

**STATE OF NEW YORK  
DEPARTMENT OF HEALTH**

---

In the Matter of the Appeal of:	:	
	:	
<b>Presbyterian Home for Central New York</b>	:	<b>Decision</b>
Provider ID# 00316789	:	<b>After Hearing</b>
	:	
Appellant,	:	
	:	
from a determination by the NYS Office of the	:	Audit # 13-2806
Medicaid Inspector General to recover	:	
Medicaid Program overpayments.	:	
	:	

---

Before:	Jude B. Mulvey Administrative Law Judge
	Sean D. O'Brien Administrative Law Judge

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

Hearing Date:	April 19, 2016
---------------	----------------

Record closed October 7, 2016

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

	Presbyterian Home for Central New York 4920 Middle Settlement Road New Hartford, New York 13413 By: John F. Darling, Esq. Bond, Schoeneck and King 359 Linden Oaks, Suite 310 Rochester, New York 14625
--	---

**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) Section 363-a. The New York State Office of the Medicaid Inspector General (OMIG), is an independent office within the Department. OMIG 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) Section 31.

OMIG issued a final audit report for Presbyterian Home for Central New York (Appellant) in which OMIG concluded that Appellant had received Medicaid Program overpayments during the audit period of February 1, 2006 through January 31, 2010. Appellant requested a hearing pursuant to SSL Section 22 and former Department of Social Services (DSS) regulations at Title 18 of the New York Codes, Rules and Regulations (NYCRR) Section 519.4 to review the overpayment determination.

**HEARING RECORD**

OMIG witness: Lynne Holloway, Operations Manager, H.M.S.

OMIG exhibits: 1-12

Appellant witness: Russell Clark, Chief Financial Officer of Appellant

A transcript (T), pages 1-151, of the hearing was made. Each party submitted a post hearing brief. The record was closed on October 7, 2016.

**Post Record Closure History:**

The originally assigned Administrative Law Judge, who heard the case, subsequently left state employment without issuing a decision. The attorney for the Appellant by letter dated August 23, 2019, requested dismissal of the audit findings due to the failure of a decision being issued. By letter dated September 23, 2019, the Chief Administrative Law Judge stated the record of the appeal was unable to be located in the Bureau of Adjudication's files. The Chief Judge requested OMIG to send copies of the exhibits, briefs and transcripts from the hearing to the Bureau and a new Administrative Law Judge, Sean D. O'Brien, was assigned to review the record and to issue a decision on the submitted record. The OMIG's copy of the record of appeal including exhibits, briefs and transcripts, with notice to Appellant's attorney, was received by the Bureau of Adjudication on October 11, 2019.

**SUMMARY OF FACTS**

1. At all times relevant hereto, Appellant was a residential health care facility enrolled as a provider in the Medicaid Program. (Exhibit 1).
2. All Medicaid claims paid to the Appellant for the dates of service from February 1, 2006, through January 21, 2010 (the audit period) were examined. (Exhibit 1; T 20).
3. The purpose of this audit was to identify potential Medicaid overpayments, if such payments were not reduced in whole or in part, by the Net Available Monthly Income (NAMI) or resident contribution of Medicaid benefits. (Exhibit 1; T 21-21)
4. Appellant submitted a response to the draft audit report on October 9, 2013. (Exhibit 3).
5. On December 13, 2013, OMIG issued the Final Audit Report (#13-2806) that identified overpayments in the amount of \$59,120. 34. (Exhibit 1).
6. On January 7, 2014, Appellant requested a hearing to review the overpayment determination. (Exhibits 1, 4).

7. NAMI is the amount each nursing home resident is required to pay each month for their nursing home care. It is determined by the Local Department of Social Services (LDSS) case worker and is based on all sources of income a resident receives. The caseworker will subtract out any allowable deductions such as personal needs allowance, insurance premiums, spousal allowances. The net result after those deductions is the NAMI. (Exhibit 1; T 22).

8. Medicaid providers are instructed to enter the NAMI amount approved by the LDSS on the claim that is submitted for payment per “UB-04 Billing Guidelines”. The “UB-04” states as part of its purpose the “... document is to assist the provider in...complying with...(NYS Medicaid) requirements...for billing and submitting claims....” (Exhibit 7).

9. Medicaid providers are further instructed by a Department “Dear Administrator” letter dated October 26, 2001, which informs providers to wait to file claims until their receipt of the NAMI amount calculated for the resident by the LDSS. (Exhibit 8; T 30).

### **ISSUE**

Has Appellant established that OMIG’s audit determinations are incorrect?

### **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 resident care. 10 NYCRR 86-2.17. These kinds of costs are allowed if they are incurred and the amount is reasonable.

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 resident’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).

This proceeding focuses on payments Medicaid recipients are obligated to contribute for the cost of their care in a nursing home facility, known as NAMI. (Exhibits 7, 8, 9; T 21-22). At issue here, Appellant did not include or partially included the NAMI amounts for claims it submitted to the Medicaid program. This resulted in overpayments to the Appellant. (Exhibit 1). 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).

The NAMI determination is performed by the LDSS pursuant to SSL Section 366 and 18 NYCRR Part 360. The LDSS performs an analysis of the monthly income of the individual to determine the amount of such income which is available to their applied cost of care. 18 NYCRR Sections 360-4.6, 360-4.9. The amount of income remaining after authorized deductions is the NAMI to be obtained from the resident for the specific budgeted period.

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 the determination of the Department was incorrect and that all costs claimed were allowable. 18 NYCRR 519.18(d)(1) and (h).

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.

### **DISCUSSION**

Ms. Lynne Holloway, an employee of Health Management Systems (HMS) testified on behalf OMIG at the Hearing. HMS was contracted by OMIG to conduct audits of Medicaid providers in New York and HMS auditors performed the audit at issue here. (T 19). The auditors pulled claims information from the State Medicaid Management Information System (MMIS) and then compared the NAMI amounts in the MMIS to those claim amounts filed by the Appellant which resulted in the conclusions stated in the Final Audit Report. (Exhibit 1; T 23-24).

The MMIS data includes the NAMI on file for each resident of the Appellant, claims data and paid Medicaid claims for the review period of the audit. (T 23). This information was compared by the auditors to determine if a proper deduction was made. (T 23-25). In addition, the auditors reviewed the financial history reports of the residents. (T 118-119). Moreover, during the response phase of the audit, the Appellant had the opportunity to provide auditors with any backup paperwork to counter the auditors' determinations as to the NAMI amounts for its residents.

The auditors found the Appellant did not comply with the billing guidelines issued by Medicaid. In particular, those guidelines contained in the document “UB-04 Billing Guidelines”. (Exhibit 7). In the “UB-04”, Medicaid providers are directed to “[e]nter the NAMI amount approved by the [LDSS] as the patient’s monthly budget...” and the “Guidelines” goes on to state, “[i]f a billing occurs more than once a month, enter the full NAMI amount on the first claim submitted for the month....” (Exhibit 7; p. 18).

In addition, the auditors determined the Appellant did not follow the Department instructions via a “Dear Administrator Letter” issued in 2001. The “Dear Administrator Letter” informs Medicaid providers not to submit a claim for payment until the provider receives a budget letter for the resident from the LDSS which sets forth the NAMI amount that must be collected from the resident. (Exhibit 8 at question 11). The NAMI amount is deducted from the claim and it is not payable from the Medicaid program. (Exhibit 7).

Per the “Dear Administrator Letter” there are no exceptions to the NAMI amount being indicated in the claim. The NAMI is that portion of the resident’s cost of care the individual is responsible for. When the resident’s NAMI amount is not included in the claim it results in overpayment to the provider of care in violation of 18 NYCRR 518.1.

The audit concluded the Medicaid program improperly paid claims for Medicaid recipients of the Appellant where the residents’ NAMI contribution was not entered on the claim or for a partial amount. The auditors determined the Appellant did not deduct the proper NAMI amount or listed an incorrect amount on each of the disputed resident reviews thereby creating overpayments of Medicaid monies to the Appellant. (Exhibit 1; T 27-30).

In its reply to the audit and at the hearing the Appellant contested a number of the Medicaid claims where the auditors concluded there were overpayments. The first of the contested claims involved resident A.J (resident initials used). Ms. Holloway testified the NAMI amount for the resident A.J. was for \$6,543.99. (T 40). However, this amount was not deducted from the Medicaid claims filed by the Appellant. This resulted in overpayments for each of the three claims submitted by Appellant for the dates of services for the weeks of [REDACTED] 2008, [REDACTED], 2008 and [REDACTED], 2008 for a total of \$3214.05. (Exhibit 11, T. 40-41).

The Appellant contends the NAMI amount required for resident [REDACTED] has already been recovered by Medicaid in the amount of \$6,543.99. However, as explained by Ms. Holloway that is not the case, "...because the NAMI was greater than what they [Appellant] billed it resulted in a negative claim which means Medicaid actually recouped five thousand one sixty-six fifty-four [\$5,166.54]". (T 43). This recouped amount was later voided and then paid back to the Appellant by Medicaid. (T 44). The auditors determined, "[h]ad the void not occurred then the NAMI would have been applied to 4/1 to 4/9 [2008]...[b]ut because the claim was voided and is no longer paid, and the facility [appellant] received that money back...we have the overpayment again". (T 45).

For the claim regarding resident [REDACTED] no resident contribution was deducted for claims submitted for the dates of service of [REDACTED] 2009, through [REDACTED] 2009. The NAMI amount for resident [REDACTED] was \$1075.45. However, the NAMI was not applied to the Medicaid claim submitted by Appellant which resulted in a \$1075.45 overpayment. (T 45-48).



In the matter of resident [REDACTED] the NAMI amount was \$1615.00 for the service dates [REDACTED] 2007 through [REDACTED], 2007, but Appellant did not apply resident contribution to the claims it submitted for the service dates. (T. 48-50).

For resident [REDACTED]. there was a Fair Hearing Determination on June 1, 2009, which determined Medicaid eligibility for the resident retroactive to [REDACTED] 2009. (T 86). The Appellant in its brief argues it cannot be held responsible for the NAMI amount not being included in its [REDACTED] and [REDACTED] 2009 Medicaid claims. (T 85-88). However, the Appellant could not cite the regulatory authority to allow for this overpayment.

The remaining disputed claims regarding residents: [REDACTED]  
[REDACTED] . and [REDACTED]  
are similar to the claims for residents [REDACTED] and [REDACTED] where the Medicaid claims submitted for service dates by the Appellant do not include the resident NAMI amount or only the partial NAMI amount for the resident contribution thereby creating an improper claim. (Exhibits 1, 12). The Appellant does provide any persuasive authority or evidence to disturb the findings of the Final Audit Report.

It is fundamental the information provided to the government by a facility provider be "...true, accurate and complete." 18 NYCRR 504.3(h). What Appellant received due to its errors was an overpayment in government monies. "An overpayment includes any amount not authorized to be paid...whether paid as the result of ...fraud, abuse or mistake." 18 NYCRR 518.1(c).

The failure of Appellant to enter each of the designated residents' NAMI contribution on the claims at issue in this audit is an overpayment per 18 NYCRR 518.1 and is in violation of the Medicaid billing guidance document "UB-04 Billing

Guidelines”. (Exhibit 7). Moreover, per the “Dear Administrator Letter” providers are not to file a claim without the NAMI information via the budget letter from LDSS. (Exhibit 8). The guidance and regulations do not provide any exceptions to the requirement that a NAMI must be included in the Medicaid claim, no matter how late the LDSS is processing and producing a budget letter with the resident’s NAMI amount for their share of their cost of care.

Appellant in its brief argues that it should be credited for any Medicaid underpayments and the present audit failed to identify underpayments per 42 Code of Federal Rules (CFR) Section 455.506(a). That regulation states in part, “Medicaid RACs [Recovery Audit Contractors] will review claims submitted by providers of items and services...for which payment has been made...to identify underpayments and overpayments and recoup overpayments for the States.”

In addition, the Appellant cites the case Matter of Bulmahn v. NYS OMIG, 106 A.D. 3d 1504 (4<sup>th</sup> Dept). 2013, as requiring OMIG to consider underpayments while conducting an audit. In Bulmahn, there was evidence of “significant underpayment” discovered in the extrapolation audit along with testimony by the provider’s expert who testified that OMIG’s failure to consider the underpayment resulted in an inaccurate determination of the overpayment.

That is not the case here. There was no testimony or evidence of any underpayment the auditors missed. Unlike the Bulmahn case the audit in the present case was not an extrapolation audit with statistical sampling. In addition, Ms. Holloway testified the auditors adjusted claims accordingly, “...we reduced our finding to allow for the provider [Appellant] to keep what they were owed for the room and board.” (T 97,

111). Ms. Holloway went on to testify, “[i]f there was an unpaid service for the same benefit month in which the NAMI overpayment occurred, then we would allow for those service dates as long as they were due from Medicaid.” (T 111). There is no evidence of any significant underpayments in this audit. Regardless, the auditors here did give Appellant credits accordingly. The Appellant’s argument for underpayments in this audit is not persuasive.

The burden is on the Appellant to demonstrate by substantial evidence the findings by the OMIG were incorrect. 18 NYCRR 519.18(h). Appellant has offered no evidence to overturn the audit’s findings and determinations. Instead, Appellant has made arguments that it can submit Medicaid claims without following the published guidance because of the hardship to its business operations due to the LDSS not processing resident budget letters with the NAMI amounts in a timely manner. (T 139-140). This delay is exacerbated by residents’ families not directly paying for their relatives’ portion of care not covered by Medicaid. (T 133-137).

However, in the hearing, Mr. Russell Clark, the Chief Financial Officer for Appellant, admitted he does not avail himself of the Medicaid roster prepared for his facility. (T 140-144). The NAMI amounts for residents at Appellant’s facility are updated monthly. (T 143). The Appellant could use this as a resource when submitting claims, rather than waiting for the budget letters with the NAMI amounts issued by the LDSS. (T 140-143).

In addition, while 18 NYCRR 360-2.4(a) requires an application for Medicaid benefits be determined by the LDSS within 45 days of the date of application it does not mean if the LDSS fail to issue a NAMI budget letter within 45 days the Appellant is

allowed to submit claims without the required NAMI for its residents. Moreover, 18 NYCRR 360-2.4(b)(1) goes on to state “...when the district cannot reach the decision because the applicant or an examining physician has delayed or not taken required action...” the 45-day limit may be extended. So, the 45-day rule is not a complete deadline.

Regardless, for Medicaid providers, the language set forth in the in Medicaid billing guidance, “UB-04 Billing Guidelines”, is straightforward. (Exhibit 7 at page 18). The NAMI as approved by the LDSS is to be entered on the claim when it is submitted. This requirement is further explained in the “Dear Administrator Letter” (Exhibit 8 at page 3, question 11). In question 11, the “Dear Administrator Letter”, states “[w]hat is the provider’s responsibility when the NAMI hasn’t been determined yet for newly admitted residents...[f]or instance, cases where the Medicaid roster doesn’t identify the NAMI amount and the LDSS hasn’t yet sent a budget letter to the facility....” The answer is “...a provider should not bill Medicaid until they receive a budget letter...indicating the NAMI amount....” (Exhibit 8).

Appellant has not proved by substantial evidence that the interpretation and determinations made by OMIG are incorrect. No regulatory guidance has been provided to support the Appellant’s arguments that it is entitled to self-help to submit full Medicaid claims when the LDSS fails to provide Appellant a budget letter stating the NAMI amount for the Appellant’s residents. There is nothing in 18 NYCRR 518.1 to support the argument that overpayments are mitigated or waived due to the late processing of NAMI amounts by the LDSS. Appellant has failed in its burden to prove OMIG’s audit determinations were incorrect.

**DECISION**

OMIG's determination to recover overpayments based upon the findings of  
Audit #13-2806 is affirmed.

This decision is made by Sean D. O'Brien, Bureau of Adjudication, who has been  
designated to make such decisions.

DATED: Albany, New York  
January 13, 2020

---

SEAN D. O'BRIEN  
Administrative Law Judge

TO:

John F. Darling, Esq.  
Bond, Schoeneck and King  
350 Linden Oaks, Third Floor  
Rochester, New York 14625

Kendra Vergason, Esq.  
Office of the Medicaid Inspector General  
584 Delaware Avenue  
Buffalo, New York 14120