

Topic: Accurate and timely documentation of services; and Medicaid fraud, waste and abuse	Department: All programs and services
Original effective date: 3/11/02	Last revision date: 7/21/26
Owner: VP for Quality and Compliance	Frequency of reviews: Annual
Internal/Regulatory Reference(s) (all that apply): Federal sentencing guidelines chapter 8B2.1, 32 USC 3729, NYS Social Security Law 363-d, 18 NYCRR 521.3, Applicable OPWDD ADMs (designated by service or support)	
Related documents/Links: Please see references within the document	

Policy: It is the policy of The Arc of Monroe (“The Arc”) that business, administrative and support functions promote personal and organizational outcomes and sound fiscal practices.

Additional Information: This policy applies to all persons who are affected by the agency’s risk areas (to the degree that they are so affected) including our employees, the CEO and other senior management, managers, contractors, agents, subcontractors, students, interns, volunteers and independent contractors; hereafter referred to as “affected parties.”

The Arc is committed to and has an obligation to comply with all applicable federal and state standards. This includes, but is not limited to, The US Centers for Medicare and Medicaid Services (CMS), The NYS Department of Health (DOH), and Office for People with Developmental Disabilities (OPWDD).

Any and all documentation completed by affected parties needs to be accurate, timely and complete. This means writing down exactly what the affected party did or what happened. Exaggerating, embellishing, stretching the truth or documenting something that did not happen is not permitted and could result in disciplinary action up to and including termination of employment or separation from the agency.

Documentation completed by affected parties in the course of doing their work may become a legal document. It is used as evidence that we are following laws, rules and regulations of OPWDD, New York State, and the federal government including those related to payers such as Medicaid, Medicare, and other insurance companies. Accurate and timely documentation justifies our receipt of government funds. It also creates a timely and accurate clinical record of the supports and services we provide, and the response from the people we support to those services to enable The Arc to ensure the best and most appropriate supports and services are provided. This is a critical component of the treatment, habilitation and/or clinical aspect of the work that we do.

Every signature on agency-related documentation should be considered an attestation by the person that what they are signing is true and accurate to the best of their knowledge. This applies whether the documentation is done with pen, on a computer, on a tablet, in an app, on a cell phone, or any other way or place where agency documentation occurs. Documentation should also never be completed in anticipation of something that might happen later, such as documenting all of the overnight checks in a residence at the beginning of your shift, thinking they will be done later. Such a practice is considered false documentation and is not allowed.

Examples of the types of documentation this applies to include but is not limited to:

- Goal data
- Behavioral data
- Overnight check sheets
- Service notes/documentation
- Monthly summaries
- Mileage sheets
- Water temperature checks
- Progress notes
- Medical documentation
- Time sheets

The Arc acknowledges that sometimes people make mistakes, which are part of learning one's job and are not considered the same as deliberate or reckless false documentation or fraud. Affected parties may receive retraining in response to observed errors in documentation. An affected party making the same mistakes repeatedly after training or counseling, or an inability to meet the requirements of one's position may result in disciplinary action up to and including termination of employment or separation from the agency.

Although false documentation can lead to Medicaid fraud, waste or abuse, not all false documentation is considered fraud. Fraud occurs when affected parties:

- Write something down that they know for a fact, should know or are pretty sure isn't true; AND
- They document it anyway; AND
- It's likely that The Arc will think it's accurate; AND
- The Arc has relied or acted on this documentation as support and justification for agency operations and functions – including as support of claims submitted to Medicaid, Medicare or other payers.

Fraud is a crime and people can be arrested for it. It applies to any documentation that relates to Arc business, not just documentation that is tied to or used in support of billing. It doesn't matter where or how it's written down. Fraud includes either an element of deliberateness or a failure to exercise adequate due diligence (meaning that the person should have known that what they were documenting was false or inaccurate).

Examples of Medicaid fraud:

- An affected party writes something down that they know to be false and The Arc uses it to get paid from Medicaid. When this happens, the agency receives money it is not entitled to, which is illegal. This would also apply to Medicare and other payers.
- An affected party writes down that they gave MORE services than they really gave. For example, if someone was at day hab only 3 hours but an affected party documented that they were there for 4.5 hours.
- An affected party provides services that they knew the person doesn't really need. Please cross reference the policy, "Medical and Clinical Necessity."
- An affected party lies about knowing that something written down isn't true. For example: An affected party knows that something documented wasn't true and when it's investigated, they lie and say they didn't know.
- An affected party works with other people to try and help The Arc get Medicaid money it isn't entitled to.

- An affected party knows their program got Medicaid money they weren't entitled to and they don't pay all of it back. A partial repayment would not be sufficient.
- An affected party modifies or creates new documentation in an attempt to hide what was originally documented.
- An affected party believes that what is written down may not be true, but they use it anyway to get Medicaid money

Medicaid can still be misused even when fraud doesn't happen. Medicaid waste or abuse may occur when:

- Affected parties are reckless or careless, such as affected parties not really paying attention to what they're doing and as a result, we get Medicaid money we shouldn't have. For example, a day hab program estimates arrival and dismissal times (which impact billing) rather than accurately documenting them.
- Affected parties are doing things that aren't really acceptable in this field, such as engaging in unethical behavior. Being ethical means doing the right thing all the time, whether anyone will see or know (integrity, an agency value). Affected parties should always do the right thing in executing their Arc-related responsibilities.
- Managers don't take the time to understand the rules they need to follow to get Medicaid, Medicare or other money. Managers have a responsibility to know what these rules are. Staff within their programs need to follow these rules all the time as well.
- A program has repeatedly gotten Medicaid, Medicare or other money that they don't deserve and the management team doesn't try to figure out why or how to prevent it from continuing to happen.

Examples:

- When a manager suspects that their process for billing Medicaid keeps resulting in them getting paid improperly but don't try to fix it.
- Having people wait to leave a program or get on their ride without providing any authorized services just so that we can get more Medicaid money
- Keeping people in one program when they are ready to go to a different program. For example, someone doesn't really need the support that one program gives but agency staff don't let them go where they can get the right support just so they can keep their numbers up and make more money.
- When someone has achieved a goal but the goal doesn't get changed. It's wrong and unethical to ask the government to pay us to work on something that the person already knows.

Even though these situations may not constitute fraud, the False Claims Acts might still apply. Please cross reference that policy.

Affected parties should never be asked, coerced or required to create false documentation by anyone at any level of the organization, including a coworker, supervisor, director, member of agency leadership, or other staff person. If an affected party feels they have been asked to do so, they should refuse to do so and notify a member of the agency's leadership team, the VP for Quality and Compliance, or they can contact the agency's hotline. Please cross reference the policy, "Non-compliance detection and response, and confidential communications," for further information on reporting concerns.

Procedure	
Task:	Responsible party:
General Guidelines:	
1. Affected parties will complete documentation according to the following rules: *If writing by hand, affected parties should use black or blue ink (because it will copy more clearly if we ever have to make a copy). * Affected parties cannot document or sign anything in pencil (because pencil can be erased or changed). * Affected parties should complete goal, behavioral and other service-related documentation before the end of their shift. If that is not possible, it must be done within 3 calendar days, regardless of weekends or holidays. Situations exceeding that timeframe will be evaluated in regard to associated billing by the appropriate vice president or designee (COO) in consultation with the VP for Quality and Compliance. * Affected parties can sign work-related documentation if they wrote it themselves or someone else wrote it for them (like dictation). *When affected parties write something by hand, they should write as clearly as possible so that others can read it easily. *Whiteout (tape or liquid) cannot be used on any official Arc documents. *If affected parties make a mistake on something they wrote by hand, they need to: --draw a single line through the mistake --write the correction to the side --initial the correction --date the correction --If the reason for the change isn't obvious, staff should write why it was changed *A permanent marker should never be used to cover up a mistake. The mistake should still be visible. *The only time a sharpie should be used on official Arc documents is when we need to redact sensitive information, meaning we block it out so others can't read it. This should only be done under very specific circumstances with the knowledge and approval of a director, senior director, vice president, the CEO, COO, CHRO or CFO. * Affected parties should ask their manager what to do if they make a mistake documenting in the agency's electronic health record (EHR) or on the computer. * Affected parties should never document that they did something until they actually do it. Example: if someone plans to help someone shower later in the evening, they should not formally document it now. They need to wait till they help the person first. If they document it now and the shower never happens, it could look like they are trying to commit fraud. *Clinically-licensed affected parties who are working with us in their clinical capacity need to follow the professional standards for their discipline and NYS Education Dept requirements, including those related to documentation	Affected parties
2. For any documents that support our billing, it's prohibited to create documentation that might be untrue or misleading. This applies whether the	Affected parties

person decides to do it on their own or they are told to do it by someone else – even if that person is a manager.	
3. Affected parties cannot deliberately document something that is not true. Examples: *Someone documents something that they know never happened; or *Even though they know something didn't happen, they still write it down; or *They believe or are pretty sure that The Arc will think it's real and true	Affected parties
4. If it's proven that any affected party deliberately documented something that was not true, their employment will be terminated (employees) or they will be separated from the agency (non-employees). If we think that the actions may constitute a crime, we may contact law enforcement and/or the government.	HR, Administration, VP for Quality and Compliance
Manager Responsibilities:	
1. Managers have a responsibility to understand the agency's documentation standards. They need to ensure that systems, processes and procedures have been established to meet them.	Managers
2. Managers have a primary responsibility to ensure that the supports and services they provide are consistently provided and documented within regulatory and agency requirements.	Managers
3. Managers have a responsibility to actively respond to any indications that documentation standards are not consistently being met, that there is possibility of false documentation or fraud, or that staff are not compliant with regulatory or agency requirements. This may include retraining, coaching or counseling, disciplinary action, and/or revisions to policies and procedures.	Managers
VP for Quality and Compliance:	
1. Acts as the agency's Compliance Officer, as required in NYS law.	VP for Quality and Compliance
2. Has primary responsibility for administering the agency's compliance program, and related policies and procedures.	VP for Quality and Compliance
3. Acts as a resource for agency staff, managers, and leadership related to ensuring documentation requirements are met, and will provide technical support as appropriate in the development of related systems and procedures.	VP for Quality and Compliance
4. Has primary responsibility for the reporting and ongoing management of any reports to the state or federal government of fraud, including keeping Executive Management Team and the board apprised.	VP for Quality and Compliance

Document revision record:

Revision Date	Release Date	Reason for change	Approver
---------------	--------------	-------------------	----------

The Arc of Monroe

12/29/06	12/29/06	Reason for change not documented	P Dancer
7/27/07	7/27/07	Reason for change not documented	P Dancer
5/30/08	5/30/08	Reason for change not documented	P Dancer
6/15/11	7/20/11	Reason for change not documented	P Dancer
3/29/12	4/1/12	Reason for change not documented	P Dancer
5/2/12	5/2/12	Reason for change not documented	P Dancer
5/25/12	5/25/12	Reason for change not documented	P Dancer
11/12/12	11/12/12	Reason for change not documented	P Dancer
5/30/13	5/30/13	Reason for change not documented	P Dancer
10/24/14	10/24/14	Reason for change not documented	P Dancer
7/28/15	7/28/15	Reason for change not documented	P Dancer
5/8/17	5/8/17	Reason for change not documented	P Dancer
11/9/18	11/9/18	Reason for change not documented	P Dancer
10/29/19	10/29/19	Transitioned to new procedural format	P Dancer
3/4/21	6/23/21	Fleshed out details and added discrete sections for managers and the VPQC	ICC
2/20/23	3/15/23	Added a statement regarding our commitment and obligation to comply with applicable standards; specified whom this policy applies to; updated terms throughout	ICC
7/26/23	7/26/23	Spelled out an acronym; added a link to another document; removed reference to a specific EHR in favor of just the term "EHR"	ICC
2/29/24	4/1/24	Revised the contemporaneous documentation standard from 7 days to 5	ICC
6/28/24	7/18/24	Added a statement about the clinical importance of accurate and timely documentation; removed redundant text; added clarifying language; corrected typos	ICC
5/22/25	7/23/25	Provided clarifying language and examples	ICC
1/1/26	1/1/26	Revised documentation standard from 5 to 3 calendar days	ICC
7/21/26	7/21/26	Added clarifying language; added additional documents to not be falsified	ICC