

**STATE OF NEW YORK  
DEPARTMENT OF HEALTH**

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In the Matter of the Appeal of	:	
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<b>The Hurlbut Nursing &amp; Rehabilitation</b>	:	<b>Decision After</b>
Provider #00308558	:	<b>Hearing</b>
	:	
from a determination by the NYS Office of the	:	
Medicaid Inspector General to recover	:	
Medicaid Program overpayments	:	#13-2428

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Before: John Harris Terepka  
Administrative Law Judge

Held at: New York State Department of Health  
259 Monroe Avenue  
Rochester, New York 14607  
February 9, 14; March 28, 29, 2017  
Record closed: August 4, 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. SSL 363-a; PHL 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 a final audit report for The Hurlbut Nursing & Rehabilitation (the Appellant) in which the OMIG concluded that the Appellant had received Medicaid Program overpayments. The Appellant requested this hearing pursuant to SSL 22 and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the overpayment determination.

**HEARING RECORD**

OMIG witness: Launa Garrett, R.N.

OMIG exhibits: 1-11

Appellant witnesses: [REDACTED], Administrator  
[REDACTED], Rehabilitation Coordinator  
[REDACTED], Documentation Care Coordinator  
[REDACTED], Physical Therapist  
[REDACTED], health care consultant  
[REDACTED], M.D.  
[REDACTED], M.D.

Appellant exhibits: A-D

A transcript of the hearing was made. (Transcript, pages 1-731. Pages 140-153 appear twice, at the end of hearing day 1 and the beginning of day 2.) Each side submitted two post hearing briefs, and the record was closed on August 4, 2017.

### SUMMARY OF FACTS

1. At all times relevant hereto, The Hurlbut Nursing & Rehabilitation was 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 Rochester, New York.

2. The OMIG reviewed the Appellant's documentation in support of its Minimum Data Set (MDS) submissions for a sample of thirty five facility residents from its January 2012 census. (Exhibits 1, 2.) These MDS submissions were used to determine the Appellant's reimbursement from the Medicaid Program for the rate period July 1 through December 31, 2012. (Exhibit 3.)

3. The OMIG determined that Resource Utilization Group (RUG) categories assigned to five of the residents reviewed were not supported by the Appellant's records because the Appellant failed to document that physical therapy (PT) and/or occupational therapy (OT) services ordered and provided were medically necessary and reasonable for the residents' conditions.

4. On August 25, 2016, the OMIG issued a final audit report that identified overpayments in the Appellant's Medicaid reimbursement in the amount of \$59,232.86. (Exhibit 5.) The overpayments were the result of a recalculation of the Appellant's Medicaid reimbursement rate that corrected the five residents' RUG categories in accordance with the audit findings.

5. By letter dated October 21, 2016, the Appellant requested an administrative hearing to challenge the OMIG's audit findings and overpayment determination. (Exhibit 6.)

Resident 32.

6. Resident 32's MDS submission for the audit period had an "assessment review date" (ARD) of [REDACTED] 2011. (Exhibit 7, sample 32, page 1.) The seven day "look back" period for skilled therapy reported on the MDS was [REDACTED] 2011.

7. The Appellant reported a RUG category of "RMA" for resident 32. The minimum skilled therapy requirement for this category is 150 minutes given over five days per week. (Exhibit 8.) The OMIG does not dispute that there was a valid physician's order for the OT, nor does it dispute that the resident did receive OT in the minimum amount. (Exhibit 7, page 14; Transcript, pages 66-68, 132, 425.)

8. On November 17, 2011, an occupational therapist's evaluation of resident 32 recommended a course of OT. The resident's physician signed the therapist's recommendation and OT was commenced. (Exhibit 7, sample 32, pages 14-19.)

9. On December 1, 2011, a rehabilitation note recommended that therapy continue. (Exhibit 7, sample 32, page 21.)

Resident 20.

10. Resident 20's MDS submission for the audit period had an ARD of [REDACTED] 2011. (Exhibit 7, sample 20, page 1.) The seven day look back period for skilled therapy reported on the MDS was [REDACTED], 2011.

11. The Appellant reported a RUG category of "RMC" for resident 20. The minimum skilled therapy requirement for this category is 150 minutes given over five days per week. (Exhibit 8.) The OMIG does not dispute that the care was ordered by a physician and was given. (Exhibit 7, page 22; Transcript, pages 145, 154.)

12. On [REDACTED] 2011, an occupational therapist's screening and evaluation of resident 20 recommended a course of OT. The resident's physician signed the therapist's recommendation and OT was commenced. (Exhibit 7, sample 20, pages 25, 26.)

13. Rehabilitation notes on [REDACTED], 2011 recorded continued improvement in functions. (Exhibit 7, sample 20, pages 4, 7, 8.) The resident was discharged from therapy on [REDACTED] because he had reached his treatment potential. (Exhibit 7, sample 20, page 8.)

Resident 21.

14. Resident 21's MDS submission for the audit period had an ARD of [REDACTED], 2011. (Exhibit 7, sample 21, page 1.) The seven day look back period for skilled therapy reported on the MDS was [REDACTED], 2011.

15. The Appellant reported a RUG category of "RMA" for resident 21. The minimum skilled therapy requirement for this category is 150 minutes given over five days per week. (Exhibit 8.) The OMIG does not dispute that the care was ordered by a physician and was given. (Transcript, pages 255-56.)

16. On [REDACTED] 2011, therapists' evaluations of resident 21 after a hospital stay recommended both OT and PT, each in the amount of [REDACTED] minutes, [REDACTED] days per week, for [REDACTED] weeks. (Exhibit 7, sample 21, pages 6-7, 14-15.) The resident's physician signed the therapists' recommendations and OT and PT were commenced.

17. It is uncontroverted that PT rehabilitation notes on [REDACTED] [REDACTED], and [REDACTED] document the necessity for PT until [REDACTED] 2011. (Transcript, pages

279, 297.) Rehabilitation notes on [REDACTED] and [REDACTED] continue to document PT and the need for it in a similar manner.

18. It is uncontroverted that OT rehabilitation notes on [REDACTED] [REDACTED] document the necessity for OT until [REDACTED], 2011. (Transcript, pages 296-97, 308.) The resident record fails to document medical necessity for OT after [REDACTED] 2011.

Resident 28.

19. Resident 28's MDS submission for the audit period had an ARD of [REDACTED] 2011. (Exhibit 7, sample 28, page 1.) The seven day look back period for skilled therapy reported on the MDS was [REDACTED], 2011.

20. The Appellant reported a RUG category of "RMA" for resident 28. The minimum skilled therapy requirement for this category is 150 minutes given over five days per week. (Exhibit 8.) The OMIG does not dispute that the care was ordered by a physician and was given. (Transcript, page 336, 348.)

21. On [REDACTED], 2011, a therapist's evaluation of resident 21 was done after she had [REDACTED] because of difficulty while [REDACTED] (Exhibit 7, sample 28, pages 6-7.) A course of PT was recommended, the resident's physician signed the therapist's recommendation, and PT was commenced.

22. A [REDACTED] rehabilitation note records "Res making progress. Res hasn't had [REDACTED] since therapy started." (Exhibit 7, sample 28, page 9.) On [REDACTED], the resident's physician recorded "After the [REDACTED] she was referred to physical therapy, and I did talk with the physical therapist, who tells me she is doing much better." (Exhibit A, page 15.)

Resident 29.

23. Resident 29's MDS submission for the audit period had an ARD of [REDACTED], 2011. (Exhibit 7, sample 29, page 1.) The seven day look back period for skilled therapy reported on the MDS was [REDACTED] 2011.

24. The Appellant reported a RUG category of "RHC" for resident 29. The minimum skilled therapy requirement for this category is 325 minutes given over five days per week. (Exhibit 8.) The OMIG does not dispute that the care was ordered by a physician and was given. (Transcript, page 373, 381.)

25. A [REDACTED], 2011 therapist's evaluation of resident 29 recommended OT for [REDACTED] minutes, [REDACTED] days per week. A [REDACTED] therapist's evaluation recommended PT for [REDACTED] minutes, [REDACTED] days per week. The resident's physician signed the therapists' recommendations and OT and PT were commenced. (Exhibit 4, pages 35, 39.)

26. On [REDACTED] 2011, OT and PT rehabilitation notes documented that the resident had reached his treatment potential. He was accordingly discharged from both OT and PT. (Exhibit 4, pages 38, 42; Transcript, pages 550-52.)

ISSUE

Has the Appellant established that the OMIG's audit determinations to recover Medicaid overpayments attributable to the claimed skilled therapy needs of five residents is 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). Pertinent portions of the CMS RAI Manual are in evidence as Exhibit 10.

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 8.) 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). (Transcript, page 30.)

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. (Transcript, pages 27-28.) 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. 10 NYCRR 86-2.37, 415.11. (Transcript, pages 31-33.)

Particularly pertinent to this hearing is Section O of the CMS RAI Manual (Exhibit 10), which provides instructions for facilities on how and when to identify and report special treatments, procedures and programs, including skilled therapy services that residents receive. Each resident's RAI evaluates the resident as of a specific "assessment review date" (ARD). Skilled 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 period will be "coded" in a RUG category that reflects the extent of the therapy. The facility's CMI, and consequently its reimbursement rate, will be calculated accordingly for an entire six month rate period.

The standard for recognizing and “coding” 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 final audit report included findings about many of the thirty five residents reviewed, but not all of the findings had an impact on reimbursement. (Exhibit 5, pages 4-5.) At issue for this hearing are the OMIG's determinations that the Appellant's records failed to document that physical and/or occupational therapy services provided to five residents were medically necessary and reasonable for the residents' conditions. Disallowance of the OT and PT services changed the resident's RUG categories, leading to a reduction in the facility CMI and consequently the direct component of its reimbursement rate.

An MDS report asks the facility to record therapies administered in the last seven days prior to the resident's "assessment review date" (ARD). CMS RAI Manual, pages O-14&16. In this audit, the OMIG accordingly looked for documentation to support the medical necessity for the therapies during that "look back" period.

The OMIG does not dispute that the PT and OT services in question were ordered by a physician, and were provided in the amounts required for the reported RUG category. The only issue is whether the resident records document the medical necessity for the services. 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 claims that the OMIG disallowed these services on the basis of a nonexistent requirement of "interdisciplinary documentation" from "all three disciplines, therapy, medicine, and nursing" to support a need for therapy. (Appellant reply, pages 2-7.) A final audit report is required, pursuant to 18 NYCRR 517.6(b)(1), to advise the

provider of the legal authority for its action. In this case, the OMIG's audit report (Exhibit 5) cited two authorities in support of its audit determinations: 42 CFR 483.20(b)(xvii), and CMS RAI Manual O0400-0500 (pages 14-41), which is most of Section O of the Manual.

42 CFR 483.20(b)(xvii) requires the RAI to include: "Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS)." The pertinence of this regulation to this audit is not clear, but to the extent it is applicable, the therapists' evaluations primarily relied upon by the Appellant in this case appear to fit this requirement more closely than raw data in the progress notes recording day to day observations of hands on care staff, which is what the OMIG appears to be demanding.

CMS RAI Manual O0400-0500 instructs providers that skilled PT and OT services must meet six conditions. (CMS RAI Manual, pages O-18&19.) Only the first two contain specific documentation requirements, which are for a certified physician's order, and for a written treatment plan. For the requirement of additional documentation from the "interdisciplinary team," the OMIG relies on another Manual provision:

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. (CMS RAI Manual, page O-15.)

This is the very same provision the Appellant relies on to support its claim that it has met the documentation requirements. (Appellant brief, pages 8-9.) The OMIG singles out the language "in conjunction with the physician and nursing administration" as the critical requirement. The Appellant, in turn, points out that "the qualified therapist... is responsible."

According to the OMIG, “Appellant was unable to show that information which would indicate a need for physical therapy had been collected from any source other than from physical or occupational therapy.” (OMIG brief, page 12.) The physicians, Dr. [REDACTED] and Dr. [REDACTED] signed orders for therapy. (Exhibit 7, sample 28, page 6; Exhibit 4, page 35; Transcript, day 2 pages 154-56, pages 675-80.) For residents 20, 21, 28 and 29, these signatures are essentially the only documentation actually created by the ordering physicians. There are also referrals and requests for evaluations from the nursing staff to the physicians and therapists documented in these records. (Exhibit 7, sample 32, pages 14, 17-18; sample 20, page 22; sample 29, page 5; Exhibit A, pages 11-14.)

The OMIG, however, maintains that “in conjunction with the physician and nursing administration” must mean considerably more detailed documentation written in the progress notes by physicians, nurses and other hands on caregivers. The CMS RAI Manual hardly makes that clear by simply requiring that the therapies be “documented in the resident’s medical record.” (CMS RAI Manual, page O-15.)

The MDS is a multi-purpose tool intended to encourage best practices for care, not just establish minimal requirements for billing:

[D]ocumentation 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. CMS RAI Manual, page 1-7.

It is inappropriate to use these prescriptive “best practices” provisions as the standard in an audit intended to determine whether minimal requirements for Medicaid reimbursement have been met. The OMIG’s witness said:

A. We look at whether it's whatever they scored on their M.D.S. Is there a story, is there a reason for it? So what we look for is the documentation from the nurse – said no the nurse's aide came and, you know, when I got up [REDACTED] she was complaining that her – her [REDACTED] hurt and it took [REDACTED] today to put her in her [REDACTED] instead of [REDACTED] (Transcript, page 71.)

...

A. We are looking for documentation that supports how they came to the conclusion that that was needed. Why did – why did that happen?...

Q. Why do they have to have a reason?

A. Best practices is that you – and also the M.D.S. manual says, you know, that we don't – they don't tell us how to chart – but there has to be for best practices for the modality or the clinician that is writing the notes, and you would expect that there would be documentation to support this. (Transcript, pages 202-203.)

“Is there a story” is a valid and perceptive criticism to make in reviewing documentation for “good clinical practice.” It is less helpful in assessing whether minimum reimbursement requirements have been met. The OMIG’s criticism that information should be reflected in the ongoing progress notes is clearly reasonable as a matter of best practice, but that requirement is not clearly articulated as a minimum reimbursement standard as well.

The OMIG auditors’ tendency to confuse “best practices” with minimum reimbursement requirements was well illustrated at the hearing when its nurse reviewer and only witness testified that rehabilitation notes for resident 21 were not signed by a physician because there was “nothing to substantiate that squiggle as a physician and there is no date... the best practices is the physician’s signature is dated and identified as such.” (Transcript, pages 317-18.) The notes clearly were signed, and the very physician who signed them testified and verified his signatures. (Transcript, pages 675-77.)

The Appellant’s point that the OMIG cannot demand more specificity than the rules can reasonably be construed to require is well taken. “CMS does not impose



specific documentation procedures on nursing homes in completing the RAI.” The CMS RAI Manual does go on to state, however, that “documentation must substantiate a resident’s need for Part A SNF-level services.” CMS RAI Manual, page 1-7. Under Medicaid:

Medical care services or supplies ordered or prescribed 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).

Under this Medicaid payment regulation in particular, there must be some intelligible connection between skilled therapy evaluations and the rest of the resident record. (Transcript, day 2 page 153.) That there 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, is a reasonable interpretation of Medicaid regulations at 10 NYCRR 86-2.17, 18 NYCRR 504.3(a), 518.3(b) & 517.3, and the CMS RAI Manual requirement that skilled therapy be “reasonable and necessary for the treatment of the resident’s condition.” CMS RAI Manual, page O-19.

The standard that will be applied in this decision is not a rigid requirement of “interdisciplinary documentation” from each of the three sources mentioned, or a subjective assessment whether “a story” has been told. Nor is it, as the Appellant suggests (Transcript, page 495), simply a therapist’s evaluation and a signed physician’s order. 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.

Resident 32. ARD look back [REDACTED], 2011.

The OT this patient was receiving during the [REDACTED], 2011 look back period was ordered on [REDACTED], 2011. (Exhibit 7, sample 32, page 14.)

The physician's order says the OT evaluation and treatment were ordered because of a "decline" in ADLs, yet there is no documentation going back for the past year that shows any decline in these functions. (Transcript, pages 92-95, day 1 page 145.) Even the evaluation itself leaves blank the sections for previous ADLs. (Exhibit 7, sample 32, pages 15, 19.) The [REDACTED] evaluation also records knee pain as a reason for the evaluation but the resident record does not document elsewhere that she has been or is being monitored for knee pain or how it affects function. (Exhibit 7, sample 32, page 19; Transcript, pages 87, 90-91.)

A lengthy [REDACTED], 2011 progress note by Dr. [REDACTED] the treating physician who ordered the OT on [REDACTED] mentions that the resident takes Tylenol for [REDACTED] pain, but records "no [REDACTED]," fails to mention [REDACTED] pain or other physical difficulties, nor does it even mention that she had been receiving OT for [REDACTED] weeks by then. The assessment and plan contain nothing relevant to OT. "The patient says she is feeling okay." (Exhibit 7, sample 32, pages 4-5; Transcript, pages 72-73.)

While the Appellant claims the resident's [REDACTED] 2011 [REDACTED] is also a reason for the OT (Appellant brief, page 12), the evidence fails to support such a connection. The detailed progress note documenting her [REDACTED] contains no mention of OT, no mention of pain, and states she is independent in [REDACTED] with assist in [REDACTED] [REDACTED] and [REDACTED] (Exhibit 7, sample 32, pages 6-7; Transcript, page 73, day

1 page 147.) A [REDACTED] note by the therapist records only that “[REDACTED]” [REDACTED] (Exhibit 7, sample 32, page 22.)

A nursing interim review dated [REDACTED], 2011, which is the ARD, reported no pain, no limitations in joint function, and reports ADLs as supervision only, except [REDACTED] assistance in [REDACTED] and [REDACTED], and [REDACTED] person assist in [REDACTED] (Exhibit 7, sample 32, pages 8-11.) This nursing interim review, prepared as part of the MDS reporting process, reports only ADL functioning on the day shift, although the form itself, and CMS RAI Manual Section G instructions for ADL evaluations in connection with the MDS (CMS RAI Manual, pages G-3&4) require information from all three shifts. (Exhibit 7, sample 32, page 11.) There is no mention of OT in the nursing interim review.

The Appellant’s claim the record is “replete” (Appellant brief, pages 13-14) with documentation indicating a need for therapy amounts to the [REDACTED] evaluation itself, and the therapist’s comment in a [REDACTED], 2011 rehabilitation note that report the resident had [REDACTED] pain and some improvements in ADLs since [REDACTED] (Exhibit 7, sample 32, page 21; Transcript, pages 446-47, 703.) The more detailed evaluations by treating physicians do not support such a need. Dr. [REDACTED] when his attention was drawn to the two page progress note written by him, answered “she was a [REDACTED] resident” and then began talking about the [REDACTED] and [REDACTED] rehabilitation notes instead. (Transcript, pages 700-703.) The resident record fails to document a medical basis and specific need for the OT during the look back period [REDACTED].

Resident 20. ARD look back [REDACTED], 2011.

The look back period for the OT under review was [REDACTED], but the therapy began on [REDACTED] 2011. An evaluation was done after an annual OT screen on [REDACTED] indicated that the resident had a change in functional status. Dr. [REDACTED] said “So it’s basically... this was an annual review and the nursing staff had pointed out that this particular patient was requiring a lot more assistance... And then they outlined a plan.” (Transcript, page 698.)

The OT evaluation, and the OT order itself, both also dated [REDACTED] recorded a decline in ADLs as the reason for OT. (Exhibit 7, sample 20, pages 22, 25-26; Transcript, pages 155, 585-87.) The Appellant relies entirely upon the screen and the evaluation to document the initial order for OT.

A [REDACTED] week assessment on [REDACTED] documents improvement in function. (Exhibit 7, sample 20, page 7; Transcript, pages 592-95.) Dr. [REDACTED] approved continuation of therapy at that point because two of six goals were achieved and some new ones were added. (Transcript, pages 699-700.) Rehabilitation “[REDACTED] notes substantiate the improvement by recording objective findings of [REDACTED] at [REDACTED] on [REDACTED] [REDACTED] on [REDACTED], and [REDACTED] on [REDACTED] (Exhibit 7, sample 20, pages 4, 7, 8.) The resident was discharged from therapy on [REDACTED] when it was concluded there was little room for further improvement. (Exhibit 7, sample 20, page 8.)

The OMIG argues there is no documentation of a decline in skills from nursing staff and others who cared for this resident. This is basically true for the initiation of therapy. The OMIG reviewer acknowledged, however, that this resident required a high

level of assistance for all ADLs. (Transcript, page 214.) The OMIG's witness also acknowledged that evidence of improvement might support the OT. (Transcript, pages 168, 236, 243-44.)

The look back period comes in the last week of a month of OT 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 during the look back period. The OMIG determination to disallow the OT 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 21. ARD look back [REDACTED], 2011.

Resident 21 had been receiving PT and OT since [REDACTED], 2011. (Exhibit 7, sample 21, pages 6, 14; Transcript, page 251.) Either one would be adequate to justify the reported RUG category. (Transcript, pages 309-10, 512.)

The records document that the resident returned from hospitalization on [REDACTED] with functional deficits, was evaluated, and that both OT and PT were ordered and continued through the ARD. (Transcript, pages 503, 519-21.) There is no dispute that both OT and PT were initially appropriate for this resident upon his return from hospitalization in [REDACTED] and into [REDACTED] 2011. (Transcript, pages 258-60, 520-21; OMIG brief, page 17.) It is the continuation into the [REDACTED] look back period that is in dispute.

PT rehabilitation notes on [REDACTED] document a [REDACTED] by [REDACTED] but the resident began to show improvement by [REDACTED] (Exhibit 7, sample 21, pages 8-10; Transcript, page 263.) An [REDACTED] rehabilitation note, signed

by the physician assistant [REDACTED] showed further progress but the resident was “starting to reach max potential” and goals remained largely unchanged. (Exhibit 7, sample 21, page 12; Transcript, page 264.) The OMIG’s witness acknowledged that this documentation was in order as justification for PT up to [REDACTED] (Transcript, pages 279, 297.) The OMIG witness did not address an [REDACTED] PT rehabilitation note, which also documented progress but potential for improvement, to explain why it was not also adequate to document the therapy. (Exhibit 7, sample 21, page 20.)

On [REDACTED], the physical therapist added [REDACTED] or “[REDACTED] which uses a device to [REDACTED]. (Exhibit 7, sample 21, page 11; Transcript, page 304.) The OMIG witness criticized the [REDACTED] rehabilitation note, saying “There’s no more measurable goals at that point, except for [REDACTED] task and [REDACTED]... There’s nothing about how he’s doing.” (Exhibit 7, sample 21, page 11; Transcript, pages 266, 274.) When it was pointed out that the [REDACTED] rehabilitation note does include two goals, regarding [REDACTED] and [REDACTED] the witness then agreed that was the case, but then objected that the evaluation included changes in the treatment plan but was not signed by a physician. (Transcript, page 275, 285-87, 290-93.) The rehabilitation note, which the OMIG witness agreed constituted a physician order when signed (Transcript, pages 282-83), is, in fact, signed by Dr. [REDACTED]. All of the rehabilitation notes are signed by either a physician or physician assistant, most of them by Dr. [REDACTED] (Transcript, pages 675-77.)

The OMIG witness nevertheless repeatedly argued (Transcript, pages 275, 280-82, 284, 285-89) that medical necessity was not documented for the continuation of PT or

OT into the look back period because a physician had not signed a plan of treatment and order:

- A. They don't show need based on that the doctor hasn't signed the plan of care... The doctor has not signed the plan of care for medical necessity.
- Q. Right. Is there any other problem?
- A. No. (Transcript, page 282.)

This is not the grounds for disallowance offered in the audit report or initially at the hearing. The same witness had already specifically agreed that "we do have an order" and that the issue was whether the documentation supported the order. (Transcript, page 256.) More importantly, it is clear that the [REDACTED] and [REDACTED] rehabilitation notes are both signed. (Exhibit 7, sample 21, pages 11, 13.)

The [REDACTED] rehabilitation note was more detailed than the [REDACTED] note that the OMIG witness criticized. It listed both past and future goals, and noted that "[REDACTED] was being used "in conjunction" with the already established plan of care including therapeutic exercise, [REDACTED] training, [REDACTED] training, [REDACTED] activities and [REDACTED] training. (Exhibit 7, sample 21, page 13.)

The OMIG's criticism of the OT is similar. (Transcript, pages 307-08.) There is no dispute that OT was necessary and the documentation is in order from [REDACTED] until [REDACTED] 2011. (OMIG brief, page 17; Exhibit 7, sample 21, page 22; Transcript, pages 296-97, 308.) There are OT rehabilitation notes dated [REDACTED], [REDACTED], 2011. (Exhibit 7, sample 21, pages 14, 16, 17, 18, 19, 21, 22; Transcript, page 294.)

The [REDACTED] rehabilitation note narrative records that a trial of the [REDACTED] ordered in connection with the PT was being made. (Exhibit 7, sample 21, page 21;

Transcript, pages 300-302.) The OMIG witness again testified that this note failed to document the necessity for the skilled therapy because “their changing the plan and they’re adding something different that isn’t signed by the physician.” (Transcript, pages 301-302.) The rehabilitation note is signed, but it leaves the assessment portion of the form blank and so does not state the resident is a candidate for services, is improving, has achieved any goals, or has potential for restoration. It does not establish any new goals, instead simply noting “continue goals above.” Unlike the [REDACTED] rehabilitation note, which the OMIG reviewer accepted as justification for OT up to [REDACTED] (Transcript, page 302), the [REDACTED] note documents no rationale for continuing the OT in addition to the PT and [REDACTED] therapy already being provided.

The OMIG reviewer disallowed both therapies because “they changed the therapy, you know, O.T. and P.T. is just about the same time, [REDACTED] And neither’s signed.” (Transcript, page 306.) The PT rehabilitation notes of [REDACTED] and [REDACTED] are signed, and they document continuation of therapies that the OMIG agrees were necessary in a manner consistent with the earlier documentation. The Appellant met its burden of establishing that the PT continuing into the [REDACTED] look back period was documented to be reasonable and necessary for the resident’s condition. The OT is not documented as being necessary as well after the PT plan was changed to include the e-stim.

Resident 28. ARD look back [REDACTED], 2011.

Resident 28 was totally independent with a minimum ADL dependency score of [REDACTED] according to the Appellant’s [REDACTED], 2011 MDS filing. (Exhibit 7, page 1; Transcript, pages 340-41.) A PT evaluation done on [REDACTED] 2011 indicated she was



within functional limits, although apparently, for reasons that are nowhere explained, unable to █████ her █████. (Exhibit 7, sample 28, pages 7-8; Transcript, pages 647-48.) The evaluation states it was done following █████ while █████ (Exhibit 7, sample 28, page 6.)

The OMIG claims the PT was not medically necessary because the resident's ADL score reported in █████ 2011 was the same as reported on the █████, 2011 MDS. "There was no significant change in the resident's status – 'all of the ADLs remained the same from the previous MDS of █████/11.'" (OMIG brief, page 21.) The issue for this therapy, however, is clearly documented to be concern about █████ during █████ a concern that only began to be apparent in █████ 2011 and for which the resident had been receiving PT since █████ █████

The Appellant was advised at the entrance conference, in writing, that its response to the draft audit report must raise any issues and submit any documentation it wanted to be considered. (Exhibit 2.) The Appellant did respond to the draft audit report, and submitted 42 pages of documentation in support of that response. (Exhibit 4.) With its hearing request, however, the Appellant submitted additional resident records. (Exhibit 6.) Some of these were in the audit file and had been reviewed, some were not. Among the additional records were several pages of progress notes and orders from resident 28's record. (Exhibit A.) The OMIG objected that these records were not included in the response to the draft audit report. (Transcript, page 622.)

The Appellant's argument that 18 NYCRR 517.5(b) "issues to be addressed at an administrative hearing will be limited to those matters contained in any objection to the proposed action" does not include documentation is rejected. (Appellant reply brief,

pages 10-12.) Section 517.5(c) goes on to state “Any objection must... provide any additional material or documentation which the provider wishes to be considered.”

There is good reason to impose a limitation on submission of documents. This hearing is to review a completed audit, not to continue the audit. The Appellant’s argument that it would be “unfairly prejudicial” to require it to produce, during the audit, its documentation justifying the therapies it provided, is not convincing. That is the purpose of an audit. Additional documentation not provided to the Department is clearly “new matter not considered by the department upon submission of objections to a draft audit.” 18 NYCRR 519.18. It may be precluded if it is produced for the first time at the hearing.

In this case, however, there is evidence that the OMIG did not share with the Appellant or make entirely clear what documents it had reviewed until the prehearing conference. As the Appellant may not have known, at the time the audit exit conference was held, what the OMIG was relying on, it may not have known what additional documents needed to be included with the response to the draft audit report. (Transcript, pages 622-27, 668-69.) For this reason, the documents (Exhibit A) will be considered.

The physician’s order for the PT states the reason is “[redacted] difficulty.” (Exhibit A, page 14.) Nursing notes contain several entries documenting discussion between nursing and medical staff regarding the possible cause of falls while transferring. An [redacted] physician assistant note reviewing possible reasons for the resident’s [redacted] which included [redacted] and a “[redacted],” recommends “PT consult for [redacted] and [redacted].” An [redacted] physician assistant entry reads: “Received notification that pt had [redacted]... Per nursing the pt

had [REDACTED]... Discussed event with Dr. [REDACTED]. An [REDACTED] note records another [REDACTED] on [REDACTED]: "Res states she [REDACTED] and [REDACTED] because she uses [REDACTED]." A physician assistant note later that day reads: "[REDACTED] - unclear why patient is having [REDACTED]. Case discussed with Dr. [REDACTED]... Will consult PT to re-evaluate [REDACTED] ability." The physician's order for the evaluation reads: "PT consult for [REDACTED]." (Exhibit A, pages 10-13.) These notes document "interdisciplinary" consultation among the nursing, medical and therapy staff to evaluate and recommend the resident for therapy because of [REDACTED] leading to [REDACTED] during [REDACTED].

PT began on [REDACTED], and a [REDACTED] interim therapy note records "Res making progress. Res hasn't had [REDACTED] since therapy started." (Exhibit 7, sample 28, page 9.) As she had been making progress since [REDACTED] but still needed to improve [REDACTED] it was appropriate to continue the therapy. (Transcript, pages 643-45.) A [REDACTED] detailed progress note by the ordering physician later records: "After the [REDACTED] she was referred to physical therapy, and I did talk with the physical therapist, who tells me she is doing much better." (Exhibit A, page 15.)

The resident record documents that the therapy was recommended "in conjunction" with nursing and medical staff, and that its continuation in the look back period was also documented to be appropriate. The PT reported during the look back period should be allowed.

Resident 29. ARD look back [REDACTED] 2011.

OT and PT were both provided during the look back period [REDACTED]. As the RUG category reported for resident 29 required 325 minutes of skilled therapy per

week, both therapies must be documented to be reasonable and necessary for the resident's condition to justify that RUG category. (Transcript, pages 382, 555-57.)

This resident suffered from [REDACTED]. (Exhibit 7, sample 29, page 4.) From the [REDACTED] of [REDACTED] through [REDACTED] 2011 the nursing notes record [REDACTED] that did not result in any injury or pain. (Exhibit 7, sample 29, pages 4-8.)

An OT evaluation done on [REDACTED], 2011 states there was a "decline with ADLs, especially with [REDACTED]" (Exhibit 4, page 39; Transcript, pages 539-40.) A [REDACTED] 2011 rehabilitation note documents the resident has been actively participating in OT with good results. (Exhibit 4, page 41; Transcript, page 547.) On [REDACTED] the ARD, the resident was reported to have achieved four of his six goals, and was discharged from OT because he had "achieved a new baseline with [REDACTED]" (Exhibit 4, page 42; Transcript, pages 550-52.)

The Appellant has presented no facility records substantiating a decline in ADLs prior to [REDACTED]. The progress notes that were produced are almost exclusively about the resident's recurring [REDACTED] which were predicted to and did continue to occur even after he was discharged from skilled therapy. There is no mention of the [REDACTED] issue alleged on the OT evaluation to be the primary reason for the OT referral. Range of motion (ROM) was within normal limits on [REDACTED] and a quarterly [REDACTED] assessment on [REDACTED] mentioned no [REDACTED] or [REDACTED] problems. (Exhibit 7, sample 29, pages 4-8.)

A PT evaluation was done on [REDACTED] 2011. The reason for referral was "recent [REDACTED] and decline in [REDACTED] and [REDACTED]" (Exhibit 4, page 35.) On [REDACTED] [REDACTED] a rehabilitation note recorded the resident was showing improvements and

achievement of the goals set for him. (Exhibit 4, page 37.) On [REDACTED] the ARD, he was discharged from PT because he had achieved all goals set for him and he “seems to be at his functional baseline level.” (Exhibit 4, page 38.)

Progress notes, however, record the resident as already “at baseline” on [REDACTED], “able to [REDACTED]” on [REDACTED], “ROM WNL” on [REDACTED] and there is never a complaint of pain. (Exhibit 7, sample 29, pages 4-6.) Only in the therapy evaluations themselves is there any mention of the claimed decline in the resident’s [REDACTED] and [REDACTED]. A [REDACTED] physician assistant note records:

[REDACTED] Received notification that pt [REDACTED]. Pt has [REDACTED] with history of [REDACTED]. [REDACTED] assessment completed x [REDACTED] in the past. Pt. [REDACTED]. Does deny pain. Per nursing pt is at baseline.... No evidence of injury....  
[REDACTED]: [REDACTED] – continue to provide safe environment for pt. [REDACTED] in further are likely unavoidable. Will continue to have safety checks. Pt does use [REDACTED] F/u PRN. (Exhibit 7, sample 29, page 4; Transcript, page 376.)

This was the resident’s situation before the therapy began. To be reimbursable under Medicaid, skilled therapy services must be provided with the expectation the condition of the patient will improve. CMS RAI Manual, page O-18. Simply having a history of [REDACTED] is not necessarily a reason for therapy when, as the OMIG reviewer pointed out, there is no indication in this case that skilled therapy could help or prevent such [REDACTED]. This resident was already “at baseline” and they were predicted to be “unavoidable.” (Exhibit 7, sample 29, page 4; Transcript, page 376.) The OMIG reviewer testified: “That means the patient’s as good as he gets.” (Transcript, page 376.)

A: [T]hat this was ongoing and that it wasn’t going to be preventable.

Q: Why would that militate against an order for therapy?

A: You're not going to have – you're not going to prevent anything. You're not going to have any kind of outcome with it. You have to change the environment. (Transcript, pages 392-93.)

The resident's record after therapy confirms these assessments: He continued to have [REDACTED] after being discharged from both OT and PT. (Exhibit 7, sample 29, page 8.)

The resident record fails to document that the OT was reasonable and necessary for the resident's medical condition because it does not demonstrate a need. It fails to document that the PT was reasonable and necessary for the resident's medical condition because it fails to demonstrate that the condition for which the patient was evaluated could be expected to improve. The OT and PT were properly disallowed.

**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 residents' medical conditions is affirmed in part and reversed in part.

The OMIG is directed to recalculate the overpayment in accordance with the following:

Resident 32: The OMIG's determination to disallow OT during the look back period is affirmed.

Resident 20: The OMIG's determination to disallow OT during the look back period is reversed.

Resident 21: The OMIG's determination to disallow PT during the look back period is reversed.  
The OMIG's determination to disallow OT during the look back period is affirmed.


Resident 28: The OMIG's determination to disallow PT during the look back period is reversed.

Resident 29: The OMIG's determination to disallow PT during the look back period is affirmed.

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

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

  
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John Harris Terepka  
Bureau of Adjudication