

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

In the Matter of the Appeal of	:	
	:	
Elderwood at Cheektowaga	:	Decision After
Provider #01243512	:	Hearing
	:	
from determinations to recover Medicaid Program	:	#15-3825
overpayments.	:	#15-3826
	:	

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
584 Delaware Avenue
Buffalo, New York 14202
October 25, 2017
Record closed: March 9, 2018

Parties: New York State Office of the Medicaid Inspector General
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JURISDICTION

The New York State Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State. Social Services Law 363-a; Public Health Law 201.1(v). The New York State Office of the Medicaid Inspector General (OMIG), an independent office within the Department, is responsible for the Department's duties with respect to the prevention, detection and investigation of fraud and abuse in the Medicaid Program and the recovery of improperly expended Medicaid funds. PHL 31, 32.

The OMIG issued two final audit reports for Elderwood at Cheektowaga (the Appellant) in which the OMIG concluded that the Appellant had received Medicaid Program overpayments. The Appellant requested hearings pursuant to SSL 22 and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the overpayment determinations. The two requests were combined for this hearing.

HEARING RECORD

OMIG witnesses: Launa Garrett, R.N.

OMIG exhibits: 1-22

Appellant witnesses: [REDACTED], D.P.T.
[REDACTED], MACCC/SLP, Ph.D.
[REDACTED], R.N.

Appellant exhibits: A-B

A transcript of the hearing was made. (Transcript, pages 1-194.) The parties submitted post hearing briefs and the record was closed on March 9, 2018.

SUMMARY OF FACTS

1. Elderwood at Cheektowaga is a residential health care facility (RHCF), licensed under PHL Article 28 and enrolled as a provider in the Medicaid Program. The

facility is located in Cheektowaga, New York, and has approximately 170 beds. (Appellant brief, page 4; Transcript, page 189.)

2. In July 2015, the OMIG commenced two audits (#15-3825 and #15-3826) to review the Appellant's documentation in support of Minimum Data Set (MDS) submissions used to determine its Medicaid Program reimbursement. (Exhibit 1.)

3. Audit #15-3825 reviewed records for a sample of twenty-one facility residents from the Appellant's January 2014 census, used to determine reimbursement for the rate period July 1 through December 31, 2014. (Exhibits 2, 8.) Audit #15-3826 reviewed records for a sample of twenty-four facility residents from the July 2014 census, used to determine reimbursement for the rate period January 1 through June 30, 2015. (Exhibits 2, 15.)

4. The OMIG determined that the Resource Utilization Group (RUG) categories assigned to several residents were not accurate because the Appellant's records failed to document the medical basis and specific need for their occupational therapy (OT), speech therapy (ST) and physical therapy (PT). The OMIG corrected the residents' RUG categories and recalculated the Appellant's Medicaid reimbursement rate accordingly.

5. On February 28 (#15-3825) and May 18 (#15-3826), 2017, the OMIG issued final audit reports that identified Medicaid overpayments from the correction of the Appellant's reimbursement rate to reflect the audit findings. The OMIG advised the Appellant that it intended to recover overpayments in the amount of \$34,434.37 in audit #15-3825, and \$18,293.57 in audit #15-3826. (Exhibits 8, 15.)

Resident four

6. The Appellant's MDS submission for resident four had an "assessment review date" (ARD) of [REDACTED] 2014. The seven day "look back" period for skilled therapies reported on the MDS submission was [REDACTED], 2014. (Exhibit 10, page 1.)

7. The MDS submission assigned resident four to RUG category '[REDACTED]'. She was reported to be receiving [REDACTED] minutes of OT and [REDACTED] minutes of PT per week. (Exhibit 10, page 1.) The minimum skilled therapy requirement for category [REDACTED] is at least [REDACTED] minutes given over five days per week. (Exhibit 19.)

8. On [REDACTED], 2013, a physical therapist's evaluation of resident four, ordered "for a [diagnosis] of [REDACTED] [sic] with [REDACTED] in [REDACTED]" recommended a course of PT. A physician signed the therapist's recommendation and PT was commenced. (Exhibit 10, pages 5-6, 9-10.)

9. Resident four received PT services from [REDACTED] 2014. (Exhibit 10, pages 15-18.) She was discharged from therapy on [REDACTED] 2014 on the grounds "progress ceased." (Exhibit 10, pages 13-14.)

10. On [REDACTED] 2013, an occupational therapist's evaluation of resident four, ordered for "[history] of [REDACTED] w/ resulting [REDACTED]," recommended a course of OT. A physician signed the therapist's recommendation and OT was commenced. (Exhibit 10, pages 7-8, 22-23.)

11. Resident four received OT services from [REDACTED], 2014. (Exhibit 10, pages 28-32.) She was discharged from therapy on [REDACTED] 2014 on the grounds "progress ceased." (Exhibit 10, pages 26-27.)

Resident five

12. At the hearing the OMIG withdrew its audit finding disallowing PT provided to resident five, and agreed to recalculate the overpayment accordingly. (Transcript, page 5.)

Resident eleven

13. The Appellant's MDS submission for resident eleven had an ARD of [REDACTED], 2014, with a seven day look back period for skilled therapies of [REDACTED] 2014. (Exhibit 12, page 1.)

14. The MDS submission assigned resident eleven to RUG category '[REDACTED]'. She was reported to be receiving [REDACTED] minutes of ST and [REDACTED] minutes of OT per week. (Exhibit 12, page 1.) The minimum skilled therapy requirement for category [REDACTED] is at least [REDACTED] minutes given over five days per week. (Exhibit 19.)

15. On [REDACTED], 2014, a speech therapist's evaluation of resident eleven, ordered to "assess and evaluate cognitive [sic] changes" and for "[REDACTED] and [REDACTED]," recommended a course of ST. A physician signed the therapist's recommendation and ST was commenced. (Exhibit 12, pages 5-11.)

16. Resident eleven received ST services from [REDACTED], 2014. (Exhibit 12, pages 16-19.) She was discharged from therapy on [REDACTED] 2014 on the grounds "progress ceased." (Exhibit 12, pages 14-15.)

Resident twenty-one

17. The Appellant's MDS submission for resident twenty-one had an ARD of [REDACTED] 2014, with a seven day look back period for skilled therapies of [REDACTED], 2014. (Exhibit 17, page 1.)

18. The MDS submission assigned resident twenty-one to RUG category [REDACTED]. The resident was reported to be receiving [REDACTED] minutes of PT per week. (Exhibit 17, page 1.) The minimum skilled therapy requirement for category [REDACTED] is at least [REDACTED] minutes given over five days per week. (Exhibit 19.)

19. On [REDACTED] 2014, a physical therapist's evaluation of resident twenty-one, ordered "for a diagnosis of [REDACTED] Unspecified with [REDACTED] [REDACTED] recommended a course of PT. A physician signed the therapist's recommendation and PT was commenced. (Exhibit 17, pages 6-8; Exhibit 14, page 6.)

20. Resident twenty-one received PT services from [REDACTED] 2014. (Exhibit 17, pages 14-17.) He was discharged from therapy on [REDACTED] 2014 on the grounds "long term goal met." (Exhibit 17, page 12.)

Resident twenty-three

21. The Appellant's MDS submission for resident twenty-three had an ARD of [REDACTED] 2014, with a seven day look back period for skilled therapies of [REDACTED] 2014. (Exhibit 18, page 1.)

22. The MDS submission assigned resident twenty-three to RUG category [REDACTED]. She was reported to be receiving [REDACTED] minutes of ST per week. (Exhibit 18, page 1.) The minimum skilled therapy requirement for category [REDACTED] is at least [REDACTED] minutes given over five days per week. (Exhibit 19.)

23. On [REDACTED] 2014, a speech therapist's evaluation of resident twenty-three, ordered "due to [REDACTED]," recommended a course of ST. A physician signed the therapist's recommendation and ST was commenced. (Exhibit 18, pages 7-11.)

24. Resident twenty-three received ST services from [REDACTED], 2014. (Exhibit 18, pages 19-23.) She was discharged from therapy on [REDACTED], 2014 on the grounds “long term goal met.” (Exhibit 18, pages 17-18.)

ISSUE

Has the Appellant established that the OMIG’s audit determinations to correct the RUG categories reported for residents four, eleven, twenty-one and twenty-three, and to recover the resulting Medicaid overpayments, are not correct?

APPLICABLE LAW

A residential health care facility, or nursing home, can receive reimbursement from the Medicaid Program for costs that are properly chargeable to necessary patient care. 10 NYCRR 86-2.17. As a general rule, these kinds of costs are allowed if they are actually incurred and the amount is reasonable. The facility’s costs are reimbursed by means of a per diem rate set by the Department on the basis of data reported by the facility. PHL 2808; 10 NYCRR 86-2.10.

It is a basic obligation of every Medicaid provider “to prepare and maintain contemporaneous records demonstrating its right to receive payment under the [Medicaid Program], and to keep for a period of six years... all records necessary to disclose the nature and extent of services furnished.” 18 NYCRR 504.3(a). Medical care and services will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client’s medical record. 18 NYCRR 518.3(b). All reports of providers which are used for the purpose of establishing rates of payment, and all underlying books, records, documentation and reports which formed the basis for such reports are subject to audit. 18 NYCRR 517.3(a).

A facility's rate is provisional until an audit is performed and completed, or the time within which to conduct an audit has expired. 18 NYCRR 517.3(a)(1). If an audit identifies an overpayment the Department can retroactively adjust the rate and require repayment. SSL 368-c; 10 NYCRR 86-2.7; 18 NYCRR 518.1, 517.3. An overpayment includes any amount not authorized to be paid under the Medicaid Program, including amounts paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. 18 NYCRR 518.1(c).

If the Department determines to recover an overpayment, the provider has the right to an administrative hearing. 18 NYCRR 519.4. The provider has the burden of showing that the determination of the Department was incorrect and that all costs claimed were allowable. 18 NYCRR 519.18(d)(1).

DSS regulations pertinent to this hearing are found at 18 NYCRR Parts 517, 518 and 519, and address the audit, overpayment and hearing aspects of this case. Also pertinent are DOH regulations at 10 NYCRR Parts 86-2 (Reporting and rate certifications for residential health care facilities) and 415 (Nursing homes – minimum standards), federal regulations at 42 CFR 483.20 (Requirements for long term care facilities – Resident assessment), and the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (CMS RAI Manual).

Among the reports of providers that are used for the purpose of establishing rates of payment is the Minimum Data Set (MDS). MDS data submissions to the Department's Bureau of Long Term Care Reimbursement (BLTCR) are used to classify residents into numerically scored Resource Utilization Group (RUG) categories in order to calculate a nursing home's "case mix index" (CMI). The facility's case mix, and

consequently the “direct” component of its reimbursement rate, is adjusted in July and January of each year for an entire six month rate period. 10 NYCRR 86-2.10(a)(5)&(c); 86-2.37; 86-2.40(m)(6); CMS RAI Manual, page 1-7. The higher the CMI, the higher the reimbursement rate. Elcor Health Services, Inc. v. Novello, 100 N.Y.2d 273, 763 N.Y.S.2d 232 (2003).

MDS assessments of residents’ functional capacities are made and reported by the facility using the “resident assessment instrument” (RAI). Resident assessment is performed and reported by the facility periodically in accordance with requirements set forth at 42 CFR 483.20 and further detailed in the CMS RAI Manual. 10 NYCRR 86-2.37, 415.11. (Exhibits 20-22.)

Section O of the CMS RAI Manual provides instructions for facilities on how and when to identify and report special treatments, procedures and programs, including skilled therapy. (Exhibit 22.) Each resident’s RAI evaluates the resident as of a specific “assessment review date” (ARD). Therapies are reported by the number of minutes of therapy provided in a seven day “look back” before the ARD. CMS RAI Manual, page O-16. A resident who is receiving skilled therapy during the seven day period will be “coded” in a RUG category, with its associated numerical CMI score, reflecting that care. (Exhibit 19.)

Regarding documentation, the CMS RAI Manual states:

Nursing homes are left to determine...how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained in this manual. CMS RAI Manual, pages 1-7&8.

Nursing homes also remain obligated to comply with documentation requirements applicable to all Medicaid reimbursement, including 10 NYCRR 86-2.17 and 18 NYCRR

Parts 504, 517 & 518. Consistent with those requirements, the CMS RAI Manual specifies “Code only medically necessary therapies... documented in the resident’s medical record.” CMS RAI Manual, page O-16.

DISCUSSION

The OMIG’s audit findings changed these four residents’ RUG categories, lowering their associated numerical scores, which led to adjustment of the Appellant’s CMI and a reduction in the direct component of its rate. (Exhibit 8, pages 3-5; Exhibit 15, pages 3-5.) The OMIG does not dispute that there were valid physician orders for the skilled therapies reported on the MDS submissions, nor does it dispute that residents did receive the therapies in the reported amounts. (Transcript, page 38.) The sole issue for this hearing is whether the Appellant’s records document the medical basis and specific need for the provision of those skilled therapies during the one week look back periods under review.

Both parties rely on essentially the same documentation. (Exhibits 7, 10, 12, 14, 17, 18.) The Appellant has produced the therapists’ evaluations and physician orders for the skilled therapies provided during the look back periods, and argues that these professional evaluations and orders must be accepted because the OMIG audit staff is not qualified to second guess them. This view that a nursing home provider is under no obligation to document anything other than the existence of a therapist’s recommendation and a physician’s order to justify reimbursement for skilled therapies is rejected. The OMIG has determined it to be inconsistent with Medicaid reimbursement requirements, including at 18 NYCRR 504.3(a) and 518.3(b). The OMIG’s application of Department

regulations and Medicaid reimbursement requirements in this case is not unreasonable and is not arbitrary or capricious.

The Appellant argues that the CMS RAI Manual is “only a guidance document” that “does not present concrete documentation requirements.” (Appellant brief, page 17.) “Rather, the RAI Manual provides therapy coding requirements... and only mentions documentation in passing.” (Appellant brief, page 10.) That does not mean documentation requirements do not exist. The “therapy coding requirements” are not at issue in this hearing. At issue are the documentation requirements applicable to Medicaid reimbursement for the therapies themselves, which are found in the regulations.

According to the Appellant, the OMIG is misusing the MDS submissions by expecting the facility’s lead data collector (MDS RN coordinator), when preparing the MDS submissions, to review and reevaluate therapists’ and physicians’ determinations of medical necessity before reporting skilled therapies. [REDACTED], who oversees the MDS submission process for the Appellant (Transcript, pages 182-83), explained that in “coding” skilled therapies the MDS coordinator looks for the therapist’s assessment and physician’s order, and confirmation that the minimum time requirements were met. The MDS coordinator does not evaluate medical necessity beyond that evidenced by therapist and physician orders. (Transcript, pages 186-88.)

The Appellant argues:

[I]t is not the purpose of the MDS, nor the MDS RN’s role, to determine whether services are medically necessary... The MDS data collection and communication tool simply reports the therapy services the physician and therapist determined were medically necessary and the therapist actually provided... Because the MDS is a data collection and communication tool which reports and reports the services actually provided to and received by the resident, the critical source of information/data rightfully is the therapist’s documentation. (Appellant brief, page 3.)

It is understandable that the facility's MDS RN coordinator may have "coded" these therapies on the MDS submissions simply because they were ordered and provided. The inquiry in this audit, however, is not whether the services were ordered and provided, it is whether the medical basis and specific need for them is fully and properly documented in the resident records. Completion of the MDS submission does not obviate the need for nor is it a substitute for such documentation. It is hardly a "blatant misuse of the MDS" (Appellant brief, page 3) to audit the underlying records and documentation which formed the basis for an MDS submission. Indeed, such an audit is specifically authorized by 18 NYCRR 517.3(a).

The Appellant's assertion "[t]he OMIG logic seems to be that in the absence of 'interdisciplinary notes,' the therapists and physicians were wrong to say therapy was medically necessary" (Appellant brief, page 4) is not accurate. The audit findings are not that unnecessary skilled therapies were provided. The audit findings are that the Appellant is not entitled to be paid for providing these services because the medical basis and specific need for them were not fully and properly documented in the residents' medical records. The auditors were not disagreeing with the therapists' and physicians' conclusions. They were looking for documentation that supported those conclusions:

The determination here did not require an evaluation of the quality of care provided by [the facility] but simply an analysis of documentary evidence to determine if it contained necessary information, an endeavor that does not require professional medical expertise. Zuttah v. Wing, 243 A.D.2d 765, 674 N.Y.S.2d 130 (3rd Dept. 1997).

The Appellant has a fair point that the OMIG's insistence in the audit reports on "interdisciplinary" documentation is not a requirement specified in the regulations. (Appellant brief, pages 11-12; Exhibit 8, pages 8-9; Exhibit 15, pages 9-10.) This

argument that specific kinds of notes in the records are not required hardly establishes that records documenting the medical necessity are not required.

The Appellant does not dispute that a decision to evaluate for skilled therapy at any particular time must be based upon something. [REDACTED], director of rehabilitation, testified:

There would be discussions during the day, throughout the week. We have what's called morning meeting where all the disciplines get together. They have discussion regarding patient care, any changes over the past few days or past week. From there, we would either go through the documentation and look to see what's available... heavily relying on communication... It could be through daily notes, referrals, documentation throughout the morning report. Every day, our director will come back with a list of items that were discussed in the morning meeting... (Transcript, pages 140-41.)

[REDACTED] testified that reasons for referral for a skilled therapy evaluation come from "[t]he same place. We either get communication from nursing, from C.N.A.s, from the interdisciplinary team, comes in referrals or documentation, looking at twenty-four hour report." (Transcript, page 150.) There is no record of this process for any of these four residents showing why the referrals for skilled therapy were made when they were made. [REDACTED] said the facility did not retain the documentation of the morning meetings. (Transcript, pages 156-58.) The Appellant is not entitled to a presumption, from the therapist's evaluations and physician's orders, that everything leading up to those entries in its records was done and observed appropriately. (Transcript, pages 116-23.) The Appellant's suggestion "Wouldn't it be routine to ask the staff where these levels were – were determined?" (Transcript, page 122) simply ignores the documentation issue.

The therapists' evaluations presented by the Appellant all record onset dates, "when it's brought to our attention that there's been an issue," as the day of the referral

for evaluation. (Transcript, pages 135, 144.) The evaluations report the residents' prior levels and their current levels of functional deficit in various categories. The current levels are self evidently the therapists' own assessments. (Transcript, page 144.) The Appellant has produced no documentation substantiating the prior levels that the therapists recorded, nor is there an indication of what "prior" means. (Transcript, pages 69, 133.)

The requirement that these matters be fully documented is a reimbursement, not a patient care issue. The inquiry in this audit is not whether the Appellant should have provided these therapies. The inquiry concerns its determination to do so during the few days that they counted for reimbursement for an entire six month rate period. The OMIG concedes:

If the MDS assessment, and more specifically the therapy services, were not tied to the facility's reimbursement, the Appellant's reliance solely on the therapy documentation would be reasonable. (OMIG March 9, 2018 reply brief, page 2.)

The reported services under review in this hearing, however, were "used for the purpose of establishing rates of payment." Because of this circumstance, it is reasonable and appropriate for the OMIG to scrutinize the documentation to substantiate the decision to provide them when they were provided. The sparse documentation presented by the Appellant fails to withstand such scrutiny.

Resident four. OT and PT. Look back [REDACTED] 13-[REDACTED]/14. (Exhibit 10.) The physical therapist's evaluation of resident four was done on [REDACTED], 2013, five days before the look back period began, "for a dx of [REDACTED] [sic] with resulting [REDACTED]." There is no documentation in this record, other than the

evaluation itself, of a decline in functional status requiring skilled therapy, and no documentation in the resident record to indicate any [REDACTED].

Resident four's occupational therapy evaluation was done on [REDACTED], 2013. Interdisciplinary progress notes include an OT recommendation on [REDACTED] 2013 for the issuance of "[REDACTED] for all [REDACTED] and [REDACTED] for all [REDACTED]." There is no indication that any other OT services were needed. A dietary note dated [REDACTED] mentions "that OT has assessed res at nursing request" and ordered the [REDACTED] and [REDACTED] still with no indication that any further OT services might be needed. (Exhibit 10, page 4; Transcript, pages 41-42.) Two weeks later, just as the look back period began, another evaluation was done for "hx [REDACTED] w/resulting [REDACTED] [REDACTED] and a full course of OT was initiated although there are no nursing notes or any other documentation of a change or further decline in functional status. (Transcript, page 40.)

[REDACTED] testified that the prior levels of functioning recorded on resident four's evaluations were obtained "off of our last discharge summary... From a previous therapy plan of care." (Transcript, pages 143-46.) The December 2013 evaluations for resident four stated she had PT "previously in 2013" and OT in [REDACTED] 2013. (Exhibit 10, pages 9, 22.) The Appellant produced no records of these previous therapies and no documentation of the discharge summaries.

Resident eleven. ST. Look back [REDACTED]/14. (Exhibit 12.) The speech therapist's evaluation of resident eleven was done on [REDACTED], 2014, one day before the look back period began, ostensibly because a "[REDACTED]" was noticed on [REDACTED]

14. (Exhibit 12, page 9.) The evaluation is not supported by any documentation of the decline.

██████████, a speech language pathologist who reviewed the records of resident eleven and resident twenty-three on the Appellant's behalf (Transcript, pages 166-67), testified that prior levels for these residents were obtained from previous speech therapy discharges. (Transcript, page 175.) She did not say how she knew this. The therapy evaluations for both residents stated: "This patient has not had prior speech therapy for this same condition in the past year." (Exhibit 12, page 9; Exhibit 18, page 9.)

Resident twenty-one. PT. Look back ██████████/14. (Exhibit 17.) Resident twenty-one was evaluated by a physical therapist on ██████████ 2014, the day the look back period began, for a complaint of ██████████ pain in connection with ██████████ (Exhibit 14, page 4; Exhibit 17, pages 6-8.) According to the evaluation, the current level of functioning differed from the unspecified prior level only by the presence of pain. (Exhibit 17, page 7.) By ██████████ the resident was reporting no pain. (Exhibit 17, page 15.) His PT was nevertheless continued through the look back period until he was discharged ██████████ days after it ended.

The therapist's evaluation for resident twenty-one stated he had PT "in the past year." (Exhibit 17, page 7.) The Appellant produced no record of any previous therapy or documentation of a discharge summary.

Resident twenty-three. ST. Look back ██████████/14. (Exhibit 18.) Progress notes by a nurse making the referral of resident twenty-three for a speech therapy evaluation on ██████████ 2014, three days before the look back period began, state "staff reports cognitive changes." (Exhibit 18, pages 5-6; Exhibit 14, page 27.) There is no

documentation, other than the evaluation itself, that indicates any difficulties in

██████████ testified that prior levels for this resident, as for resident eleven, were obtained from a previous speech therapy discharge. (Transcript, page 175.) The therapy evaluation for resident twenty-three stated: "This patient has not had prior speech therapy for this same condition in the past year." (Exhibit 18, page 9.)

As the timing of these skilled therapies is critical to the reimbursement issue, the question why they were provided at the time they were provided matters. What these records document is that the residents were assessed for and given therapies timed to coincide with the look back periods for their MDS submissions. The therapy evaluations on which the treatment recommendations were based rely on claims about prior functioning that are not substantiated by any documentation. The therapies were initiated shortly before, then discontinued shortly after the look back periods whether the residents' goals were met or not.

The skilled therapies reported on the MDS establish rates of payment under Medicaid, and must be substantiated in accordance with Medicaid reimbursement requirements. There must be some substantiation of need in the resident record, some documented indication the resident actually has a problem in functioning, and not just a single evaluation from the therapist timed to coincide with the look back period. This is a rational interpretation of Medicaid regulations at 10 NYCRR 86-2.17, 18 NYCRR 504.3(a), 517.3 and 518.1&3, and the CMS RAI Manual requirement that skilled therapy reported during the look back period be both "documented in the resident's medical record" and "reasonable and necessary for the treatment of the resident's condition."


CMS RAI Manual, pages O-16, 19. The Appellant's documentation for these four residents fails to meet its burden of proving compliance with these requirements.

DECISION:

The OMIG's audit determinations to correct the RUG categories reported for residents four, eleven, twenty-one and twenty-three, and to recover the resulting Medicaid overpayments, are affirmed.

This decision is made by John Harris Terepka, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Rochester, New York
April 11, 2018



John Harris Terepka
Bureau of Adjudication