STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **Palm Gardens Center for Nursing and Rehabilitation,** Provider ID# 00309586, Appellant, from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.	**Decision After Hearing** Audit # 14-1139

Before: Ann H. Gayle
Administrative Law Judge

Held at: New York State Department of Health
Metropolitan Area Regional Office
90 Church Street[1]
New York, New York 10007

Hearing Dates: March 23 and June 15, 2017, and June 6, 2018
Record closed November 29, 2018

Parties: Office of the Medicaid Inspector General
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[1] *The hearing on June 15, 2017 was held at 217 Broadway, New York, New York 10007*

JURISDICTION

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

OMIG issued a final audit report for Palm Gardens Center for Nursing and Rehabilitation (Palm Gardens or Appellant) in which OMIG concluded that Appellant had received Medicaid Program overpayments. Appellant requested a hearing pursuant to SSL §22 and former Department of Social Services (DSS) regulations at Title 18 of the New York Code, Rules and Regulations (NYCRR) Section 519.4 to review the overpayment determination.

HEARING RECORD

OMIG witness:	Anie Cyriac, R.N.
OMIG exhibits:	1-20
Appellant exhibits:	B, C, D, and F[2]
Appellant witnesses:	[redacted], O.T. [redacted], R.N.

A transcript (T), pages 1-643, of the hearing was made. Each party submitted a post hearing brief and reply brief. The record was closed on November 29, 2018.

[2] *Exhibits A and E were marked for identification but not accepted into evidence; they remained with Appellant.*

SUMMARY OF FACTS

1. At all times relevant hereto, Palm Gardens Center for Nursing and Rehabilitation, located in Brooklyn, New York, was a residential health care facility, licensed under PHL Article 28 and enrolled as a provider in the Medicaid Program.

2. In February 2014, OMIG commenced Audit #14-1139 to review Appellant's documentation in support of its Minimum Data Set (MDS) submissions used to determine its reimbursement from the Medicaid Program. An Entrance Conference and an Exit Conference were held at the Facility on March 11 and 12, 2014, respectively. (Ex 1; Ex 2; Ex 3; Ex 4)

3. The audit reviewed MDS submissions related to Appellant's census period ending January 25, 2012, used to determine reimbursement from the Medicaid Program for the rate period July 1, 2012 through December 31, 2012. OMIG reviewed records for a sample of thirty-two facility residents. On October 5, 2015, OMIG issued a draft audit report that included findings for seventeen of the thirty-two samples which resulted in an estimated rate adjustment of $60,545.75. (Ex 8)

4. On October 26, 2015, Appellant submitted a response to the draft audit report. On September 27, 2016, OMIG issued a final audit report that identified overpayments in Appellant's Medicaid reimbursement resulting from the correction of its reimbursement rate to reflect the audit findings for the same seventeen of the thirty-two samples. OMIG advised Appellant that it intended to recover Medicaid Program overpayments in the amount of $60,096.72. On November 21, 2016, Appellant requested a hearing to review the overpayment determination. (Ex 9; Ex 10; Ex 11)

5. At issue for this hearing were the findings concerning one of the samples identified in the final audit report, specifically the sample for Resident [redacted]/Sample #1 (Resident 1). OMIG determined that the Resource Utilization Group (RUG) category and Case Mix Index (CMI) assigned to this resident was not accurate because Appellant's records failed to support the medical necessity for therapy and/or therapy was not reasonable for the resident's condition in the look-back period. OMIG corrected the resident's RUG category and CMI, and Appellant's Medicaid reimbursement rate was recalculated accordingly. On February 22, 2017, after re-examining the disallowance that was based on coding for therapy services, OMIG sent a revised overpayment amount to Appellant informing Appellant that OMIG was seeking to recover $30,073.85. (Ex 10; Ex 13; Ex 14; Ex 17)

6. Resident 1's MDS submission for the audit period had an assessment review date (ARD) of [redacted], 2011. The seven day look back period for skilled therapies reported on the MDS was [redacted], 2011. (Ex 10, p. 107; T 127-129)

7. Appellant's MDS submission assigned Resident 1 to RUG category "[redacted] which has a case mix index (CMI) of [redacted] (Ex 15; Ex 17; T 113-116). The criteria for assignment to this RUG category included receipt of skilled therapy services for a minimum of [redacted] minutes per week (Ex 17). Resident 1 received the minimum requirement during the look back period. (Ex 15; T 127)

8. Resident 1 was evaluated by an occupational therapist on [redacted] 2011, for a [redacted] in ADLs. The evaluation recommended occupational therapy (OT), which was accordingly ordered by a physician. (Ex 15, pages 142-144; T 130-131)

[3] *The derived RUG score was "[redacted] which has a CMI of [redacted] (Ex 17; T 113, 116)*

9. The OT Evaluation & Plan of Treatment dated [redacted] 2011, and the OT Discharge Summary dated November 16, 2011, document that Resident 1 made progress with her ADLs, going from "[redacted]) for toileting and dressing on [redacted] 2011, to "[redacted] on [redacted] 2011. She was discharged from therapy on [redacted] 2011, when her highest practical level was achieved (Ex 15, page 149). (Ex 15, pages 146-150)

ISSUE

Has Appellant established that OMIG's audit determinations to correct the RUG category and CMI reported for Resident 1, and to recover the resulting Medicaid overpayments, are not correct?

APPLICABLE LAW

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

It is a basic obligation of every Medicaid provider "to prepare and maintain contemporaneous records demonstrating its right to receive payment under the [Medicaid Program], and to keep for a period of six years… all records necessary to disclose the nature and extent of services furnished." 18 NYCRR 504.3(a). Medical care and services will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record.

18 NYCRR 518.3(b). All reports of providers which are used for the purpose of establishing rates of payment, and all underlying books, records, documentation and reports which formed the basis for such reports are subject to audit. 18 NYCRR 517.3(a).

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

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

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

Not all nursing home residents require the same level of care; some require 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 RUG categories reflecting the level of their functional care needs, and each RUG category is assigned a numerical CMI score. (Ex 17). Residents in RUG categories with higher CMI scores require greater resources for their care. The higher the average of a facility's RUG and associated CMI scores, the higher the facility's per diem rate, and reimbursement, will be. Elcor Health Services v. Novello, 100 N.Y.2d 273 (2003).

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

MDS assessments of residents' functional capacities are made and reported by the facility using the "resident assessment instrument" (RAI). Resident assessment is performed and reported by the facility periodically in accordance with requirements set forth at 42 CFR 483.20 and further detailed in the CMS RAI Manual, Chapter 2. 10 NYCRR 86-2.37, 415.11.

Particularly pertinent to this hearing is Section O of the CMS RAI Manual (Ex 16A), which provides instructions for facilities on how and when to identify and report special treatments, procedures and programs, including skilled therapy that residents receive. Each resident's RAI evaluates the resident as of a specific ARD. Therapies are reported by the number of minutes of therapy provided in a seven day "look back" before the ARD. CMS RAI Manual, page O-16. A resident who is receiving skilled therapy during this seven day period will then be "coded" at that level of care. The facility's CMI, and consequently its reimbursement rate, will be calculated accordingly for an entire six month rate period.

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

> The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents….
>
> Code only medically necessary therapies that occurred after admission/ readmission to the nursing home that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist's assessment… (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. CMS RAI Manual, page O-15.

These therapy services must meet the following six conditions:

- for [Medicare] Part A, services must be ordered by a physician. For Part B the plan of care must be certified by a physician following the therapy evaluation;

- the services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility;

- the services must be of a level of complexity and sophistication… that requires the judgment, knowledge and skills of a therapist;

- the services must be provided with the expectation… that the condition of the patient will improve… or the services must be necessary for the establishment of a safe and effective maintenance program;

- 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 and 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 "Code only medically necessary therapies." CMS RAI Manual, pages 1-7 and 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

OMIG disallowed Resident 1's OT because it determined that what was documented in Resident 1's medical record failed to demonstrate the need for OT. According to OMIG, there was no "story" (T 178, 272) in the record, particularly by the nursing department and specifically in the [redacted] 2011 look back period, showing the basis or need for OT. Appellant contends that the CMS RAI Manual (Manual) does not specify who must make the entry of a need for OT, and how and where it must be documented, and that OMIG's insistence that documentation of the need for therapy must be documented within the look back period is incorrect. As its basis for OT services, Appellant submitted a Nursing/Rehabilitation Change of Status Form (Change of Status Form) dated [redacted]11 on which [redacted], R.N. wrote, "[redacted] in ADL's. Especially toileting and dressing" (Appellant's Exhibit D/OMIG's Exhibit 15, page 145). OMIG argues that even if this note were written on [redacted]/11 (as Appellant

contends) and not on [redacted]/11 (as is written on the form), it does not qualify as documentation in the chart demonstrating the need for the OT that was initiated on [redacted]/11 because a note written on [redacted]11 is outside the [redacted], 2011 look back period (OMIG brief, page 18). OMIG is incorrect on this point. The look back period looks at the services reported on the MDS that were provided during the look back period. The need for the services provided during the look back period would typically have occurred within a reasonably short time before the initiation/provision of the services during the look back period. I find that Appellant demonstrated that Ms. [redacted] note was written on [redacted]/11, not [redacted]/11 as written. Ms. [redacted] timesheets (Exhibit F) show that she worked on [redacted]/11 but did not work on [redacted]/11. The [redacted]/11 note on the Change of Status Form resulted in an OT evaluation of Resident 1 on [redacted]/11 and provision of OT services for Resident 1 from [redacted]6/11.

The issue for this hearing is whether Appellant's records document that OT was necessary for Resident 1 and if the OT Resident 1 received from [redacted] 2011 was (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 (Manual, page O-15). Resident 1's OT was ordered by a physician based on the occupational therapist's assessment (Exhibit 9, pages 51 and 53-55), and Resident 1's ADLs for dressing and toileting were care planned and periodically evaluated (Exhibit 9, pages 58-62, 65; Exhibit 15, pages 151-154).

The issue most strongly contested at the hearing was whether the documentation of the need for Resident 1's OT services was met. Pages O-18 and 19 of the Manual dictate the six conditions (see pages 8-9 of this Decision for the six conditions) that OT services must meet. OMIG did not dispute the first condition, but OMIG believes the second through sixth conditions were not met. The second condition was met. Resident 1's [redacted]/11 OT services which were based on the therapist's [redacted]/11 evaluation and signed by the physician on [redacted] and [redacted]/11, were *directly and specifically related to an active written treatment plan*; *i.e.*, the OT Evaluation & Plan of Treatment (OMIG Exhibit 9, pages 53-55).

The testimony of [redacted], Occupational Therapist, demonstrated that Appellant satisfied the Manual's third through sixth conditions. Regarding the fourth condition that *the services must be provided with the expectation that the condition of the patient will improve*, Mr. [redacted] testified that "a therapist makes their own independent clinical decision on when a patient is in need of therapy intervention. It would be contrary to our good practice act that we notice that the patient has changed or declined, and we, at that point, not provide the service that the patient deserves" (T 565).

Appellant's satisfaction of the Manual's third (*the services must be of a level of complexity and sophistication that requires the judgment, knowledge and skills of a therapist*), fifth (*the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition*), and sixth (*the services must be reasonable and necessary for the treatment of the resident's condition*) conditions was demonstrated by the physician's approval and order for OT and by Mr.

[redacted] additional testimony regarding Appellant's providing OT to Resident 1 to address her decline in ADLs, especially toileting and dressing:

> …the way a therapist determines whether a patient has had a change in function and requires therapy intervention is by comparing the patient's current physical functioning to the patient's prior level of function (T 554). …standard practices for occupation[al] therapy is, if we notice a decline in the patient, we don't wait to see how that decline or change is going to progress … we should intervene as soon as possible (T 551-552). …based on the prior level of function that has been recorded for hygiene, grooming, upper-body dressing and lower-body dressing, the patient did not need any weightbearing assistance…that is [redacted]. …min assist is [redacted] percent [redacted] assistance. That means you are bearing [redacted] percent of either the patient's [redacted] or the [redacted] of the [redacted] that you are handling. …that is obviously now a significant change in the patient's level of assistance being required. In terms of toileting, the patient was completely independent, prior level, and now, the patient requires [redacted] percent [redacted] assistance. …this patient has definitely had a significant change, because the patient has gone from an independent level to, now, the patient requires [redacted] [redacted] assistance to perform that activity. (T 560-562)

Appellant's documentation supported the RMA RUG classification with CMI of [redacted]. As such, Appellant has proven that OMIG's determination should be reversed.

DECISION

OMIG's determination to recover overpayments based upon the MDS audit findings that the RUG category and CMI assigned to Resident 1 was not accurate is reversed.

This decision is made by Ann H. Gayle, Bureau of Adjudication, who has been designated to make such decisions.

DATED: New York, New York
March 14, 2019

Ann H. Gayle
Administrative Law Judge

TO:

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