

**STATE OF NEW YORK  
DEPARTMENT OF HEALTH**

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In the Matter of the Appeal of

**Niagara Rehabilitation and  
Nursing Center**  
Provider #00475030

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

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**Decision After  
Hearing**

#13-4415

Before: John Harris Terepka  
Administrative Law Judge

Held at: New York State Department of Health  
584 Delaware Avenue  
Buffalo, New York 14202  
May 11, 2017  
Record closed: June 23, 2017

Parties: New York State Office of the Medicaid Inspector General  
584 Delaware Avenue  
Buffalo, New York 14202  
By: William L. Busler, Esq.

Niagara Rehabilitation and Nursing Center  
822 Cedar Avenue  
Niagara Falls, New York 14301  
By: Pam Hennigan, Regional Director of Rehabilitation

### **JURISDICTION**

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

The OMIG issued a final audit report for Niagara Rehabilitation and Nursing Center (the Appellant) in which the OMIG concluded that the Appellant had received Medicaid Program overpayments. The Appellant requested this hearing pursuant to SSL 22 and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the overpayment determination.

### **HEARING RECORD**

OMIG witness: Anie Cyriac, R.N.

OMIG exhibits: A-R

Appellant witness: [REDACTED], Regional Director of Rehabilitation

Appellant exhibits: None

A transcript of the hearing was made. (Transcript, pages 1-178.) Each party submitted one post hearing brief. The record was closed on June 23, 2017.

### **SUMMARY OF FACTS**

1. Niagara Rehabilitation & Nursing Center is 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 Niagara Falls, New York.

2. Commencing in July 2015, the OMIG reviewed the Appellant's documentation in support of its Minimum Data Set (MDS) submissions used to determine its reimbursement from the Medicaid Program for the rate period January 1 through June 30, 2013. The OMIG requested records for a sample of thirty seven facility residents from its July 2012 census. (Exhibits E, F, G.)

3. The OMIG determined that the resource utilization group (RUG) category assigned to two of the residents (samples one and six) was not accurate because the Appellant's records failed to document that occupational therapy services ordered and provided were reasonable and necessary for the treatment of the residents' conditions. The OMIG corrected the residents' RUG categories and recalculated the Appellant's Medicaid reimbursement rate accordingly.

4. The Appellant's [REDACTED] 2012 MDS submissions assigned RUG category 'RMA' to residents one and six. (Exhibits M and N, page 1.) Assignment to this category meant they required skilled therapy for a minimum of 150 minutes per week. The OMIG audit reclassified resident one's RUG category to 'BA1' and resident six's RUG category to 'PA1.' (Exhibit A, page 4.) The case mix index (CMI) score for category RMA is [REDACTED]. The CMI score for BA1 is [REDACTED], and for PA1 it is [REDACTED]. (Exhibit P.)

5. On [REDACTED] 2016, the OMIG issued a final audit report that identified overpayments resulting from the recalculation of the Appellant's Medicaid reimbursement to reflect the audit findings. The OMIG advised the Appellant that it intended to recover Medicaid Program overpayments in the amount of \$64,049.50. (Exhibit A.) The overpayment included amounts attributable to the change in RUG categories and reduction in CMI scores for residents one and six.

Resident one.

6. Resident one's [REDACTED] 2012 MDS submission had an "assessment review date" (ARD) of [REDACTED] [REDACTED] (Exhibit M, page 1.) The seven day "look back" period for occupational therapy reported on the MDS was [REDACTED], 2012.

7. On [REDACTED] 2012 an occupational therapy (OT) evaluation of resident one recommended a course of OT for up to [REDACTED] minutes, [REDACTED] days per week. The resident's physician signed the therapist's recommendation and OT was commenced. (Exhibit M, pages 4-5.)

8. On [REDACTED], 2012, after [REDACTED] days of therapy, another OT evaluation found that the resident had reached her treatment potential and that the long term care staff could provide necessary assistance with ADLs. She was accordingly discharged from OT. (Exhibit M, pages 6, 8.)

Resident six.

9. Resident six's [REDACTED] 2012 MDS submission had an ARD of [REDACTED] (Exhibit N, page 1.) The seven day "look back" period for occupational therapy reported on the MDS was [REDACTED] 2012.

10. On [REDACTED], 2012 an OT evaluation of resident six was performed. The evaluating therapist recommended a course of OT for up to [REDACTED] minutes, [REDACTED] days per week. The resident's physician signed the recommendation and OT was commenced. (Exhibit N, pages 9-10.)

11. On [REDACTED] 2012, after ten days during which treatment was given on seven days (Exhibit N, pages 6-7), a discharge note documented that the resident had met her goals, and she was accordingly discharged from the OT. (Exhibit N, page 8.)

**ISSUE**

Has the Appellant established that the OMIG's MDS audit determinations to recover Medicaid overpayments attributable to the claimed occupational therapy needs of residents one and six 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 that the determination of the Department was incorrect and that all costs claimed were allowable. 18 NYCRR 519.18(d)(1).

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

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 P; Transcript, pages 41-43.) Residents in RUG categories with higher CMI scores require greater resources for their care. The higher the average of a facility’s RUG and associated CMI scores, the higher the facility’s per diem rate, and reimbursement, will be. Elcor Health Services v. Novello, 100 N.Y.2d 273 (2003). (Transcript, pages 25-26.)

The Minimum Data Set (MDS) is a core set of screening, clinical and functional status elements which form the foundation for the assessment of residents in nursing homes certified to participate in Medicare and Medicaid. Its primary purpose is as an assessment tool to identify resident care problems that are then addressed in an individualized care plan. CMS RAI Manual, page 1-5. The MDS has other uses, however, including Medicare and Medicaid reimbursement. 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, Chapter 2. 10 NYCRR 86-2.37, 415.11.

Particularly pertinent to this hearing is Section O of the CMS RAI Manual (Exhibit Q), 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 “assessment review date” (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...
- the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident’s condition; and,
- the services must be reasonable and necessary for the treatment of the resident’s condition... CMS RAI Manual, pages O-18&19.



Regarding documentation, the CMS RAI Manual states:

Nursing homes are left to determine...how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained in this manual. CMS RAI Manual, page 1-6.

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare PPS. CMS RAI Manual, page 1-7.

MDS reporting requirements set forth in the CMS RAI Manual do not supersede, they supplement Medicaid documentation requirements in Department regulations. Of primary importance for the purposes of this Medicaid reimbursement audit is that nursing homes remain obligated to comply with the documentation requirements for Medicaid generally, including 10 NYCRR 86-2.17 and 18 NYCRR 504.3(a), 518.3(b) & 517.3. Consistent with those requirements, the CMS RAI Manual specifies "documentation must substantiate a resident's need for Part A SNF-level services" and "Code only medically necessary therapies." CMS RAI Manual, pages 1-7, O-15.

In this case, the CMS RAI Manual does not, in fact, add much to the documentation requirements set forth in Medicaid regulations. For skilled therapies, it mainly sets parameters for the scope of the review by identifying an ARD and look back period as determinative of the scope of inquiry for reimbursement purposes. As "specific documentation procedures" have not been imposed for MDS reporting, the standard will

remain, as with all Medicaid reimbursement, whether the resident record as a whole reasonably documents a medical basis and specific need in compliance with Medicaid regulations.

### DISCUSSION

The OMIG's audit report included a number of findings affecting the RUG categories assigned to the thirty seven residents in the audit sample. Most of the findings in the final audit report were not challenged by the Appellant. (Transcript, pages 54-55.) The sole issue for this hearing is whether the Appellant's records document the medical necessity for occupational therapy (OT) services provided to residents one and six during the seven day "look back" before their ARDs.

The OMIG does not dispute that these services were ordered by a physician, based upon a therapist's evaluation, and were provided in the amounts reported. (Transcript, pages 90, 102, 144.) The OMIG's criticism is that the resident records failed to document the medical necessity for the OT. This issue turns on the interpretation of what constitutes, for Medicaid reimbursement purposes, "documented in the resident's medical record." CMS RAI Manual, page O-15.

#### Resident one.

The ARD for resident one was [REDACTED], 2012. (Exhibit M, page 1.) An OT evaluation was done on [REDACTED] 2012, [REDACTED] days before the ARD, for a treatment diagnosis the evaluating therapist documented as '[REDACTED] Occupational therapy was recommended and the resident's facility physician signed off on the recommendation the same day. (Exhibit M, pages 4-5.) Therapy was provided from [REDACTED]. (Exhibit M, page 8.) On [REDACTED], the ARD, the therapist determined the resident had reached her

treatment potential and that the ADL assistance she required could be provided by long term care staff. She was discharged from OT. (Exhibit M, page 6.)

According to the OMIG reviewer, Ms. Cyriac, this record failed to document a need for this OT because the facility progress notes and other records fail to document a reason for the evaluation. In particular, the records show the direct care staff did not document any changes in the resident's condition and functioning that would suggest the need for a referral for the therapy evaluation.

It is well documented that this resident had medical and behavioral issues during the period leading up to the [REDACTED] assessment. She was receiving a good deal of medical attention because of a [REDACTED] and [REDACTED] issues including [REDACTED]. The nursing notes contain detailed documentation that she was being monitored for these issues before, during, and after the OT services were given. (Exhibit M, pages 10-19.) She was, however, also documented to be completely independent in physical functioning, which is the primary issue in determining whether there is a need for OT. (Transcript, pages 77-84.)

As Ms. Cyriac pointed out:

Every day – every shift, she was being monitored. And there was absolutely no mention of any type of decline. There was absolutely no mention of an occupational – of a need for an occupational therapy to see the resident. There was no mention of an occupational therapist taking a look at the resident and/or – I mean especially since they've been giving one-to-one, there was no mention of the fact that the therapist had helped this resident in any way during that particular period of time. (Transcript, page 81.)

What is lacking is any documentation to show what led to the original decision to seek an evaluation. There is nothing to explain why the [REDACTED] evaluation was done or even a referral from the nursing staff to document who decided to recommend that it be done.

The progress notes leading up to the [REDACTED] OT evaluation do not document the kinds of functional difficulties documented in the evaluation. (Exhibit M, pages 10-15.) There are [REDACTED] entries in the nursing notes for [REDACTED] the date the evaluation was done (Exhibit M, page 15.) None mentions any concern that might support a need for OT, or even that an evaluation was being done that day. The only documentation from the ordering physician is a signature on the evaluation after it was done. (Exhibit M, page 5; Transcript, page 89.)

The [REDACTED] evaluation, furthermore, is inconsistent with the documentation that does appear in the interdisciplinary progress notes. According to the OT evaluation, the resident needed “[REDACTED] assistance” for all ADLs except [REDACTED] for which she was independent. (Exhibit M, pages 4-5; Transcript, page 94.) There is no indication that any of the direct care staff identified any such problems. To the contrary, a facility ADL worksheet, used to monitor the resident’s functioning on a daily basis, [REDACTED] times per day from [REDACTED], documents she was independent every day, on every shift, for ADL functions of [REDACTED]. (Exhibit M, page 22; Transcript, pages 103-104.) The Appellant’s MDS submission also reported the resident as independent in ADLs. (Exhibit M, page 1.)

The Appellant’s completely inadequate response to this evidence was to suggest that the ADL worksheets can be “incorrect” because staff is “very busy” and may have simply copied entries from day to day. (Transcript, pages 75, 117-18.) To claim that as many as a [REDACTED] entries per day for [REDACTED] consecutive days are all “incorrect,” is to admit that the facility failed to create and maintain documentation to support and substantiate the need for OT.

██████████ conceded: “I do agree that there is not a very specific statement or document stating that there is specific need for occupational therapy.” (Transcript, pages 124-25.) She claimed that the evaluation itself, approved by the physician, is sufficient to establish medical necessity. (Transcript, page 133.) She also argued that because the resident record documents other issues being looked at, the evaluation was justified:

I am seeing this as what is going on with the resident?...

So there is ██████████ pain. There is ██████████, ██████████. There’s a ██████████ occurring and the resident is having ██████████ to ██████████ care for A.D.L.s on the flow sheet. That would warrant me, as an occupational therapist, or the occupational therapist, to look more closely at that resident to see if there is need. That is why I believe the occupational therapy evaluation was completed at that time. (Transcript, pages 127-28.)

This rationale is not persuasive to establish medical need. Her claim that a nursing note “continued resistance to care for ADLs” (Exhibit M, page 14) establishes that the resident did indeed require assistance with ADLs even though all of the other documentation explicitly shows her to be independent (Transcript, page 127), is equally unpersuasive to establish a documented medical necessity for OT.

The OMIG reviewer, Ms. Cyriac, testified:

So to me, if a nurse did not identify this as a problem and it does not affect the patient on a daily basis, in any way, her activities of daily living, I do not see why a therapist had to spend her time, therapy time, to treat this patient.

And when I look at it, therapy was given just when – the start date, just when the reference date and/or when the M.D.S. was due. Just during that five-day period was when the therapy was given and the... therapy was taken off. (Transcript, page 85.)

In short, the therapist’s ██████████ evaluation simply appears in the chart, a few days before the MDS assessment review date, and recommends OT that led to an ██████████ in the

resident's [REDACTED]. The OT was then discontinued [REDACTED] days later, on the ARD, on the grounds the resident did not need it.

#### Resident six.

Resident six presented similar facts. The ARD was [REDACTED], 2012, the look back [REDACTED] 2012. The OT evaluation was done on [REDACTED] (Exhibit N, pages 9-10.) OT, consistent with the evaluation, was recommended and given. (Transcript, page 147; Exhibit N, pages 6-7.) On [REDACTED] after [REDACTED] therapy sessions, the OT was discontinued because the resident was determined to have met her goals. (Exhibit N, page 8.) A [REDACTED] progress note had already found "I'm doing good" with goals "partially met" and independence for all self care. (Exhibit M, page 5.)

The Appellant produced no documentation to support a need for OT other than the OT evaluation itself. (Transcript, pages 147-48, 153; Appellant brief, page 5.) The Appellant was unable to provide nursing notes. (Transcript, pages 171-72.) There is, consequently, no documented evidence of any decline in function or any other reason for an OT evaluation. (Transcript, pages 146-48.) Furthermore, as with resident one, the ADL worksheet completed by the hands on care team on every day on every shift showed the resident completely independent from [REDACTED], as did the July 3 MDS submission. (Exhibit N, pages 1, 4; Transcript, pages 145-46, 154, 156-59.)

#### Conclusion.

Ms. Cyriac explained the importance, in determining whether services are "reasonable and necessary for the treatment of the resident's condition," of documentation to support an evaluation by the therapist:

- A. [T]here are patients who have range of motion that is not complete, but yet they're able to do their activities of daily living on a normal basis. There

is no issues. So what made them trigger – what triggered this therapist to go in and look at the patient to say that this person might need therapy because the range of motion wasn't ten ten... It should not be because they are due for an M.D.S.

Q. Well let me ask you this. Are you – is it that you question the accuracy of this evaluation or that there's some other problem?

A. My problem is that a therapist is seeing the patient only for a certain period of time – a short period of time. They go in, they do the assessment. But a problem was not identified. A person – if I'm with a patient all the time, I know exactly what is going on the patient and if there is a decline with this patient, unlike a therapist.

It depends on the time when the – is the patient – was the patient ready? There are times that the patient might – might be able to do completely whatever that they can do. And then there are certain times that they don't want to be bothered with it.

What time does the therapist go in to see the patient? Was it – was it on a bad day? Was it on bad timing? So there are many issues involved with it. So my thing is where was the decline? What is the story? Why is a therapist time needed for this?

There's restorative nursing wherein nursing can give the same care. They could do the range of motion. They can do all that as preventive care. A therapist do not have to go in and treat for prevention, itself.

Q. Is that – and is that because this kind of preventive care you're talking about is in a patient who isn't really having a problem?

A. Yes. If there is a problem –

Q. Even though the patient may have, on evaluation such as this O.T. evaluation that we have in front of us here, findings that are indicative?

A. They might be, but it is not any issue, obviously, because it is not addressed as an issue because on their activities of daily living, it is – it seems to be normal because if it was abnormal or if it was something that was bothering, it would have been addressed.

Q. So in spite of these findings in the evaluation, that that alone are you telling me does not –

A. It's not conclusive.

Q. -- substantiate a need for the therapy?

A. Exactly. (Transcript, pages 148-50.)

The Appellant has failed to establish that it is “reasonable and necessary for the treatment of the resident’s condition” (CMS RAI Manual, page O-19) to evaluate for occult medical needs and provide therapy where there is no evidence that there is an actual impairment of functioning. Therapies should be substantiated by some documentation that they are reasonable and necessary, not by the approach of an MDS submission. (Transcript, pages 85-87, 143.) Routinely timing OT to coincide with a resident’s ARD, rather than observed clinical indications, can distort the facility’s case mix index for an entire rate period. Ms. Cyriac noticed this pattern with patient one [REDACTED] months earlier:

[An evaluation] was done and it also happened to be the M.D.S. timeframe... It looks like – it looks like that they did put her on therapy for [REDACTED] days, then take it off. (Transcript, pages 86-87; Exhibit M, pages 20-21.)

The OMIG rationale requiring some contextual support in the resident record, some documented indication the resident actually has a problem in functioning, and not just a single evaluation from the therapist, is a reasonable interpretation of Medicaid regulations at 10 NYCRR 86-2.17, 18 NYCRR 504.3(a), 518.3(b) & 517.3, and the CMS RAI Manual requirement that OT be “reasonable and necessary for the treatment of the resident’s condition.”

At the hearing, [REDACTED] suggested that OT assessments were appropriately done when the ARD for submitting a new MDS instrument was approaching. (Transcript, pages 126, 139; Appellant brief, page 6.) The Appellant points out that the CMS RAI Manual expects facilities to periodically evaluate residents for therapies. CMS



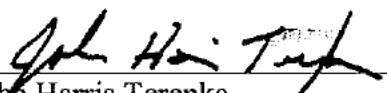
RAI Manual, page O-15. The Appellant claims “it is best practice to do it according to the M.D.S.” (Transcript page 161-63.) The MDS submission should not, however, be a trigger for ordering evaluations for which there is no indication. (Transcript, page 143.) The Appellant’s suggestion that the OT evaluations were done as a matter of routine whenever an MDS reporting instrument was due is an admission that the therapy was initiated with no involvement whatsoever from the interdisciplinary care team. This is plainly contrary to requirements that therapy determinations be made “in conjunction with the physician and nursing administration.” CMS RAI Manual, page O-15.

In any event, the Appellant presented no evidence that these evaluations were conducted pursuant to any regular policy of periodic evaluations required by the MDS manual. Even ██████████, who advanced the suggestion, offered it only as a speculation that could explain why they were done. (Transcript, page 119.) Asked directly whether the OT evaluation of resident one was in fact done for some reason reflected in the record, or as a matter of this quarterly routine, ██████████ reverted to the answer that it was because of the resident record. (Transcript, pages 128-29.) The reason remains undocumented.

**DECISION:** The OMIG’s determinations to recover overpayments based upon the MDS audit findings for resident one and resident six are affirmed.

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

DATED: Rochester, New York  
December 5, 2017

  
John Harris Terepka  
Bureau of Adjudication