reviews
- Looking at equipment or environments

We may ask the program to conduct the investigation. A lot of the time, they have a relationship with the people involved. Because of this it's sometimes easier for them to have that conversation. The Quality Improvement department can always do it if a program would prefer.

In some cases, it's clear if something happened or not. For example, if a program reports that they sent information to the wrong outside provider, we probably won't investigate. This is because the program is telling us what happened and agrees that it did. The determination would be self-evident. We will ask the program for certain things in response. Based on that, we can always do an investigation if we need to.

Procedure	
Task – Classification of Concerns:	**Responsible party:**
1. If the compliance office gets a report of something that is not a compliance concern, he will forward it to the best department to handle it.	VP for Quality and Compliance or designee

2. Staff need to report to their supervisor if they think something listed in this policy happened.	All staff
3. Managers have to let the VP for Quality and Compliance know if something happens that would be a compliance case.	Managers
4. Managers also need to contact the VP for Quality and Compliance if: *Their program got $8000 or more that it shouldn't have gotten; AND *They got all of it for the same reason.	Managers
5. Even if the program has to pay back $8000 or more total for many different reasons, they would not need to call the VP for Quality and Compliance	Managers
6. If a manger isn't sure, they can always call the VP for Quality and Compliance for help.	Managers
7. Compliance cases will be documented on the same form each time. The same goes for non-reportable cases.	VP for Quality and Compliance or Designee
Task – Investigations:	**Responsible party:**
1. We will do a formal investigation if the determination is not self-evident.	VP for Quality and Compliance or designee
2. An investigation has to be done by trained staff: *If the program director or their supervisor might be involved in the situation *If the concern is found during an audit by the VP for Quality and Compliance or designee *If the program directors asks that it be done *If administration says we should	VP for Quality and Compliance or designee
3. An investigation may be done within the program if the above reasons don't apply.	Program management
4. The VP for Quality and Compliance will oversee and review investigations conducted within programs. He may do more investigating if he thinks it's needed.	VP for Quality and Compliance
5. All investigations are documented. The documentation till include findings and a conclusion. It's OK for the VP for Quality and Compliance to write up an investigation if the program did it (pulled together the information about the situation). He will use the findings from their investigation. The VP for Quality and Compliance can also come up with a determination based on those findings.	VP for Quality and Compliance

Document revision record:

Revision Date	Release Date	Reason for change	Approver
New	6/1/11	Approved by the internal compliance committee on 5/23/11	ICC
6/6/12	6/6/12	Reasons for changes not documented	P Dancer

10/24/14	10/24/14	Reasons for changes not documented	P Dancer
7/29/15	7/29/15	Reasons for changes not documented	P Dancer
9/2/16	9/2/16	Reasons for changes not documented	P Dancer
4/28/17	4/28/17	Reasons for changes not documented	P Dancer
11/9/18	11/9/18	Reasons for changes not documented	P Dancer
11/26/19		Transitioned to new procedural format	P Dancer