STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of:

Decision
Audit #14-4901

ACHIEVE REHABILITATION and NURSING FACILITY
Provider ID# 00311422,
Appellant,

from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.

Before:	Jude B. Mulvey Administrative Law Judge Jean T. Carney Administrative Law Judge
Held at:	New York State Department of Health 90 Church Street New York, New York 10007
Hearing Date:	March 16, 2017 Record closed June 9, 2017
Parties:	Office of the Medicaid Inspector General 800 North Pearl Street Albany, New York 12204 By: Lisa Seemann, Esq. Achieve Rehabilitation & Nursing Facility 170 Lake Street Liberty, New York 12754 By: Lisa Kujanik, R.N.

JURISDICTION

The New York State Department of Health (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 Achieve Rehabilitation and Nursing Facility (Appellant) in which the 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) §519.4 to review the overpayment determination. The burden of proof is on the Appellant to demonstrate by substantial evidence that the findings by the OMIG were incorrect. (18 NYCRR §519.18[d] & [h]).

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). These kinds of costs are allowed if they are incurred and the amount is reasonable. The

facility's costs are reimbursed by means of a per diem rate set by the Department based on the 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 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 and 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 519.18[h]).

Regulations pertinent to this hearing are found at 18 NYCRR §§517, 518 and 519, and address the audit, overpayment and hearing aspects of this case. Also pertinent are the regulations at 10 NYCRR Part 86-2 (Reporting and rate certifications for residential health care facilities); 10 NYCRR §415 (Nursing homes – minimum standards); and federal regulations at 42 CFR §483.20 (Requirements for long term care facilities – Resident assessment).

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], and §86-2.40[m]). Residents are evaluated and classified into Resource Utilization Group (RUG) categories reflecting the level of their functional care needs, and each RUG category is assigned a numerical "case mix index" (CMI) score. 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).

Patients are assigned into a RUG-III category through completion of the MDS assessment tool. The MDS is part of the Resident Assessment Instrument (RAI) set by the Centers for Medicare and Medicaid Services for conducting federally mandated assessments (42 CFR §§483.20 and 483.315). The MDS represents the patient's clinical status based on the Assessment Reference Date (ARD). (42 CFR §§483.20[g] and [h]).

HEARING RECORD

In support of its determination, OMIG presented documents (Exhibits 1-8); and the testimony of Anie Cyriac, Hospital Nursing Services Consultant[1]. The Appellant presented one document (Exhibit A); and the testimony of [redacted] Director of Rehabilitation. A stenographic transcript of the proceedings was made (pages 1-121) and the record closed on June 9, 2017, upon receipt of post-hearing memoranda. The assigned Administrative Law Judge, Jude B. Mulvey, subsequently left state employment and a new Administrative Law Judge, Jean T. Carney, was assigned to review the record and to issue a decision on the submitted record.

FACTS

1. At all times relevant hereto, Appellant was a residential health care facility enrolled as a provider in the Medicaid Program. (Exhibit 2).

2. In 2014 OMIG commenced Audit #14-4901 to review Appellant's documentation in support of its Minimum Data Set (MDS) submissions used

[1] At the time of the audit, Ms. Cyriac was a Healthcare Surveyor for OMIG.

to determine its reimbursement from the Medicaid Program for the census period ending January 25, 2013. (Exhibits 2 and 4; Hearing testimony of Ms. Cyriac @ p. 52).

3. OMIG reviewed records for a sample of 31 facility residents and issued a draft audit report on July 29, 2016, identifying overpayments in the amount of $50,898.55. (Exhibit 2).

4. On August 24, 2016, Appellant submitted a response to the draft audit report. On October 5, 2016, OMIG issued a final audit report making no changes to the draft audit report. (Exhibits 3 and 4).

5. On November 29, 2016, Appellant requested a hearing to review the overpayment determination regarding samples 3, 9, 13, and 19. Appellant subsequently withdrew its requests regarding samples 3, 13, and 19, and the hearing proceeded on sample 9 only. (Exhibit 5; Transcript @ p. 7).

6. OMIG determined the Resource Utilization Group (RUG) category assigned for Sample #9 was not accurate because Appellant's records failed to contain a nursing note supporting the need for physical therapy. (Hearing testimony of Ms. Cyriac @ p. 32, 40, 46).

7. Medicaid calculates reimbursement rates based, in part, on RUG classifications, which are determined using the data collected in the Minimum Data Set (MDS). 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. The MDS has other uses, however, including Medicare and Medicaid reimbursement. (Exhibit 8; Hearing testimony of Ms. Cyriac @ p. 27).

8. Each RUG category is assigned a numerical value based upon the resources necessary to care for that type of patient, with a greater value assigned to categories that require more resources. Sample #9 (or Resident) was initially assigned a RUG classification of [redacted] in the [redacted] Category because he was receiving [redacted], and [redacted] therapies. OMIG disallowed the [redacted] therapy; but allowed the [redacted] and [redacted] therapies. (Exhibits 4 and 7; Hearing testimony of Ms. Cyriac @ pp. 31, 33-34, and 47).

9. The Resident had an Assessment Reference Date (ARD) of [redacted] 2012. The look-back period for [redacted] therapy is [redacted] days, which was [redacted]. (Exhibits 3 and 8).

10. On [redacted], 2012, the Resident's physician ordered a [redacted] therapy evaluation and treatment as per plan, for [redacted] pain. This order was clarified that same date, recommending [redacted] therapy [redacted] times a week for [redacted] weeks in order to [redacted] independence with transfers, ambulation, and to improve strength, balance, and endurance. The Resident was discharged from [redacted] therapy on [redacted], 2012, having reached his maximum potential. (Exhibit 3).

ISSUE

Has Appellant established that the OMIG's audit determinations of the RUG category for Sample #9, and resulting recovery of Medicaid overpayments, are incorrect?

DISCUSSION

The OMIG based its determination to disallow [redacted] therapy for Sample #9 on a lack of documentation supporting the need for providing skilled therapy services during the one week look-back period.

The OMIG witness was asked to explain the sort of documentation she was looking for to support the claim for [redacted] therapy. She explained that she would want to see documentation that the patient was unable to [redacted] unable to use the [redacted], had difficulty [redacted] or had an [redacted]. (Hearing testimony of Ms. Cyriac @ p. 59). A review of Sample #9's medical records reveal nurses notes dated [redacted], 2012 and [redacted], 2012 stating that the Resident needed [redacted]-person assistance with transfers, and full assistance in mobilizing in the bathroom. (Exhibit 3 @ p.15). These notes document a change in the Resident's condition that could reasonably warrant a referral to [redacted] therapy. Subsequently, when the Resident was evaluated on [redacted], 2012, the [redacted] therapist noted a [redacted] in the Resident's ability to transfer and ambulate. (Hearing testimony of Ms. [redacted] @ p. 70; Exhibit 3 @ p.42). Therefore, the record

contains sufficient documentation to support the need for the provision of [redacted] therapy for Sample #9.

DECISION

The Appellant has shown that the OMIG's determination to disallow physical therapy for Sample #9 was incorrect. The OMIG is directed to recalculate the overpayment in accordance with this decision.

This Decision is made pursuant to the designation by the Commissioner of Health of the State of New York to render final decisions in hearings involving Medicaid provider audits.

DATED: June 3, 2019
Albany, New York

JEAN T. CARNEY
Administrative Law Judge

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