

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

In the Matter of the Appeal of	:	
	:	
Elderwood at Grand Isle	:	Decision After
Provider #01148136	:	Hearing
	:	
from determinations by the NYS Office of the	:	#14-3414
Medicaid Inspector General to recover	:	#14-3415
Medicaid Program overpayments	:	
	:	

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
259 Monroe Avenue
Rochester, New York 14607
June 28, 2017
Record closed: October 5, 2017

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. 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. Public Health Law 31.

The OMIG issued two final audit reports for Elderwood at Grand Isle (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 witness: Launa Garrett, R.N.

OMIG exhibits: 1-8, 10-29

Appellant witnesses: [REDACTED], Ph.D.
[REDACTED], D.P.T.

A transcript of the hearing was made. (Transcript, pages 1-217.) Each party submitted a post hearing brief and the record was closed October 5, 2017.

SUMMARY OF FACTS

1. At all times relevant hereto, Elderwood at Grand Isle was a residential health care facility (RHCF), licensed under PHL Article 28 and enrolled as a provider in

the Medicaid Program. The facility, which has approximately 80 residents, is located in Grand Island, New York.

2. In July 2014, the OMIG commenced two audits (#14-3414 and #14-3415) to review the Appellant's documentation in support of its Minimum Data Set (MDS) submissions used to determine its reimbursement from the Medicaid Program. (Exhibits 8, 26, 27.)

3. Audit #14-3414 reviewed MDS submissions related to the Appellant's January 2013 census, used to determine reimbursement from the Medicaid Program for the rate period July 1 through December 31, 2013. (Exhibit 1.) The OMIG reviewed records for a sample of fifteen facility residents. (Exhibit 13.)

4. Audit #14-3415 reviewed MDS submissions related to the July 2013 census, used to determine reimbursement for the rate period January 1 through June 30, 2014. (Exhibit 17.) The OMIG reviewed records for a sample of eight facility residents. (Exhibit 29.)

5. The OMIG determined that the Resource Utilization Group (RUG) categories assigned to one resident in each review were not accurate because the Appellant's records failed to document residents' medical need for speech therapy (audit #14-3414, resident 6) and occupational therapy (audit #14-3415, resident 5.) The OMIG corrected the residents' RUG categories and recalculated the Appellant's Medicaid reimbursement rate accordingly.

6. On October 17 (#14-3414) and October 24 (#14-3415), 2016, the OMIG issued final audit reports that identified overpayments in the Appellant's Medicaid reimbursement resulting from the correction of its reimbursement rate to reflect the audit

findings. The OMIG advised the Appellant that it intended to recover Medicaid Program overpayments in the amount of \$10,309.60 in audit #14-3414, and \$10,156.56 in audit #14-3415. (Exhibits 1, 17.)

7. The Appellant requested hearings to review both overpayment determinations. (Exhibits 4, 20.) On consent of the parties, the two audit determinations were combined for this hearing.

Resident 6. (Audit #14-3414.)

8. Resident 6's MDS submission for the audit period had an "assessment review date" (ARD) of [REDACTED], 2012. (Exhibit 10, page 1.) The seven day "look back" period for skilled therapies reported on the MDS was [REDACTED], 2012.

9. The Appellant's MDS submission assigned resident 6 to RUG category "RMC." (Exhibit 10, page 1.) The criteria for assignment to this RUG category included her receipt of skilled therapy services at a minimum of 150 minutes per week. (Exhibit 15.) Resident 6 received in excess of the minimum requirement during the look back period. (Exhibit 10, pages 30-31.)

10. Resident 6 was evaluated by a speech therapist on [REDACTED] 2012 for deficits in the [REDACTED] area and [REDACTED] [REDACTED] skills. The evaluation recommended speech therapy (ST), which was accordingly ordered by a physician. (Exhibit 3, pages 15, 16; Exhibit 10, pages 16-17, 34-35.)

11. Speech therapist's progress notes dated [REDACTED] [REDACTED] [REDACTED] document that resident 6 made continuous progress in [REDACTED], [REDACTED] [REDACTED] and [REDACTED]. (Exhibit 10, pages 24-28.)

12. Resident 6 was discharged from therapy on [REDACTED] 2012 after meeting short term goals for [REDACTED]. [REDACTED] had improved her ability to perform [REDACTED] tasks for ADL's with a reduction of assist to a [REDACTED] level. (Exhibit 3, pages 18, 22; Exhibit 10, page 18.)

Resident 5. (Audit #14-3415.)

13. Resident 5's MDS submission for the audit period had an ARD of [REDACTED] 2013. (Exhibit 25, page 1.) The seven day look back period for skilled therapies reported on the MDS was [REDACTED], 2013.

14. The Appellant's MDS submission assigned her to RUG category "RMB." (Exhibit 25, page 1.) The criteria for assignment to this RUG category included her receipt of skilled therapy services for a minimum of 150 minutes per week. (Exhibit 15.) Resident 5 received the minimum requirement during the look back period. (Exhibit 19, pages 32-33.)

15. Resident 5 was evaluated by an occupational therapist on [REDACTED] 2013 for [REDACTED] and [REDACTED]. The evaluation recommended occupational therapy (OT), which was accordingly ordered by a physician for treatment of those conditions. (Exhibit 19, page 20; Exhibit 25, page 58.)

16. Occupational therapist's progress notes dated [REDACTED] [REDACTED] document that resident 5 made [REDACTED] with her [REDACTED]. Prior level and current level of function remained the same as recorded in the [REDACTED] evaluation. (Exhibit 19, pages 23-28.)

17. Resident 5 was discharged from therapy on [REDACTED] 2013 due to no [REDACTED] improvement. (Exhibit 25, page 59.) The discharge summary concluded:

Patient continues to require [REDACTED] assist with [REDACTED] Patient continues to demonstrate [REDACTED] of [REDACTED] No significant change noted in [REDACTED] due to [REDACTED] and ability to make needs known for training. (Exhibit 25, page 59.)

ISSUE

Has the Appellant established that the OMIG's audit determinations to correct RUG categories reported for resident 6 and resident 5, 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).

Not all nursing home residents require the same level of care, some requiring more costly attention than others. A facility's reimbursement rate accordingly takes into account the kind and level of care it provides to each resident by including, in the calculation of the "direct" component of the facility's "operating" rate, data about the facility's "case mix." 10 NYCRR 86-2.10(a)(5)&(c); 86-2.40(m). Residents are

evaluated and classified into resource utilization group (RUG) categories reflecting the level of their functional care needs, and each RUG category is assigned a numerical “case mix index” (CMI) score. (Exhibit 15.) Residents in RUG categories with higher CMI scores require greater resources for their care. The higher the average of a facility’s RUG and associated CMI scores, the higher the facility’s per diem rate, and reimbursement, will be. Elcor Health Services v. Novello, 100 N.Y.2d 273 (2003).

The Minimum Data Set (MDS) is a core set of screening, clinical and functional status elements which form the foundation for the assessment of residents in nursing homes certified to participate in Medicare and Medicaid. Its primary purpose is as an assessment tool to identify resident care problems that are then addressed in an individualized care plan. CMS RAI Manual, page 1-5. The MDS has other uses, however, including Medicare and Medicaid reimbursement. In New York, MDS data submissions to the Department’s Bureau of Long Term Care Reimbursement (BLTCR) are used to classify residents into RUG categories and calculate a nursing home’s overall case mix index (CMI). CMS RAI Manual, pages 1-5&6; 10 NYCRR 86-2.37.

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, Chapter 2. 10 NYCRR 86-2.37, 415.11.

Particularly pertinent to this hearing is Section O of the CMS RAI Manual (Exhibit 16), which provides instructions for facilities on how and when to identify and report special treatments, procedures and programs, including skilled therapy that

residents receive. 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 this seven day period will then be "coded" at that level of care. The facility's CMI, and consequently its reimbursement rate, will be calculated accordingly for an entire six month rate period.

The standard for recognizing a resident's need for and receipt of skilled therapy is:

The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents....

Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist's assessment... (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. CMS RAI Manual, page O-15.

These therapy services must meet the following six conditions:

- for [Medicare] Part A, services must be ordered by a physician. For Part B the plan of care must be certified by a physician following the therapy evaluation.
- the services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility;
- the services must be of a level of complexity and sophistication... that requires the judgment, knowledge and skills of a therapist;
- the services must be provided with the expectation... that the condition of the patient will improve...

- the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition; and,
- the services must be reasonable and necessary for the treatment of the resident's condition... CMS RAI Manual, pages O-18&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, page 1-6.

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare PPS. CMS RAI Manual, page 1-7.

MDS reporting requirements set forth in the CMS RAI Manual do not supersede, they supplement Medicaid documentation requirements in Department regulations. Of primary importance for the purposes of this Medicaid reimbursement audit is that nursing homes remain obligated to comply with the documentation requirements for Medicaid generally, including 10 NYCRR 86-2.17 and 18 NYCRR 504.3(a), 518.3(b) & 517.3. Consistent with those requirements, the CMS RAI Manual specifies "documentation must substantiate a resident's need for Part A SNF-level services" and "Code only medically necessary therapies." CMS RAI Manual, pages 1-7, O-15.

In this case, the CMS RAI Manual does not, in fact, add much to the documentation requirements set forth in Medicaid regulations. For skilled therapies, it mainly sets parameters for the scope of the review by identifying an ARD and look back

period as determinative of the scope of inquiry for reimbursement purposes. As “specific documentation procedures” have not been imposed for MDS reporting, the standard will remain, as with all Medicaid reimbursement, whether the resident record as a whole reasonably documents a medical basis and specific need in compliance with Medicaid regulations.

DISCUSSION

The issue for this hearing is whether the Appellant’s records document the medical necessity for resident 6’s speech therapy, and resident 5’s occupational therapy, during the one week look back periods under review. This issue turns on the interpretation of what constitutes, for Medicaid reimbursement purposes, “documented in the resident’s medical record.” CMS RAI Manual, page O-15.

The Appellant argues that these determinations represent an OMIG nurse reviewer making determinations of medical necessity for therapies, which can only be made by a qualified therapist in conjunction with a physician. (Appellant brief, pages 16, 21.) As the Appellant’s brief puts it:

The underlying issue is not whether the OMIG representative has the authority to analyze the sufficiency of documentation, but arises when the representative opines to the medical necessity of the services provided. (Appellant brief, page 28.)

The OMIG is not opining to the medical necessity of the services, it is opining on the sufficiency of the documentation to enable the determination to be made. The Appellant’s reliance on Zuttah v. Wing is contrary to the holding in that case. (Appellant brief, pages 28-29.) As the Appellant itself pointed out, Zuttah held:

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 (3rd Dept. 1997.)

The Appellant's argument that the OMIG is imposing a "phantom set of guidelines" (Appellant brief, pages 13-14) ignores Medicaid regulations at 10 NYCRR Part 86-2 and 18 NYCRR Parts 500-540. According to the Appellant, "there is simply no existing statutory or regulatory basis for the documentation requirements, audit criteria or conclusions OMIG used in the instant audits." (Appellant brief, page 8.) Pointing out that there is "no particular documentation required" (Appellant brief, page 10), and that nursing homes are entitled to determine "how the assessment information is documented" (CMS RAI Manual, page 1-7), however, does not establish that there is no documentation requirement.

The "phantom" documentation requirements and guidelines are the same in all Medicaid reimbursement audits: to prepare and keep records necessary to disclose the services furnished, which services will be considered not medically necessary unless the medical basis and specific need for them are fully and properly documented. 18 NYCRR 504.3(a), 518.3(b); Zuttah v. Wing, supra.

Resident 6. ARD look back [REDACTED], 2012.

The OMIG's witness agreed that this resident required [REDACTED] assistance with activities of daily living (ADLs). (Transcript, page 55; Exhibit 10, page 21.) According to the [REDACTED] evaluation and plan of care, the resident's [REDACTED] ability to perform ADLs was determined to be attributable to [REDACTED] difficulties and [REDACTED] issues, for which ST was appropriate. (Exhibit 10, page 16; Transcript, pages 144-45.)

Therapy was given from [REDACTED] to [REDACTED]. The seven day look back period under review is at the end of this period, [REDACTED]. According to [REDACTED]

█ the therapist, there was improvement and it was documented. (Exhibit 10, pages 21-22.) The resident was discharged on █, 2012 because she was hitting her previous ADL level, and so had met her goals. (Exhibit 10, page 18.)

The OMIG pointed out that on the evaluation the goal of the ST was to achieve █ functioning. According to the OMIG, because this goal was to achieve a level of function the resident already had there is no need for the therapy. (OMIG brief, page 8.) This argument is not consistent with the evidence because it relies on an inaccurate assertion by the OMIG's witness that the resident was documented to be at █ functioning when she began therapy. The █ functional levels she cited for this assertion were the levels documented between █ and █ which is not even in the look back period. (Transcript, pages 49-50; Exhibit 10, page 18.) The functional levels documented on █, when the resident began therapy, were in the range of █ (Exhibit 10, pages 16-17.) As █ █ was after the resident was discharged from therapy for having achieved her previous level, the OMIG's argument is, if anything, supportive of the therapy.

The OMIG's witness also inaccurately claimed about the daily treatment record that "Actually, it shows a █ when she's in therapy because she had █ accuracy and then she goes down to █." (Transcript, page 68.) The witness conflated "1 step" with "2 step" directions in order to make this claim. (Exhibit 10, page 29.)

Contrary to the OMIG's inaccurate representations of the evidence, the documentation supports the Appellant's claim that an improvement was documented. (Exhibit 10, page 18, 21-22.) The resident was documented at █ functioning on the

evaluation, at on at and on on and at on days after the ARD. (Exhibit 10, pages 16, 25, 24, 27, 28.) Nursing notes made during the look back period reflect that staff monitored the resident's tolerance for the ST. (Transcript, page 54; Exhibit 10, page 20.)

The look back period comes in the last week of a month of ST in which the record documents continuous progress in achieving the resident's goals. These several weeks of actual therapy with documented progress substantiate the need for continuing the ST into the look back period. The OMIG determination to disallow the ST on the grounds that it was not documented to be reasonable and necessary for the treatment of the resident's condition during the look back period should be reversed.

Resident 5. ARD look back 0, 2013.

Resident 5 was referred for the OT evaluation because of (Exhibit 25, page 58; Transcript, page 114.) The had only recently become an issue for her: An evaluation on 2013 had documented that she did not have. (Exhibit 19, pages 13-14.)

The OMIG disallowed the OT because the resident record failed to document that it was medically necessary and reasonable for the resident's condition. The Appellant went right to OT with no documentation of any other attempts to address the new issue for this resident. The OMIG witness commented:

And what we look at is why was the therapy started, what was the medical necessity... And also there is no – the therapist has a diagnosis here of. There's no documentation in the medical record to support the diagnosis from the physician or from, you know, a. There is no assessment of a assessment, which normally would be done by nursing staff to establish pattern. There is no documentation of a care plan the resident and to go from to therapy with with no other documentation. (Transcript, page 118.)

This failure to document a fuller evaluation of this resident's new issue was coupled with a resort to OT without documenting how and why it could be expected to be effective.

The resident had a well established history of [REDACTED] as a chief complaint. (Exhibit 19, pages 13-14.) The [REDACTED] evaluation reported her prior and current [REDACTED] at the same level of function. (Exhibit 25, page 58; Exhibit 19, pages 13-14.) Physical therapist [REDACTED], who wrote the Appellant's response to the draft audit report (Exhibit 19, pages 15-18), testified:

[I]t's really important that you – that the patient has at least some kind of cognitive ability to follow some commands... So the fact that she had [REDACTED] [REDACTED] for following command was really important. (Transcript, page 197.)

[REDACTED] did not explain where she got her impression of "[REDACTED]." When asked if this resident actually had the ability to follow commands and learn a routine, [REDACTED] went on to say: "Not doing that assessment and being involved, I can't give you that determination." (Transcript, page 197-98.)

The resident record, however, does document an answer to that question: The discharge summary recorded what the Appellant was aware of from the start: that the resident's [REDACTED] and [REDACTED] cognition interfered with her ability and her willingness to participate in or benefit from OT. The discharge summary concluded:

Patient continues to require [REDACTED] assist with [REDACTED]. Patient continues to demonstrate [REDACTED]. No significant change noted in [REDACTED] due to [REDACTED] and ability to make needs known for [REDACTED] training." (Exhibit 25, page 59.)

The therapy had effected no improvement. The resident was discharged from OT on [REDACTED] with continuing [REDACTED] of [REDACTED] episodes per day.

The Appellant's claim "as a result of treatment, the patient did have [REDACTED] episodes of [REDACTED]" (Exhibit 19, page 16) is not consistent with the documentation. There is one nursing note indicating [REDACTED] rather than [REDACTED] episodes of [REDACTED] on one day, [REDACTED] (Exhibit 25, page 57.) To the extent there was an improvement, it was mainly due to [REDACTED] awareness of the problem and corresponding vigilance on the part of caregivers, not the effects of OT. The discharge summary notes:

The patient demonstrates [REDACTED] episodes per day of [REDACTED]. Patient demonstrates [REDACTED] amount of [REDACTED] with [REDACTED] when [REDACTED] regularly. (Exhibit 25, page 59.)

In order to be reimbursable under Medicaid, skilled therapy services must be provided with the expectation that the condition of the patient will improve, and that they are reasonable and necessary for the resident's condition. CMS RAI Manual, pages O-18&19. The Appellant failed to document an assessment of the resident's condition that could provide either a reason to commence therapy or a rationale for an expectation of improvement. The inadequacy of this assessment was confirmed by the complete failure of the therapy to have any meaningful effect. The Appellant has failed to meet its burden of proving that this resident record documents the OT services provided during the look back period were reasonable and necessary for the resident's medical condition.

DECISION:

The OMIG's determination to recover overpayments based upon the MDS audit findings that skilled therapies were not documented to be reasonable and necessary for facility resident's medical conditions is affirmed in part and reversed in part, as follows:


Resident 6: The OMIG's determination to disallow ST during the look back period is reversed.

Resident 5: The OMIG's determination to disallow OT during the look back period is affirmed.

The OMIG is directed to recalculate the overpayments in accordance with this decision.

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

DATED: Rochester, New York
December 5, 2017



John Harris Terepka
Bureau of Adjudication