STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of

MEADOWBROOK HEALTHCARE

Provider No.: 02994732
Appellant,

DECISION AFTER HEARING

For Hearing pursuant to Part 519 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York ("NYCRR") to review the determination of the Department to recover $310,081.00 in Medicaid overpayments.

Before: David A. Lenihan
Administrative Law Judge

Held at: New York State Department of Health
Bureau of Adjudication
150 Broadway, Riverview Center, Suite 510
Albany, New York 12204

Date: August 19, 2014
Record closed October 29, 2014

Parties: New York State Department of Health
Office of the Medicaid Inspector General
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Albany, New York 12204

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JURISDICTION

The New York State Department of Health (hereinafter the Department or DOH) acts as the single state agency to supervise the administration of the Medicaid Program in New York State pursuant to Social Services Law § 363-a. The New York State Office of the Medicaid Inspector General (hereinafter OMIG) is an independent office within the Department, responsible for the Department's duties with respect to the recovery of improperly expended Medicaid funds pursuant to Public Health Law § 31.

The OMIG in this case issued a final audit report for Meadowbrook Healthcare (the Appellant) in which the OMIG concluded that the Appellant had received Medicaid program overpayments. The Appellant requested this hearing pursuant to Social Services Law § 22 and Department of Social Services regulations at 18 NYCRR 519.4 to review the Department's determinations. The hearing was held on August, 19, 2014 Evidence was received. Testimony was taken under oath. A transcript of these proceedings was made.

The entire record was considered in reaching this decision.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers below in parentheses refer to exhibits, denoted by the prefix “Ex.” or transcript references, denoted by the prefix “T” and “__ “ for the page. An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The Appellant, Meadowbrook Healthcare (hereinafter “Appellant), is a proprietary 207 bed skilled nursing facility located at 154 Prospect Avenue, Plattsburgh, Clinton County, New York. It is fully certified and enrolled in both the Medicare and Medicaid programs. (T. 7)
2. In December 2006, in conformance with Department of Health (DOH) regulations, the Appellant submitted Patient Review Instruments (hereinafter, PRIs) for its residents. (T. 41-42)
3. PRIs are a core feature of DOH rate setting methodology, allowing for the categorization of residents as to diagnoses, acuity, care and service needs. (T. 8)
4. The DOH rate setting methodology, pursuant to 10 NYCRR § 86-2.10, uses PRIs to categorize residents into 16 resource utilization groups (hereinafter, RUGs), which are then used to calculate the direct price component of a skilled nursing facility’s reimbursement rate. (T. 9)

5. OMIG commenced the instant audit of Appellant's December 2006 PRIs on January 11, 2011. (Dept. Ex.1)

6. OMIG issued two draft audit reports to Appellant dated January 6, 2012 and December 13, 2013, respectively, disclosing numerous adjustments to Appellant's reported RUG categorization of the 206 residents reviewed. (Dept. Ex. 9)

7. In response to the draft audit reports, Appellant submitted responses dated May 1, 2012 and December 18, 2013, respectively, including general objections, legal and factual bases for contesting the adjustments, and additional documentation, both including clinical records. (Dept. Ex. 11, T. 99)

8. On May 15, 2014, OMIG issued its final audit report disclosing numerous adjustments to Appellant's reported RUGs categorization of several of the residents reviewed. (Dept. Ex. 15)

9. By letter dated May 22, 2014, Appellant requested a hearing to contest the final audit report findings. (Dept. Ex. 17)

10. At a hearing held on August 19, 2014 before the undersigned Administrative Law Judge, David A. Lenihan, the hearing was limited to the issues of (1) whether OMIG had jurisdiction to audit the PRI submissions of Appellant, (2) whether OMIG was authorized to conduct the audit in the manner it did, (3) whether the audit was foreclosed by prior action of DOH, and (4) whether OMIG's audit findings regarding disallowed level 5 toileting were based upon a standard of documentation which was authorized by law and regulation and/or in conformity

with legally enforceable interpretations of statute, and whether Appellant's scheduled toileting documentation factually met appropriate legally enforceable standards. (OMIG Post Hearing brief, 11 *et seq.)*

11. OMIG did not contest the fact that the scheduled toileting in question for each of the contested resident PRI adjustments was actually rendered, medically necessary, properly ordered and within the resident's plan of care. (T. 21)

12. Appellant's clinical documentation of the performance of the scheduled toileting consists of monthly flow sheets for each resident which include the date and time of day when the resident was toileted, the initials of the aide that performed the toileting service, and the results thereof. (Dept. Ex. 14)

13. This contemporaneous documentation was prepared, maintained and provided to OMIG auditors by the Appellant for each of the residents whose PRI's are at issue for toileting. (Dept. Ex. 14)

14. OMIG inspectors did not observe or interview aides providing the toileting services. (T. 87-88)

15. The aides that prepared and certified the toileting flow sheets were trained by the Appellant in conformity with DOH's PRI Manual and advisories issued by DOH prior to December 2006. (T. 89-91)

16. Appellant's aides were instructed to fill out the flow sheets with the time of toileting entered. The flow sheets were filled out as closely as possible to the actual provision of the service. (T. 163-168)

17. Pursuant to a DOH “Dear Administrator Letter” dated December 29, 2005, the provision of the care must be documented as performed within fifteen minutes of the care plan time. (App. Ex. A)

18. The PRIs under review in this audit were prepared and signed in conformity with DOH’s PRI Manual and the DOH letter of December 29, 2005. (T. 164)

19. No evidence of record establishes that the times noted by aides were not the specific times that the services were actually rendered or that the documentation policy of the Appellant was contrary to DOH regulations, the PRI Manual, or other DOH regulatory interpretations. (T. 32-105)

20. At least through the date of review of the June 2006 PRI submissions, DOH, through its contractor IPRO, conducted all PRI reviews. (T. 62-64)

21. The June 2006 PRIs were reviewed as part of a “full house” assessments “on-site” review by IPRO (Island Peer Review Organization). (T. 148)

22. The flow sheets regarding scheduled toileting have been used by the Appellant since 2001, and were reviewed by IPRO during the June 2006 PRI review as well as previous reviews. (2003, 2005, and 2006, T. 150)

23. IPRO did not revise, adjust or negatively comment on the flow sheets, or otherwise adjust level 5 toileting in these audits. (T. 152)

24. All IPRO findings were sent to DOH for incorporation into the reimbursement rate, as per 10 NYCRR § 86-2.30. (T. 65-67)

25. DOH is, pursuant to PHL § 2808(2-b)(b)(ii) and 10 NYCRR § 86-2.30, authorized to review and adjust facility case mixes and PRI based RUGs categories for residents based upon IPRO "on-site" audits or "in-house" reviews." (T.40, 72)

ISSUES

There were four questions presented for resolution in this case, namely:

I. Did OMIG have the statutory authority to conduct the instant audit?

II. Did OMIG follow the audit methodology and procedure set forth in the regulations?

III. Even if OMIG is authorized by law to conduct a review of the Appellant's PRI submissions, is the instant audit foreclosed as a result of the prior (2003, 2005, and 2006) DOH reviews of the PRI submissions?

IV. Must the OMIG findings be reversed as arbitrary, capricious and in violation of the regulatory interpretation in effect at the time the PRIs in question were prepared and submitted by the Appellant to DOH?

ISSUE I

Does OMIG have the Statutory Authority to Conduct this Audit of PRIs?

The first issue in this case involves the threshold question of the statutory authority of OMIG to conduct audits such as the one that occasioned the present proceeding. The attorney for the Appellant, Mr. Darling, has argued that OMIG has acted in an illegal, arbitrary and capricious manner in conducting the audits at the basis of this case. It is the position of the Appellant that it is DOH, rather than OMIG, that should have conducted the audits in this matter. I disagree.

To support his contention, Mr. Darling cited the authority of *In Matter of New York State Health Facilities Assn., Inc. v. Sheeh*an. 100 A.D.3d 1086 [3rd Dept. 2012]). In that case, the Appellate Division held that claims regarding OMIG's failure to follow regulatory mandated audit policies and procedures "…must be raised in a CPLR article 78 proceeding following a final agency determination" (*id*. at 1088).

A review of the legal authorities submitted by both sides on this point shows that PHL § 32 authorizes OMIG to conduct a multitude of audits and reviews relating to Medicaid reimbursement. However, there is no specific grant of authority to OMIG to calculate or set rates under the Medical Assistance Program (Medicaid). Under the Public Health Law, authority is vested only in DOH as the "single state agency" for federal Medicaid reimbursement purposes under PHL §§ 201(v) and as the "rate setter" pursuant to PHL §§2807 and 2808. As the "single state agency," DOH is responsible for

preparation of the State Medicaid plan, which, subject to federal approval, establishes methods and amounts of provider reimbursement (42 U.S.C. § 1396[a]).

For some time prior to the instant audit, DOH had conducted audits and reviews of PRIs with the assistance of contracted professional medical reviewers pursuant to its promulgated regulations.[1] Because the correct categorization of resident acuity is so closely connected with rate setting,[2] this reservation of authority, and the lack of delegation of authority to OMIG in the PHL § 32 has been deemed logical and consistent.

Supporting this conclusion is the fact that the DOH rate methodology for the reimbursement periods at issue is tied to statewide prices for RUGs categories. It was pointed out by the Appellant's attorney that DOH's performance of PRI audits is not only consistent with its rate-setting responsibilities, but is also consistent with its institutional expertise on clinical aspects of skilled nursing care and standards of care responsibilities for inpatient care (Social Services Law § 364[2][a]). Although the purpose of the PRI is to provide data to calculate a nursing facility's reimbursement rate, the data reported on the PRI is patient-specific clinical information. According to the Appellant, only registered nurses who are specially trained and certified to perform PRI assessments may complete a PRI form. Mr. Darling has pointed out that the PRI form and instructions are very detailed documents and these nurses are expected to be familiar with all such details.

Further, and following up on the above, the Appellant's attorney went on to argue in his brief that OMIG's expertise does not involve clinical knowledge of medical conditions

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[1] See 10 NYCRR § 86-2.30 and *Matter of Blossom View Nursing Home v Novello,* 4 N.Y.3d 581 (2005).

[2] See *Matter of Blossom View,* at 594 and PHL § 2808 [2-b]; 10 NYCRR § 86-2.10).

and treatments. Mr. Darling argued that the OMIG does not have authority over the clinical components of Medicaid rates. Rather, OMIG is responsible for auditing Medicaid "expenditures," (PHL §32[14]), and OMIG's powers and expertise are limited to financial issues with an emphasis on fraud and the prevention, detection, investigation, and prosecution of fraud.[3]

To summarize the Appellant's argument: it is DOH, not OMIG, which is the agency that should be conducting these audits. According to the Appellant, it is DOH that is mandated to audit the PRIs and then adjust the facility's reimbursement rates as and if warranted. According to Mr. Darling, to the extent that OMIG has conducted the instant audits without reliance upon the expertise of DOH to perform the clinical reviews, OMIG has acted in an arbitrary and capricious manner and without statutory authority. I disagree.

The attorney for OMIG, Mr. Shevy, responded to this argument by pointing out that this is a rehash of an old argument of the Appellant that has been rejected by the Appellant Division. It was noted in the OMIG's brief that an identical challenge by the New York State Health Facilities Association, Inc. ("NYSHFA") was heard by the Appellate Division, Third Department, in 2012. In that case, NYSHFA had petitioned Supreme Court, Albany County, seeking a writ of prohibition enjoining OMIG from conducting PRI audits, asserting that authority lies only with the Department of Health, as the single state agency designated to administer and supervise the State's Medicaid

[3] See generally PHL § 32; see also *Tze Chun Liao v New York State Banking Dep't*, 74 N.Y.2d 505, 510 [1989], stating that "[a)dministrative agencies…can act only to implement their charter as written" and cannot "empower themselves" to exercise powers that the Legislature has not granted.

program. Ancillary arguments were raised as to OMIG's PRI audit methodology, insofar as it differed from that which the Department, through IPRO, employed. Supreme Court (McDonough, A.J.) rejected these contentions and dismissed the petition in its entirety, whereupon NYSHFA appealed.

This matter was then heard by the Appellate Division, Third Department, and by Decision and Order, dated November 1, 2012, the Third Department affirmed the dismissal, stating,

> The statute creating OMIG . . . expressly acknowledged the "single state agency" requirement and, therefore, "created [OMIG] *within the Department*." *Citing* PHL §31(1) (emphasis the Court's). The statute further provides that OMIG is the office of the Department that is to "be responsible for the Department's duties as the single state agency with respect to" Medicaid fraud and abuse, and recovery of improperly expended Medicaid funds, "includ(ing) but not … limited to (the) medical assistance program audit functions" of the Department that were transferred from the former Department of Social Services. *Citing* PHL §31(1) *and* Blossom View Nursing Home, *supra*, at 591-592. New York State Health Facilities Association, Inc. v. Sheehan 100 A.D.3d 1086, 1087 (Third Dept., 2012).

It is also noted that as to NYSHFA's contention that only the Department has been given express statutory authorization to audit PRIs – i.e., "patient classifications" – in connection with rate-setting,[4] the Court ruled:

> . . . PRIs significantly influence a facility's Medicaid reimbursement rate. Inasmuch as PRIs are therefore directly related to reimbursement rates and implicate the expenditure of medical assistance program funds, [NYSHFA] has not established the clear legal right to relief required for a writ of prohibition preventing OMIG from auditing PRIs. *Id.* at 1088.

[4] *See* PHL §2808(2-b)(b)(ii).

Having decided that the audit of PRIs was within OMIG's purview and that OMIG had not violated or misapplied its enabling statute, the Court declined to address NYSHFA's arguments as they pertain to OMIG's audit methodology, reasoning:

> . . . [NYSHFA's] arguments amount to claims that OMIG acted arbitrarily and capriciously in disregarding regulatory requirements, or that OMIG's interpretation of the Public Health Law as providing that it is not bound by the Department's regulations regarding the methodology of auditing PRIs is affected by an error of law. Inasmuch as such claims must be raised in a CPLR Article 78 proceeding following a final agency determination, Supreme Court properly dismissed the petition. *Id.* at 1088-1089.

In the Appellant's December 18, 2013 response to the Revised Draft Audit Report, though it acknowledged the Third Department's holding that OMIG is authorized to conduct PRI audits, the Appellant nevertheless repeated the entirety of its argument as to why OMIG should be deemed without such authority. (Dept. Ex. 14 at 2-3) It is clear that the Third Department's decision in New York State Health Facilities Association, Inc. is controlling on this issue. Accordingly, as to the first issue, I conclude that the OMIG does have the authority to conduct the audits in this case.

On review of the legal arguments submitted by both sides, I find that the attempt to disqualify the OMIG in this matter is without legal justification. As the courts have ruled, OMIG is **within** the Department of Health and, as such, is authorized to conduct the audits of PRIs that are the substance of this case.

ISSUE II

Did OMIG Follow Mandated Regulatory Audit Methodology?

The second issue in this case questions whether OMIG properly followed the mandated audit methodology. In particular, the Appellant has contended that the PRI Manual has set forth specific audit steps that should be taken in a particular order, with the facility audited to be afforded specific contest rights as a part of the process. The Appellant's attorney has pointed out in his brief that the Court of Appeals, in *Blossom View Nursing Home v. Novello*, examined at length and with approval the processes and protocols adopted by DOH for these types of reviews. (4 N.Y.3d 581, 584 [2005]).

Attorney Darling has maintained that OMIG has failed to follow the clear mandates of the DOH audit protocols governing the audit of PRI submissions. However, it must be noted that OMIG is not required by law or regulation to conduct its audit in accordance with Department/IPRO PRI audit protocols. The OMIG attorney has argued, correctly, that the OMIG is bound by the New York State Regulations pertaining to the conduct of PRI audits, which contain far less direction in terms of audit methodology than the protocols under which IPRO conducted its PRI audits.[5]

A review of the regulations germane to this case shows that 10 NYCRR 86-230(e) does not mandate that PRI audits be conducted in "stages."[6] In point of fact,

[5] See 10 NYCRR 86-2.30(e).

[6] Supreme Court, Bronx County, in the Matter of Terrace Healthcare Center, Inc. v. Novello, quite clearly and succinctly described the "staged" audit process: "In the event of an audit finding a certain requisite percentage of inconsistencies in 'Stage I' of the audit, a broader sampling is then audited during 'Stage II'. If the second audit finds

10 NYCRR 86-2.30(e) merely requires that the Department monitor and review each facility's performance of its patient assessment function through analysis of patient case mix profiles and statistical data. The regulation goes on to direct that the Department review information provided by the facility and conduct on-site inspections. In addition, the Department is to review the PRI forms and any underlying books, records and/or documentation. Finally, the regulation calls for on-site observations and/or interviews of patients and their medical records.

On review of this regulation, I find that the fact that the Audit was not conducted in stages is not a violation of law or regulation. The failure to conduct a "staged" review does not constitute a failure on the part of OMIG to adhere to established protocols. In the conduct of its PRI audits, OMIG is not obliged to follow Department of Health or IPRO protocols. This is because when the Department requested that OMIG undertake the conduct of PRI audits, OMIG-specific audit protocols were designed, approved by the Department, and implemented. (T. at 37)

At the hearing in this case there was testimony on this point as follows:

> "Mr. Shevy: And did there come a time when OMIG began conducting PRI Audits?
>
> Ms. Quackenbush: Yes. It was toward the end of the IPRO contract. [The Department] had contacted us to see if we would be interested in doing the

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a certain percentage of inconsistencies (meaning that it moves patients out of the categories given in the PRI, usually because of insufficient backup documentation), then a 'Stage III' audit is conducted. This last audit generally involves all the patients. At each stage, the nursing home is able to defend its categorization and backup documents, and, as each further audit stage begins, the nursing home can reargue the results found in the earlier audit stage. If enough inconsistencies are found in the Stage III audit, the nursing home can be required to stop using its own personnel to prepare the future PRIs. In such case, the nursing home may be required to use preparers from an outside (private) agency approved by the government." Terrace Healthcare Center, Inc. v. Novello, 31 Misc. 3d 1201 (Sup. Ct., Bronx Co., 2006).

> PRI audits. They had about seven or eight facilities that needed to [be] finish[ed] up for that particular fiscal year. And at that point we worked with [the Department] to develop audit protocols and plans to do an audit. We had the IPRO tools. We had all their clarification sheets. And, in discussion with [the Department], it was felt that our audit would not necessarily be a staged audit but would rather follow the protocols that OMIG had in place for audits." (T. at 37-38)

It is well-settled law that an agency's failure to follow its own procedures or rules in rendering a decision is arbitrary and capricious.[7] This, though, is not what has happened in this case. By asserting that OMIG was bound by Department/IPRO protocols, the Appellant is arguing that the protocols developed by OMIG and the Department are a nullity – that the Department lacked all exercisable authority and discretion to determine how OMIG – which had never conducted a PRI audit to this point – would conduct its PRI audits. This argument is not persuasive.

On review of the record in this case, it is clear that the regulations as pertaining to PRIs, the Department's PRI Audit Instructions and Clarification Sheets remained the governing authority and remained the standard to which the facilities were held. A new auditing entity was engaged – an auditing entity which had conducted many provider audits under the "entrance conference; record review; exit conference; draft audit report; provider response; final audit report" framework.[8] I agree with Mr. Shevy in observing that if efficiency, effectiveness and accuracy are at all worthy pursuits, the Department's

[7] *See Gilman v. New York State Division of Housing and Community Renewal,* 99 N.Y.2d 144 (2002); *see also Frick v. Bahou*, 56 N.Y.2d 777 (1983).
[8] *See* 18 NYCRR 517.

determination that the standard OMIG audit methodology would be the most efficient, effective, and accurate means of ensuring provider compliance, must be held a perfectly reasonable and proper exercise of discretion. I find that OMIGs actions in this regard are by no means arbitrary or capricious.

Therefore, the record in this case shows that the OMIG PRI audit protocols were properly implemented and consistent with law and regulation. Furthermore, the OMIG's conduct of the Audit in this case was in accordance with these protocols and resulted in no manifest unfairness to the Appellant. Thus, I find that the Appellant's contentions in this regard are without merit. Accordingly, I conclude that the OMIG followed the audit methodology and procedure laid out in the applicable regulations.

ISSUE III

Even if OMIG is authorized by law to conduct a review of the Appellant's PRI submissions, is the instant audit foreclosed as a result of the prior DOH audit of the PRI submissions?

It is well settled law that the OMIG must follow its own departmental regulations. In fact, OMIG has stated in the final audit report that it conducted its review in accordance with Part 517 of Title 18 NYCRR. (Dept. Ex. 15) The Appellant has argued that, pursuant to Part 517, this audit must now be reversed and dismissed. I find that the facts in this case simply do not support the Appellant's argument.

The pertinent regulation reads as follows at 18 NYCRR § 517.3(h):

> “(h) In its discretion, the department may terminate an audit at any time in the audit process. The provider shall be notified in writing of such termination. This written notification shall serve in the place of a closing conference, draft audit report or final audit report, as appropriate. If an audit is terminated, the department is precluded from recommencing an audit of those items which were the subject of the terminated audit.”

It is the position of the Appellant that the very PRIs that OMIG has attempted to audit in this case were, in fact, subject previously to review by DOH, and that that review, terminated in the manner prescribed by the above regulation should now, therefore, be foreclosed from a re-audit. I disagree. I note that it is the position of the OMIG that there was no termination of an audit in this case. I find that to be a correct interpretation of what transpired.

To support its contention, the Appellant has pointed out that the Court of Appeals in the *Blossom View Nursing Home* case noted that Medicaid rate reimbursement principles applicable to fiscal audits may also be applicable to PRI reviews. Specifically germane to the instant review is the principle that “Rates are provisional until reports are audited or the time within which to conduct an audit has expired” (*supra*. at 586, n. 10; emphasis added). However, under the Court’s holding in the *Matter of Concord Nursing Home v. Axelrod* (66 N.Y.2d 169 [1985]), and OMIGs reliance upon Part 517, the audit of PRIs is no different than a cost report in the context of whether they may be subject to multiple audits for purposes of rate finality.

The Appellant has argued that, in this case, DOH/IPRO had previously conducted an "audit" of the December 2006 "full house" assessment and determined that no adjustments were warranted.[9]

However, an "on-site" review is not the sole method of conducting an "audit." Rather, DOH, including its OMIG office, may conduct reviews of claims and cost reports "in-house", also known as "desk reviews". This situation is addressed by 10 NYCRR § 517.2 (b) as follows:

> "(b) Draft audit report and final audit report refer to the formal audit reports produced by the department after an on-site review of a provider's records and denominated as such on their face, as well as to those notices sent to providers advising them of overpayments detected through <u>in-house claims reviews or other post-payment reviews</u> (emphasis added) of a provider's claims."

It should be noted that an "on-site" audit is but one of three methods that DOH may employ, but it is not a mandatory tool. Clearly, an "in-house" review of a provider's reported patient case-mix for a given PRI submission period, and comparative statistical analysis of trends regarding past or current submissions for significant deviation is a legitimate, authorized and fully valid "audit" methodology under PHL § 2808(2-b)(b)(ii). While conducted as an "in-house" review of the case-mix index, it is directly tied to, and reflective of, PRI submissions of the facility. This type of review is indistinguishable, according to the Appellant's argument, from an "on-site" review for purposes of constituting an audit for purposes of 18 NYCRR Part 517. Therefore, the Appellant argues, DOH has

[9] Dept. Ex. 11, Exhibit E to Response to Original Draft Audit Report, February 1, 2007 letter from DOH.

conducted an audit of the PRI submissions for purposes of rate finality in this case.[10] I find that this argument of the Appellant is not persuasive.

The Appellant's contention is that the DOH letter to the Appellant advising them of the Department's determination that no further review or adjustment was required constitutes the termination of an audit within the meaning of 18 NYCRR § 517.3, and that "the department [including OMIG] is precluded from recommencing an audit of those items which were the subject of the terminated audit." Further bolstering this position, the Appellant contends that the DOH termination letter was not issued in a vacuum. At the hearing, the Appellant presented the following series of communications from DOH to demonstrate[11] that the Appellant had experienced only minimal changes to its submitted PRIs as a result of previous IPRO/DOH reviews:

- December 2003 "Full House" Assessment – Stage 1 review passed. Only one change of 40 cases reviewed (PT level of care).
- December 2005 "Full House" Assessment – No review deemed necessary by DOH based upon in-house review of PRI submissions.
- June 2006 – "Full House" Assessment – Stage 1 review passed. Only two PRI changes: one case as to transfers and toileting and one case as to terminal illness designation.
- December 2006 "Full House" Assessment – No review deemed necessary by DOH based upon in-house review of PRI submissions.

According to the Appellant's argument, DOH took into consideration this prior review history in determining to exercise its judgment to terminate the December 2006 PRI review, and finalize the rates in regard to the case-mix index. Attorney Darling has

[10] See 10 NYCRR §§517.2 & 517.3.
[11] See Dept. Ex. 11, Exhibit E to Response to Original Draft Audit Report.

argued that DOH made a judgmental determination that Appellant's December 2006 full-house assessment case-mix index was acceptable, and would not be subject to further review. According to the Appellant, DOH made this judgment based upon its own criteria and expertise as to what case mix index would be reviewable for each facility based upon consideration of past reviews and past PRI submittals.

The Appellant's contention is that since it was already subjected to a 2006 full-house assessment of its PRIs by DOH it should not now be subjected to a second audit conducted by OMIG. The facts in this case do not support the Appellant's contention and I conclude that the Appellant is not, in fact, being made subject to a second audit on the same matter all over again as the 2006 matter was not, after all, an audit, *per se*.

Another point raised by the Appellant is that of timeliness. The Appellant contends that OMIG should now be deemed time-barred from conducting this audit. The OMIG, in its brief, rejected this argument of the Appellant and pointed out that the Appellant offered no testimony at hearing as to how the timing of the Audit negatively impacted its ability to support its RUG-II classifications during the present Audit process. On review of the record, I find that the audit was conducted in a timely fashion. Accordingly, it cannot now be deemed time-barred.

As for timeliness, the regulations at 18 NYCRR 517.3(a) (1) provide:

> [a]all fiscal and statistical records and reports … used for the purpose of establishing rates … and all underlying books, records, documentation and reports which formed the basis for such fiscal and statistical records and reports are subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports filed by a provider with any State agency responsible for the establishment of rates of payment or fees must be kept and maintained by the provider for

> a period of not less than six years from the date of filing of such reports, or the date upon which the fiscal and statistical records were required to be filed, or two years from the end of the last calendar year during any part of which a provider's rate or fee was based on the fiscal and statistical reports, whichever is later. […] Any rate of payment certified or established … will be construed to represent a provisional rate until an audit is performed and completed, or the period within which to conduct an audit has expired without such audit having been begun or notice of such having been issued, at which time such rate or adjusted rate will be construed to represent the final rate as to those items audited. 18 NYCRR 517.3(a)(1).

In addition regulation 18 NYCRR 517.3(a)(2) specifies that,

> [a]ll required fiscal and statistical reports are subject to audit for a period of six years from the date of their filing or from the date when such reports were required to be filed, whichever is later. 18 NYCRR 517.3(a)(2).

As for the Appellant's estoppel argument, the OMIG attorney has correctly observed that in the matter of *Blossom View Nursing Home v. Novello,*[12] the petitioner nursing home sought to estop the Department from auditing its 1994 PRIs in August, 2002 on timeliness grounds. While 10 NYCRR 86-230(e)(3), which governs PRI audits, requires only that PRI audits be conducted "timely," without establishing an outside time limitation, the facility advocated the establishment of a bright-line rule that, on the basis of 18 NYCRR 517.3(a)(2), which governs audits of cost reports, the Department may never audit PRIs more than six years after they are filed.[13] The Court of Appeals, in declining to establish such a rule, noted that PRIs are not "fiscal and statistical records and reports." Nor are PRIs the "underlying books, records and documentation which form the basis for fiscal and statistical reports." *Id.* at 594. Accordingly, notwithstanding

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[12] 4 NY 3d 581 (2005)
[13] *Blossom View Nursing Home, supra* at 584

that PRIs significantly influence a facility's Medicaid reimbursement rate, and that 10 NYCRR 415.22(b) requires a nursing home resident's clinical records be retained for six years from the date of discharge or death, the Court concluded that it "does not follow that the Department must audit PRIs within six years of filing." *Id.*

Despite failing in its efforts to establish a six-year statute of limitations on PRI audits, the facility nevertheless prevailed. The Court reasoned, "[i]n this case, [the Department] sought to audit [the facility's] January 1994 PRIs more than [eight and one-half] years after they were filed solely because [the Department] neglected to wrap up its Stage II audit of [the facility's] July 1993 PRIs [which began in 1994] until 2002, and PRI audits take place sequentially.[14]"

In another matter, *Terrace Healthcare Center, Inc. v. Novello*[15], the Appellate Division, First Department, held timely five audits of a provider's PRIs conducted between six and seven years after submission. The Court deemed the facility's reliance upon *Blossom View* "misplaced" as no such dilatory conduct on the part of the agency was identified.[16] The record herein shows that OMIG's audit of the Appellant's December, 2006 PRIs was noticed in January, 2011, just over four years after their submission, and well within the six-year clinical record retention period.[17] The Appellant has neither alleged nor identified any unreasonable conduct by OMIG, nor has the Appellant identified a single manner in which it has been prejudiced by the timing of the

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[14] *Id.* at 595.
[15] *Terrace Healthcare Center, Inc. v. Novello,* 54 A.D.3d 643 (First Dept., 2008).
[16] *Id.* at 643-644.
[17] *See* Agency Exhibit "1"; 10 NYCRR 415.22(b).

Audit. Based on the foregoing law and regulations and because the Appellant can cite no authority on which its claim of untimeliness is sustainable, I conclude that the Audit was timely in all respects.

The Appellant has also argued that it has "[b]een subject to PRI reviews before, […] but none of these prior reviews has resulted in adjustments to its reported PRI case mix indices to the extent that the current audit purports to find, particularly in the area of toileting" From there, the Appellant postulates, "[a]s there has been no significant change in the documentation maintained by the facility and the published criteria relied upon by both IPRO and [the Appellant] to prepare/review the PRIs, the only conclusion that may be reached is that OMIG is changing the criteria for review."[18] This conclusion, however, is unsupported by fact or logic.

The Court of Appeals has "repeatedly made clear that estoppel cannot be raised against a governmental agency to prevent it from discharging its statutory duties," as, "to permit estoppel against the government could easily result in large scale public fraud.[19]" While the Court has not "absolutely precluded the possibility of estoppel against a governmental agency," its decisions have "made clear that it is foreclosed in all but the rarest cases." *Id.* The Appellate Division, Third Department's decision in *Bilow v. Daines*[20] tells us that this is certainly not the rarest of cases and that estoppel is unavailable to Medicaid providers under the circumstances complained of by the Appellant.

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[18] Dept. Ex. 14 at 7-8.
[19] See New York State Medical Transporters Association, Inc. v. Perales, 77 N.Y.2d 126, 130 (1990).
[20] 77 A.D.3d 1249 (Third Dept., 2010)

In *Bilow,* the provider erroneously, and concededly, double-billed Medicaid for certain pre-natal testing services[21]. Audits by the Department revealed this double-billing, however, for reasons unstated in the decision, the Department did not seek to recover overpayments. *Id.* A subsequent audit was conducted, whereupon, once again, similar double-billing was identified. In this instance, however, the Department pursued reimbursement. *Id.* The provider argued that the overpayments at issue must be forgiven on grounds that the Department failed to seek repayment in connection with the earlier audits. *Id.* The Court rejected the provider's argument, reasoning that it "amounts to nothing more than the assertion of estoppel, which cannot be invoked against a governmental agency to prevent it from discharging its duties." [22] The Court identified the Department's "duties" in this context as the Department's authority to "seek repayment from any person that has submitted or caused to be submitted claims for which payment should not have been made." [23]

While *Bilow* is obviously foursquare with the issues raised by the Appellant, similar instances of tribunals, including the Bureau of Adjudication, refusing to bind the State to the errors or oversights of its agents and employees, have been cited, persuasively, by the OMIG in its brief.[24]

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[21] Bilow, *supra* at 1250.
[22] *Id.*, *citing* Sunset Nursing Home v. DeBuono, 24 A.D.3d 927 (Third Dept., 2005).
[23] *Id.*, *citing* 18 NYCRR 518.1(b).
[24] *See* Press v. State of New York, 45 A.D.2d 397 (Third Dept., 1974); Mayflower Nursing Home v. Office of Health Systems Management of the Department of Health, 88 A.D.2d 192 (Third Dept., 1982); Sunset Nursing Home, *supra*; In the Matter of the Appeal of Hudson View Nursing Home, New York State Department of Social Services, Hearing No. 1735986R (Wiley, A.L.J., 1993); In the Matter of the Request of St. Barnabas Hospital, New York State Department of Health, Audit No. 09-4099 (Lepicier, A.L.J., 2014).

Accordingly, following the above decisions and the legal reasoning therein, I fully agree with the OMIG attorney that previous inaction by the Department should not now bind the OMIG or shield the Appellant from responsibility for overpayments that might otherwise be due and owing in the audit in this case. The Appellant has also contested the procedures followed by the OMIG and has asserted that "the OMIG audit findings should have been forwarded to the [Department] for proper review and potential implementation via the rate process." [25]

The record herein shows that OMIG has issued three audit reports in connection with this Audit – a Draft Audit Report, a Revised Draft Audit Report, and a Final Audit Report.[26] Prior to issuance of each Report, the Audit findings were forwarded to Mr. Adam Zawlinski, a management specialist at OMIG, who entered the proposed adjustments to the rate computation sheet system so as to determine how, if at all, the Appellant's reimbursement rate would change based on the Audit findings. (T. at 137-139.) The "from" rate computation sheets, as modified based on the Audit findings, were thereupon forwarded to the Department for review and preparation of the new or "to" rate computation sheets, which were then sent to OMIG. (T. at 143) The figures reflected in the "to" rate computation sheets were then incorporated into the Audit Reports, providing the basis for the asserted overpayment figures contained therein.[27]

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[25] Dept. Ex. 14 at 9.
[26] Note that these audits are addressed herein, collectively, as the "Audit Reports" and are set forth in Agency Exhibits "9", "12" and "15".
[27] Dept. Ex. 39, 40; T. at 45.

This matter was discussed in the testimony of Mr. Zawlinski,

> Mr. Darling: "The *to* rates that are calculated … did you actually calculate those or do you … do an estimation of them and then send them to [the Department] or do you do them and send them to Budget yourself?"
>
> Mr. Zawlinski: "No. I input the data and then basically [the Department] send[s] us the new rate sheets." [T. at 142-143]

Contrary to the assertions of the Appellant, the record in this case shows that OMIG did not endeavor to independently calculate the Appellant's revised reimbursement rates. The findings were supplied to the Department and the Department then calculated the rates in accordance with all lawful and regulatory processes. The Appellant has also argued that there exists in this case a prejudicial lack of specificity in the Audit Reports, rendering a "proper response . . . difficult, if not impossible." [28] However, I find that the Audit Reports comply in every respect with the regulatory requirements, and the Appellant's claims of prejudice are not supported by the record and testimony in this case.

18 NYCRR 517, which governs provider audits, requires, among other things, that draft and final audit reports advise the provider of the basis of the action proposed therein, as well as the legal authority therefor.[29] Taking, for example, the Revised Draft Audit Report findings as pertaining to toileting, we see that OMIG identified 87 samples which contained toileting classification errors – two at level 3 and 85 at level 5. These 87 samples were individually identified by sample number. Where a claim of level 3

[28] Dept. Ex. 14 at 10.
[29] See 18 NYCRR 517.5, 517.6.

toileting was disallowed, the PRI instructions and clarifications pertaining to level 3 toileting deviated from were cited in pertinent part. The OMIG's stated basis for all disallowances was insufficiency of documentation.[30]

As such, the requirements of 18 NYCRR 517 were, without question, satisfied. Insofar as the Appellant would require OMIG to prepare its audit reports in the manner of briefs of legal argument, this is neither practical nor required under the regulations. Moreover, issuance of a draft audit report is not the first time a provider is advised as to the bases for disallowances. Preliminary findings – and their bases – are, without exception, the subject of the exit conference conducted prior to issuance of a draft report.[31]

The Appellant has also contended that its December 2006 PRIs were subjected to duplicative audits and the audit in question should therefore be foreclosed. According to the Appellant, DOH/IPRO had previously conducted an "audit" of the December 2006 "full house" assessment (see Exhibit E to Original Response – February 1, 2007 letter from DOH). It was contended by the Appellant that this audit was conducted as a "desk review" of the CMI (Case Mix Index) submissions, but nonetheless constituted an audit of the PRI submissions for purposes of rate finality.[32] The record herein clearly establishes that Meadowbrook was duly notified that its CMI

[30] Dept. Ex. 12 at Attachment D.
[31] *See* 18 NYCRR 517.4(h)
[32] 18 NYCRR 517.2 & 517.3.

was considered, after desk review, to be acceptable within DOH review criteria and therefore final.[33]

However, the Department has pointed out that the February 1, 2007 letter from Mr. Loftus does not indicate that an audit was performed and the actual letter reads as follows:

> "Dear Administrator:
>
> Based on the PRI data submission for your full patient assessment, your facility has not been selected for an on-site review. A new Medicaid rate will be calculated based on the PRI data submitted by your facility and the rate will be sent to the Division of Budget for approval. Once the rate is approved, a schedule will be sent to the Office of Medicaid Management and your facility will be notified of the new rate. This rate is retroactive to the first month in which your assessment was performed.
>
> Enclosed for your information is the controverted item summary, which details the specific RUG-II category for each patient. Since you were not selected for audit, there should not be any entries under the controverted item side of the page.
>
> If you have any questions, please contact the PRI Unit at (518) 486-1371."
>
> Sincerely,
>
> /s/ Robert Loftus
>
> Robert Loftus

For clarity, the terms "full house assessment" or "full patient assessment" refer to the Appellant's assessment of its residents in connection with the preparation of its December, 2006 PRIs – not an audit or review of these submissions conducted by

[33] Dept. Ex. 14 at 11.

IPRO, the Department, or OMIG. The letter plainly and simply states that the Department was prepared to accept as true and correct the Appellant's December, 2006 PRI submissions and to calculate its Medicaid rate thereupon. To say that the Department's conduct as described above was based upon an "audit" or "desk review" constitutes a clear mischaracterization. To say that the Appellant was advised that an "audit" or "desk review" of its PRIs was conducted and deemed "acceptable within DOH review criteria" is not borne out by the record. That the Department decided to calculate the Appellant's reimbursement rate "based on [the Appellant's] PRI data submission" does not compel the conclusion that an audit or desk review was conducted. I find that above cited letter was crystal clear on this subject. It is stated in no uncertain terms, "…your facility has **not** been selected for on-site review […] you were **not** selected for audit…" [Emphasis added}

The OMIG attorney has correctly observed that whatever the nature of the audit the Appellant claims to have been conducted, be it a review of cost reports or the clinical underpinnings of its RUG-II categorizations, it could not have been conducted on PRI submissions alone, without any other documentation whatsoever. Both fiscal and PRI audits require examination of "[a]ll underlying books, records and documentation which formed the basis" for the submissions. *See* 10 NYCRR 86-2.7; 86-2.30(e)(3). Furthermore, 18 NYCRR 517.2 and 517.3, as cited by the Appellant, certainly do not stand for the proposition that the Department's stated intention to accept a provider's PRI submissions at face value constitutes an audit of such submissions.

Accordingly, in conclusion, I find that, as for Issue III, the OMIG is not foreclosed or estopped in this matter based on its review of prior PRI submissions, which do not constitute an "audit" for the purpose of the statute in question.

ISSUE IV

Must OMIG PRI Adjustments for toileting be reversed as Arbitrary, Capricious and in violation of the Regulatory and DOH Regulatory Interpretation in effect at the time of PRI Submission?

OMIG's audit, as stated in its final audit report, alleged that the Appellant's categorization of the sampled residents in contest was incorrect. The specific basis for lowering each resident's RUG category was that a recalculation of the ADL score based upon a lack of documentation of the provision of scheduled toileting for incontinent residents was required.[34] I find that these audit findings must be reversed as they are a product of both errors of law and fact.

As testified by Ms. Quackenbush, the OMIG's down-scoring of the toileting ADL score for incontinent residents on a toileting schedule is solely because the clinical documentation of the provision of the service does not disclose the "specific time" that the Appellant's aides provided the service (T. 91). The result is that the numerical PRI score for these residents who received the service is lowered and they are placed in a RUG category which does not reflect the provision of the service or the cost related thereto.

[34] Dept. Ex. 15.

The Appellant's attorney, Mr. Darling, has correctly observed in his brief that this placement in a lower level category of acuity/need is not based upon the fact that the resident either did not need or did not receive the service of scheduled toileting. At the hearing the OMIG conceded that it is not contesting that the toileting was not needed, was not done and performed, or that it was not performed according to a toileting schedule in conformity with the regulatory timing requirements. There was no dispute about the fact that the toileting in question was properly ordered and set forth within the residents' care plans. (T. 21-22). The down-scoring is based only on a perceived failure to document the *exact* time each resident was toileted. I find that the down-scoring in this case was not based on dispositive evidence that was presented at the hearing.

Mr. Darling has pointed out in his brief that there is simply no regulatory requirement for the level of documentation that OMIG is demanding for toileting. As noted above, DOH has promulgated a regulation at 10 NYCRR § 86-2.30 regarding the PRIs to be submitted by facilities for Medicaid reimbursement purposes. This regulation, as previously discussed, establishes audit protocols for the review of PRIs and the calculation of the CMI or case-mix index.

However, this regulation also specifically provides for the documentation required to substantiate the PRI submission. At 10 NYCRR §86-2.30(i), the regulation provides the general documentation requirements necessary to support the PRI information:

> "DOCUMENTATION - Some of the questions require specific medical record documentation to be present. Otherwise, the question cannot be answered yes for the patient."

"

On the PRI form and in the instructions set forth in the regulation, there are specific data elements that must be completed, as well as specific frequency and qualifiers which must be met for many of the items of care or services that are to be reported. Specific as to toileting (at §86-2.30[i], form section 22), the regulation provides that only the following requirements be met for the incontinent resident receiving toileting to be appropriately classified at level 5:

> “Definition - INCONTINENT - 60% or more of the time the patient loses control of his/her bladder or bowel functions, with or without equipment.
>
> #5 "Incontinent... Taken to a Bathroom..." refers to a patient who is on a formal toileting schedule, <u>as documented in the medical record</u>. This patient may be on a formal bowel and bladder rehabilitation program to regain or maintain control, or the toileting pattern is known and it is better psychologically and physically for the patient to be taken to the toilet (for example, to prevent decubiti).”
>
> A patient may have different levels of toileting capacity for bowel and bladder function. To determine the level of such a patient, note that level four and five refer to incontinence of either bladder or bowel. Thus if a patient receives the type of care described in one of these levels for either type of incontinence, enter that level.”

The only documentation specifically mandated under the regulation is evidence that the resident “ be on a formal toileting schedule as documented in the medical record.” OMIG has not contested that this requirement has been met and thus I find that the adjustments in this case must be reversed.

The Appellant’s attorney has also correctly noted in his brief that there are other “qualifiers” for level 5 toileting categorization which DOH has issued to supplement, or interpret, the regulations. DOH has provided these qualifiers in its “Clarifications”, set out

in the PRI Manual.[35] As the agency promulgating 10 NYCRR §86-2.30, these "Clarifications" represent the DOH interpretation of its regulations. These "Clarifications" provide an interpretation of the qualifiers necessary to meet the level 5 toileting standard, and, by implication, the documentation that would be necessary to establish that the standard has been met.

Attorney Darling has noted that the pertinent "Clarifications" provided in the PRI Manual, which can be said to represent the DOH "interpretation" of the regulation, state as follows:

> "22. TOILETING:
>
> Q) What is meant by the 60 percent rule? ;
>
> A) There are actually two 60 percent rules that apply to toileting. As with other ADL questions, assess how the resident completed the task 60 percent of the time. Additionally, the incontinent resident is defined as one who loses control of his/her bladder or bowel functions (with or without equipment) 60 percent or more of the time. Equally, the continent resident is one who has control of his/her 'bladder and bowel functions 60 percent or more of the time. This continence may be achieved through the use of equipment, such as catheter.' Keep in mind that for levels 1 and 2, this second 60 percent rule is irrelevant because it is immaterial for PRI classification purposes whether the resident is continent or incontinent. For level 3 the resident must be continent by the 60 percent rule, while for levels 4 and 5 the resident must be incontinent by the 60 percent rule.
>
> "Q) What kinds of residents are included at level 5 and what are the associated care planning requirements?
>
> A) Level 5 requires that the resident is incontinent presently and is on a scheduled toileting program. If the resident appears continent only because he/she is on this formal toileting schedule, then this is applicable for level 5. The resident's care plan must establish a toileting assistance program that is based on an assessment of resident needs. The

[35] See Dept. Ex. 11, Exhibit C to Response to Original Draft Audit Report, Parts 2 & 3.

> assessment should establish the needs of the resident which led to the development of the program. The program documented in the care plan must constitute more than taking the resident to the bathroom after meals. The goal of this program may be for restoration or maintenance; refer to the PRI Instructions for examples. The plan must establish either specific times or time intervals for toileting assistance to be provided. In no instance can the plan establish a toileting assistance schedule with any less frequency than every 2-4 hours during the day. The toileting intervals may vary during the day; for example, the resident may be toileted at two-hour intervals during the morning and at four-hour intervals during the afternoon and evening. The plan may provide for use of a bed pan at night as needed. The care plan document is separate and apart from the document used to record when toileting occurs and who provides toileting assistance." (Dept. Ex. 11, Exhibit E to Response to Original Draft Audit Report, Part 2, "Clarifications" rev. 5/99, pages 11-13 of 36)

Specific to documentation of toileting, the "Clarifications" state:

> Q) What documentation-is needed at level 5 to adequately demonstrate that the resident has been toileted in conformance with the care plan?
>
> A) The facility MUST have a mechanism in place to substantiate that the resident is taken to the bathroom in conformance with the schedule established in the care plan. This mechanism for documentation could be in the form of a checklist or flow sheet. The name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance is provided. In instances where use of a bedpan is documented on the toileting record: this must be distinguished from taking the resident to the toilet. The document used to record when toileting occurs and who provides toileting assistance is separate and apart from the care plan. (Ibid.)"

As interpretations of the regulation, these "clarifications" must meet the test of reasonableness in order to be enforceable. In this regard, New York courts have held that the interpretation given to a regulation by the agency which promulgated it and is

responsible for its administration is entitled to deference if that interpretation is not irrational or unreasonable.[36]

It should be noted, moreover, that the OMIG is not contesting that the Appellant's documentation has failed to meet the documentation requirements found in the DOH interpretation except as to the documentation of the "specific time" of service provision, even though it concedes that its expectations in this regard are "unclear. " (T. 20, line 16) The OMIG auditors did not rely upon the DOH interpretations, but rather imposed a requirement that Appellant's staff record the *exact* time that the service was rendered in its records.

A review of the flowcharts that Appellant maintains in its clinical records shows documentation of both the time the service was performed and the initials of the aide staff performing the services.[37] As these schedules were uncontestably prepared and carried out pursuant to an appropriate plan of care, there is no failure of the documentation. I find that the OMIG has provided no evidence that the flowcharts were not individually prepared for each resident or that the time, as so indicated on the flowchart was not, in fact, the "specific time" that the service was rendered. There has been no allegation, or evidence presented, that the time certified to by the treating aide on the flowchart is inaccurate. All that remains are unproven suppositions that the times indicated are incorrect. (T. 87-88).

However, there is no basis for OMIG's suppositions. The flow sheets for the residents in question were not "cookie cutter" documents, reflecting the same time for all

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[36] See *New York State Association of Counties v. Axelro*d, 78 N.Y. 2d 158.
[37] See Dept. Ex. 14, Exhibit E to the Response to the Second Draft Report.

residents.[38] Different times for toileting are noted for residents, and even for the same resident, these times were shown to vary from day to day. (T. 159-160) The mere fact that the residents were toileted at awakening, after meals, and before bed time is probative of nothing more than that this is the time when residents would be expected to need to void, promoting and enforcing continence. (T. 159-160).

Furthermore, there is no evidence in this record that OMIG reviewers took the time to observe the operation of the Appellant or the level of staffing which would ensure timely toileting as noted. [redacted], the Appellant's Director of Nursing during both the assessment period of the PRIs in issue and DOH's prior PRI reviews (conducted by its contractor), credibly and persuasively testified at the hearing that the similarity of times of toileting were not unusual given the residents' needs (T. 159-160). She further testified that the times as reported and certified were well within the ability of the assigned aides to perform. (T. 160-162)

Therefore, even if, *arguendo*, the *exact* moment of service provision was required to be logged by the aides, there is no evidence in the record that they did not do so. I find the testimony of [redacted] to be pivotal for this case. Furthermore, the OMIG standard of the *exact* time represents a reinterpretation of the regulation that is both legally unsupportable and in direct conflict with DOH's prior interpretation of its own regulations.

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[38] See Dept. Ex. 14, Exhibit E to the Response to the Second Draft Report; T. 89-91.

Subsequent to the initial issuance of "Clarifications" in 1999 and 2001 interpreting its regulation, DOH issued further "clarifications" regarding toileting. In his letter of December 29, 2005, Mark Van Guysling stated the following:

> "The documentation required for toileting assistance for level five on the PRI has been an ongoing issue for providers. On April 20, 2001 the Department sent out a letter to all facility administrators that identified changes to the PRI Clarification Sheet related to the qualifiers for level five toileting. Page 13 of the PRI Clarification Sheet requires a mechanism be in place 'to substantiate that the resident is taken to bathroom in conformance with the schedule established in the care plan. The name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance that assistance is rendered. The Department has reviewed this documentation requirement and now further clarifies that the "specific time" must be within 15 minutes, before or after the toileting assistance was required by the care plan. This leeway does not negate the care planning requirement that toileting assistance cannot be provided with any less frequency than every two to four hours during the day." [39]

A fair and reasonable interpretation of this further clarification as used by DOH and its contract reviewers in prior PRI audits, and relied upon by the Appellant, is that "specific time" is within 15 minutes of the scheduled time and that by initialing the sheet, the aide is certifying that the service was rendered within that requirement. Curiously, prior to implementing its new, *exact* time standard for this audit, OMIG consulted with neither DOH nor IPRO [formerly *Island Professional Review Organization*]) prior to enforcing its own audit policy as to the adequacy of Appellant's clinical records on toileting (T. 67-68).

According to the testimony of [redacted] who is also certified as a PRI reviewer (T.

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[39] App. Ex. A.

147) the Appellant's staff was trained to record the provision of the toileting service as close to the time of the service rendition as possible. (T. 163-166)   All services were, to the best of her knowledge properly performed and recorded per the training. (T. 166-168) If they were not the *exact* moment of the provision of service, they were performed within the 15 minutes as per the DOH advisory (T. 163-166).

The Appellant's attorney has pointed out the weaknesses inherent in OMIG's re-interpretation of "specific time" to *exact* time. I agree with Mr. Darling on this point. Toileting, as defined in the PRI Manual, is not a single event. Rather it is a process. The Manual provides as follows:

> "Toileting: process of getting to and from a toilet (or use of other toileting equipment such as bedpan), transferring on and off toilet, cleansing self after elimination and adjusting clothes."[40]

OMIG has provided neither guidance nor instruction as to what time is the *exact* time that it expects to be recorded. In fact, Ms. Quackenbush refused to answer the question as to what time was appropriate to be entered into the record – when the aide entered the room, when the resident was lifted, when the resident voided, when the whole process was complete (T. 86-87).   I agree with the Appellant that this lack of clarity (T. 20) is the very reason that the OMIG imposed standard of *exact* time is arbitrary and capricious, and why it is incompatible with the prior review determinations of DOH.

[40] Dept. Ex 11, PRI Manual, Part 1, Contractor PRI Review form.

Furthermore, it is evident that such *exact* precision as OMIG is requiring is unnecessary or clinically probative (T. 177-181). It is also unreasonable given the work environment in a nursing facility and the workloads of individual aides working with a medically fragile resident population (T. 164-166).

Any discussion of toileting scheduling and documentation must take into account the difficult and demanding work environment of any acute nursing facility. In this case, the testimony of [redacted] (T. 141- 191) sets forth some of the difficulties encountered by the nursing home workers who are expected to document the services they provide. To begin with, [redacted] pointed out that over half of the facility's population of 207 suffer from dementia. (T. 158) In addition some 85 of the residents are on a scheduled toileting plan. (T. 155) [redacted] testified that the staff must feed these residents three meals a day and toilet them upon rising, before and after meals, and before they go to bed. The testimony of [redacted] about the documentation of these toileting services was not disputed by the Department. Of pivotal significance in this case is the fact that the OMIG investigators did not actually observe the toileting and thus were in no position to testify about the accuracy of the reporting.

A review of the documentary record herein shows that the past history of Appellant's PRI reviews by DOH and IPRO show that the flow sheets of Appellant acceptably met the then existing DOH guidelines and interpretations. As [redacted] credibly testified, these same flow sheets were reviewed in prior PRI audits done by IPRO and approved by DOH (T. 150-153; 165-166).

The DOH/IPRO audit results for prior reviews support [redacted]'s testimony:

- December 2003 “Full House” Assessment – Stage 1 reviewed passed. Only one change of 40 cases reviewed (PT level of care).
- December 2005 “Full House Assessment – No review deemed necessary by DOH based upon in-house review of PRI submissions.
- June 2006 – “Full House” Assessment – Stage 1 review passed. Only two PRI changes: one case as to transfers and toileting and one case as to terminal illness designation.
- December 2006 “Full House Assessment – No review deemed necessary by DOH based upon in-house review of PRI submissions. (Dept. Ex. 11, Exhibit E to Response to Original Draft Audit Report)

The Appellant’s attorney has correctly pointed out that OMIG’s re-interpretation of the documentation requirements is clearly a substantive change in prior DOH regulatory interpretation and policy. I find that the fact that prior PRI reviews found no fault with the level of documentation of toileting by Appellant is highly significant and clearly demonstrates the difference with the instant audit.

While an agency may be free to interpret its own regulations, it must do so within certain constraints. The Appellant’s attorney has rightly observed that, even assuming that such regulatory interpretation is permissible and reasonable, if the agency wishes to change that interpretation in a substantive way, and thereafter enforce the change to the detriment of auditees, it must do so upon fair notice to the affected parties. [41]

In New York, the Court of Appeals has held similarly on multiple occasions:

> "From the policy considerations embodied in administrative law, it follows that when an agency determines to alter its prior stated course it must set forth its reasons for doing so. Unless such an explanation is furnished, a reviewing

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[41] See, *Shell Offshore, Inc. v. Babbitt*, 238 F.3rd 622 [5th Cir. 2001]; see also, Alaska Professional Hunters Assn v. Federal Aviation Administration, 177 F.3rd 1030 [D.C.Cir. 1999]; *Gardebring v Jenkins*, 485 US 415, 430.

> court will be unable to determine whether the agency has changed its prior interpretation of the law for valid reasons, or has simply overlooked or ignored its prior decision …. Absent such an explanation, failure to conform to agency precedent will, therefore, require reversal on the law as arbitrary" (*Matter of Field Delivery Serv. v Roberts*, 66 NY2d 516, 520). [42]

As no prior notification of the change in interpretation standard was made, reversal of the adjustments is warranted in this case. A review of the testimony and documentary record in this case shows that the OMIG deemed the documentation of the Appellant as to toileting insufficient to support a level 5 reimbursement. The OMIG based this conclusion on the apparent consistency of the documentation of the toileting, at set hours of nine, eleven, one and three almost every day. It would appear that this is an approximation of the actual time, however, there was no proof at hearing that it was not the actual time and so it must stand as uncontroverted. It should be noted that this documentation does vary from day to day and is not merely a template copied from prior days. This lends credibility to the documentation prepared and submitted by the facility.

Accordingly, as to Issue IV, I find that the Appellant was correct and that the OMIG findings should be reversed as factually unsupported and arbitrary, capricious and in violation of State regulations.

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[42] See also, *Richardson v. Commissioner of N.Y. City Dep't of Social Services*, 88 N.Y.2d 35 [1996]

CONCLUSION

The evidence adduced at this hearing demonstrates that the Appellant did not meet its burden as required by 18 NYCRR Section 519.18 (d) on Issues I, II and III. The regulations provide that the Appellant must show by substantial evidence that the determinations of the OMIG were incorrect. As for Issue I, I find that the OMIG does have the authority to conduct the audit in this case. As for Issue II, I find that the OMIG did follow the audit methodology and procedure as set forth in the regulations. As for Issue III, I find that the audit in this case is not foreclosed by prior DOH reviews Of PRI submissions from the Appellant.

However, as to Issue IV, I find that the OMIG's determination to recover alleged Medicaid overpayments is reversed for the reasons set forth above.

DECISION

The Department's determination to recover Medicaid overpayments of $310.081.00 is reversed. Thus, no recovery should be had in this case. This decision is made by David A Lenihan, Administrative Law Judge, Bureau of Adjudication, who has been designated to make such decisions.

DATED:

June ________, 2015

Albany, New York

____

David Lenihan

Administrative Law Judge

Bureau of Adjudication