

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

In the Matter of the Appeal of	:	
	:	
Avon Nursing Home	:	Decision After
Provider #00365935	:	Hearing
	:	
from determinations to recover Medicaid Program	:	#14-3956
overpayments.	:	#14-3957
	:	

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
259 Monroe Avenue
Rochester, New York 14607
May 24, 2017
Record closed: August 25, 2017

Parties: New York State Office of the Medicaid Inspector General
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JURISDICTION

The New York State Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State. SSL 363-a; PHL 201.1(v). The New York State Office of the Medicaid Inspector General (OMIG), an independent office within the Department, is responsible for the Department's duties with respect to the prevention, detection and investigation of fraud and abuse in the Medicaid Program and the recovery of improperly expended Medicaid funds. PHL 31, 32.

The OMIG issued two final audit reports for Avon Nursing Home (the Appellant) in which the OMIG concluded that the Appellant had received Medicaid Program overpayments. The Appellant requested hearings pursuant to SSL 22 and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the overpayment determinations. The two requests were combined for this hearing.

HEARING RECORD

OMIG witnesses: Colleen Quackenbush, health systems specialist

OMIG exhibits: 1-24

Appellant witnesses:



Appellant exhibits: A-F

A transcript of the hearing was made. (Transcript, pages 1-231.) Each party submitted two post hearing briefs, and the record was closed August 25, 2017.

SUMMARY OF FACTS

1. At all times relevant hereto, Avon Nursing Home was a residential health care facility (RHCF), licensed under PHL Article 28 and enrolled as a provider in the Medicaid Program. The facility is located in Avon, New York.

2. In July 2014, the OMIG commenced two audits (#14-3956 and #14-3957) to review the Appellant's documentation in support of its Minimum Data Set (MDS) submissions used to determine its reimbursement from the Medicaid Program. (Exhibit 1.)

3. Audit #14-3956 reviewed MDS submissions related to the Appellant's January 2013 census, used to determine reimbursement from the Medicaid Program for the rate period July 1 through December 31, 2013. (Exhibit 6.) The OMIG reviewed records for a sample of four facility residents. (Exhibit 2.)

4. Audit #14-3957 reviewed MDS submissions related to the July 2013 census, used to determine reimbursement for the rate period January 1 through June 30, 2014. (Exhibit 15.) The OMIG reviewed records for a sample of eleven facility residents. (Exhibit 13.)

5. OMIG auditors determined that the resource utilization group (RUG) categories assigned to six of the residents in the reviews (residents 1 & 3 from audit #14-3956; and residents 2, 5, 7 & 8 from audit #14-3957) were not accurate because the Appellant's records failed to document the scores reported in the MDS submissions for the residents' needs for assistance with activities of daily living (ADL). The OMIG reduced the ADL scores, corrected the residents' RUG categories and recalculated the Appellant's Medicaid reimbursement rate accordingly.

6. On October 19, 2016, the OMIG issued final audit reports that identified overpayments in the Appellant's Medicaid reimbursement resulting from the correction of its reimbursement rate to reflect the audit findings. The OMIG advised the Appellant that it intended to recover Medicaid Program overpayments in the amount of \$21,010.64 in audit #14-3956, and \$23,123.52 in audit #14-3957. (Exhibits 6 & 15.)

7. Resident 1's MDS submission had an assessment review date (ARD) of [REDACTED] 2012. The submission assigned him to RUG category [REDACTED] (Exhibit 10, page 1.) Assignment to this category required an ADL score between [REDACTED] and [REDACTED] (Exhibit 23.) The Appellant reported a score of [REDACTED] (Exhibit 10, page 1.) The Appellant relies on a facility record titled "Nursing Interim Review," dated [REDACTED] 2012 as documentation of the reported ADL score. (Exhibit 10, page 6.)

8. Resident 3's MDS submission had an ARD of [REDACTED], 2013. The submission assigned her to RUG category [REDACTED] (Exhibit 11, page 1.) Assignment to this category required an ADL score between [REDACTED] and [REDACTED] (Exhibit 23.) The Appellant reported a score of [REDACTED] (Exhibit 11, page 1.) The Appellant relies on its Nursing Interim Review dated [REDACTED] 2013 as documentation of the reported ADL score. (Exhibit 11, page 7.)

9. Resident 2's MDS submission had an ARD of [REDACTED] 2013. The submission assigned her to RUG category [REDACTED] (Exhibit 19, page 1.) Assignment to this category required an ADL score between [REDACTED] and [REDACTED] (Exhibit 23.) The Appellant reported a score of [REDACTED] (Exhibit 19, page 1.) The Appellant relies on its Nursing Interim Review dated [REDACTED] 2013 as documentation of the reported ADL score. (Exhibit 19, page 5.)

10. Resident 5's MDS submission had an ARD of [REDACTED], 2013. The submission assigned her to RUG category [REDACTED] (Exhibit 20, page 1.) Assignment to this category required an ADL score between [REDACTED] and [REDACTED] (Exhibit 23.) The Appellant reported a score of [REDACTED] (Exhibit 20, page 1.) The Appellant relies on its Nursing Interim Review dated [REDACTED] 2013 as documentation of the reported ADL score. (Exhibit 20, page 6.)

11. Resident 7's MDS submission had an ARD of [REDACTED] 2013. The submission assigned her to RUG category [REDACTED] (Exhibit 21, page 1.) Assignment to this category required an ADL score between [REDACTED] and [REDACTED] (Exhibit 23.) The Appellant reported a score of [REDACTED] (Exhibit 21, page 1.) The Appellant relies on its Nursing Interim Review dated [REDACTED] 2013 as documentation of the reported ADL score. (Exhibit 21, page 5.)

12. Resident 8's MDS submission had an ARD of [REDACTED] 2013. The submission assigned her to RUG category [REDACTED] (Exhibit 22, page 1.) Assignment to this category required an ADL score between [REDACTED] and [REDACTED] (Exhibit 23.) The Appellant reported a score of [REDACTED] (Exhibit 22, page 1.) The Appellant relies on its Nursing Interim Review dated [REDACTED] 2013 as documentation of the reported ADL score. (Exhibit 22, page 6.)

ISSUE

Has the Appellant established that the OMIG's audit determinations to correct the six resident's RUG categories, 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 that are used for the purpose of establishing rates of payment, and all underlying books, records, documentation and reports that formed the basis for such reports are subject to audit. 18 NYCRR 517.3(a).

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

If the Department determines to recover an overpayment, the provider has the right to an administrative hearing. 18 NYCRR 519.4. The provider has the burden of showing that the determination of the Department was incorrect and that all costs claimed were allowable. 18 NYCRR 519.18(d)(1). Where the Department's determination is based upon an alleged failure of the provider to comply with generally accepted professional or medical practices or standards of health care, the Department must establish the existence of such practice or standard. 18 NYCRR 519.18(d).

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

Not all nursing home residents require the same level of care, some requiring more costly attention than others. A facility's reimbursement rate accordingly takes into account the kind and level of care it provides to each resident by including, in the calculation of the "direct" component of the facility's "operating" rate, data about the facility's "case mix." 10 NYCRR 86-2.10(a)(5)&(c); 86-2.40(m). Residents are evaluated and classified into resource utilization group (RUG) categories reflecting the level of their functional care needs, and each RUG category is assigned a numerical case mix index (CMI) score. (Exhibit 23.) 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. Elcor Health Services v. Novello, 100 N.Y.2d 273 (2003).

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

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

Particularly pertinent to this hearing is Section G of the CMS RAI Manual, which provides instructions for assessing residents' need for assistance with activities of daily living (ADLs), gait and balance, and decreased range of motion. Each resident's RAI evaluates the resident as of a specific assessment review date (ARD). The resident's ADL status for a seven day "look back" period before the ARD is reviewed and "coded" at that level of care. CMS RAI Manual, page G-3. The facility's CMI, and consequently its reimbursement, for an entire six month rate period will be calculated accordingly whether or not the resident ADL status changes during the rate period.

Detailed instructions for conducting the ADL assessment include:

Steps for Assessment

1. Review the documentation in the medical record for the 7-day look-back period.
2. Talk with direct care staff from each shift that has cared for the resident to learn what the resident does for himself during each episode of each ADL activity definition as well as the type and level of staff assistance provided. Remind staff that the focus is on the 7-day look-back period only.
3. When reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, determine the level of assistance required for moving the resident to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed.

To clarify your own understanding and observations about a resident's performance of an ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific. See page G-9 for an example of using probes when talking to staff. CMS RAI Manual, page G-3.

The ADL assessment is "coded" by assigning numerical ADL scores to the resident's functional abilities in accordance with an algorithm set forth in the manual. CMS RAI Manual, page G-6.

Regarding documentation, MDS reporting requirements set forth in the CMS RAI Manual do not supersede or replace Medicaid documentation requirements in Department and federal regulations. For Medicaid reimbursement purposes, 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. Federal regulations pertinent to this case require:

(b) The [RAI] assessment must include at least the following:

(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. 42 CFR 483.20(b)(1).

To the extent that additional documentation requirements are imposed in connection with MDS reporting, such as completion of the RAI form itself (Exhibits A-F), they are specified in CMS RAI Manual. Documentation requirements in general are addressed in the CMS RAI Manual as follows:

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, pages 1-7&8.

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 1-8.

DISCUSSION

The OMIG's audit reports included a number of findings affecting the RUG categories assigned to residents in the audit sample. These findings lowered some residents' CMI scores, leading to a reduction in the facility's overall CMI and consequently the direct component of its rate. (Exhibits 6&15, attachments A, B.) The

sole issue for this hearing is whether the Appellant's records document the ADL scores reported for residents 1 & 3 in audit #14-3956, and residents 2, 5, 7 & 8 in audit #14-3957.

In all six instances, the Appellant relied upon its "Nursing Interim Review" (Transcript, pages 78, 87-88) as documentation to substantiate the ADL scores assigned to the residents. (Exhibit 10, page 6; Exhibit 11, page 7; Exhibit 19, page 5; Exhibit 20, page 6; Exhibit 21, page 5; Exhibit 22, page 6; Transcript, pages 60-61, 180, 191.) Section five of the preprinted Nursing Interim Review form lists nine specific components, including bed mobility, transfers, toilet use and eating, recording both ADL self-performance and ADL support scores for each of the three daily shifts for the seven day look-back period. These are the ADL scores that were used to complete the ADL assistance section of the MDS submissions. (Exhibits A-F, section G0110.) The ADL scores documented in the Nursing Interim Reviews are consistent with the scores reported on the MDS. (Transcript, pages 81, 92, 152.)

The preprinted Nursing Interim Review form contains separate signature lines for the day nurse, evening nurse and night nurse. All of the forms in question are signed by one shift nurse, with arrows drawn down through the other signature lines. For residents 1, 2 and 3, the Nursing Interim Review form includes a preprinted note next to the signature lines that reads: "If one nurse obtained ADL information from all other shift nurses, the same signature may be indicated for days, evenings and nights." (Exhibit 10, page 6; Exhibit 11, page 7; Exhibit 19, page 5.) For residents 5, 7 and 8, the Nursing Interim Review form does not contain this preprinted note. (Exhibit 20, page 6; Exhibit

21, page 5; Exhibit 22, page 6.) The form also contains preprinted scoring instructions that reflect CMS RAI Manual instructions.

At the hearing, the Appellant's documentation coordinator testified that other documentation in the Nursing Interim Reviews and other records is at least consistent with these ADL scores, and that there is no information in the resident records inconsistent with the reported scores. For the required affirmative information to document the ADLs, however, the Appellant relies on the Nursing Interim Reviews. (Transcript, pages 179-80.)

The OMIG does not accept the Nursing Interim Reviews as meeting the documentation requirements set forth in Department and federal regulations and the CMS RAI Manual. The audit reports state: "Documentation must indicate an assessment was done to evaluate the need for assistance with activities of daily living [ADLs]." (Exhibit 6, page 5; Exhibit 15, page 5.) The authority the OMIG cited for this standard is the federal regulation that requires:

(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). 42 CFR 483.20(b)(1).

This is what the Nursing Interim Reviews appear to be. The "additional assessment" triggered during the completion of the RAI was the collection of approximately 54 numerical ADL scores for each resident during the look-back period. The Nursing Interim Reviews document that these assessments were done and record "summary information" regarding them.

The OMIG auditors did not accept the Nursing Interim Reviews because "there was no supporting documentation from where the numbers were obtained on their interim

report.” (OMIG brief, pages 11-12; Transcript, pages 61, 121.) The CMS RAI Manual recognizes three ways to obtain information for the MDS report: record review, observation, and interviews with direct care staff. CMS RAI Manual, page G-3. The OMIG’s witness testified the Appellant’s documentation was not found acceptable:

- A: [b]ecause nowhere on this documentation was there any indication that these numbers were obtained by interview, or observation. The record indicates that the shift nurse, after discussing it with another shift nurse, or another shift nurse got this information. (Transcript, page 61.)

- A: ... the primary purpose of filling out this M.D.S., is to get the information from the caregiver, the nursing assistant and I can’t assume that these nurses spoke to the aides, or didn’t interview, or observed anything because there’s no documentation to indicate that. It just says one nurse spoke to another and the information was correct. But where did they get the information? We’re – we’re doing a clinical-documentation audit. We’re looking for documentation to support this. (Transcript, page 62.)

The OMIG’s witness’ complaint that “I need to know where they got this from” (Transcript, page 64) is puzzling in light of her testimony that “[t]he record indicates that the shift nurse, after discussing it with another shift nurse, or another shift nurse got this information.” (Transcript, page 61.)

The OMIG’s claim “the Appellant is required to document all participation in the assessment process” (OMIG brief, page 12) is a very broad interpretation of the cited authorities that is unreasonably applied in this audit. For example, the OMIG’s witness testified that because the Nursing Interim Reviews were signed by a shift nurse, “I would expect to see that the nurse said in giving care, I did thus and so” because the witness was “presuming” that nursing assistants, as distinguished from shift nurses, “normally” provided the hands-on care. (Transcript, pages 127-28.) As the Appellant points out, this requirement to document “all participation” could also be expanded to include an expectation that it document in each case which of the many “probing questions” -

suggested by the CMS RAI Manual (pages G-3 through G-17) as ways to obtain the necessary information - were asked and what answers were received. (Appellant brief, page 15.)

The OMIG's position is that the documentation in the Nursing Interim Reviews "simply does not pass muster." (OMIG brief, page 12.) In the absence of some reason to question those reviews, it is concluded that the regulations do not clearly require more as a condition of reimbursement. At some point the accumulation of details goes beyond the need for reasonable documentation of ADL scores. A requirement to document resident ADL needs becomes a requirement to document how resident ADL needs were documented. It is also inconsistent with the stated intent of the RAI process to simplify and reduce the need for "voluminous" and "repetitive" documentation. (CMS RAI Manual, page 1-10.)

An expectation of this level of detail in documentation is not stated in Medicaid reimbursement regulations, and is not supported by federal regulations requiring "the assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts" and requiring "documentation of summary information regarding the additional assessment performed (*emphasis added*)." 42 CFR 483.20(b)(1)(xvii)&(xviii).

While rejecting the Appellant's documentation in this case, the OMIG's witness suggested she would accept twenty-one ADL sheets, one for each shift for seven days, for each resident. (Transcript, pages 117-19.) This would clearly be more detailed documentation than the Appellant's summaries. The witness went right on to acknowledge, however, that "there's no requirement in the M.D.S. manual, as to how you

would document... it tells you they expect you to document according to professional standards.” (Transcript, page 120.)

The OMIG has not identified any regulation or Department or Medicaid directive, or established the existence of a generally accepted professional standard or standard of medical care that requires providers to document, in each resident record, twenty-one pages of specific first hand observations to support seven days’ worth of ADL scores, multiple times on all three shifts during the look-back or at any other time, as a prerequisite for providing the level of ADL assistance the resident requires. There may be a difference between such documentation and the Appellant’s Nursing Interim Reviews, but a line between them has not clearly been drawn by the authorities the OMIG relies on.

The OMIG’s witness testified that “our audit is not a reimbursement audit. Our audit is a documentation audit.” She explained this meant “[w]e don’t look at any financial information to complete this audit. We look at what the facility documented, to support what they claimed.” (Transcript, page 31.) But in characterizing their “clinical-documentation audit” (Transcript, page 62) this way, OMIG auditors may have introduced a confusion in their review from the outset. Documentation can be reviewed for a variety of purposes. In this case the documentation review is being used to determine reimbursement and must be measured by minimum reimbursement standards.

The confusion is compounded by the OMIG’s citation in the audit reports to documentation requirements in a manual that does not impose them, but instead explicitly provides “[n]ursing homes are left to determine... how the assessment information is documented... CMS does not impose specific documentation procedures.” CMS RAI

Manual, pages 1-7&8. The difficulty in this case of finding the documentation requirement the OMIG seeks to impose for ADL reporting is suggested by the final audit reports' resort to citation of an entire thirty-five page chapter as the claimed CMS RAI Manual authority for its disallowances. (Exhibit 6, page 5; Exhibit 15, page 5.)


The Appellant has clearly attempted, by means of the preprinted Nursing Interim Review form, to simplify and streamline the documentation to the point where, for ADL scores, all that is necessary is for a nurse to fill in the numbers and sign the form. In these cases, a short-cut was even taken with the signatures, one nurse signing for three. There is no good reason to conclude, however, that the Appellant's Nursing Interim Reviews do not reflect a performance of the assessments required by the CMS RAI Manual, or were not understood and intended to comply with minimum documentation requirements to support the MDS submissions.

The audit reports stated that the reason for these disallowances was failure to produce the documentation required by CMS RAI Manual Section G and by 42 CFR 483.20(b)(1)(xvii) to "indicate an assessment was done." (Exhibit 6, page 5; Exhibit 15, page 5.) The evidence suggests that the Department would be well advised to issue some clarification of its requirements if it does not intend to accept documentation such as that provided by the Appellant.

DECISION: The OMIG's determinations to recover overpayments based upon the MDS audit findings are reversed.

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

DATED: Rochester, New York
January 19, 2018



John Harris Terepka
Bureau of Adjudication