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NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Acting Executive Deputy Commissioner

September 7, 2023

CERTIFIED MAIL/RETURN RECEIPT

Richard Chasney, Esq.
NYS OMIG
800 North Pearl Street
Albany, New York 12204

Warren Center for Rehab and Nursing
aka Warren Operations Associates, LLC
42 Gurney Lane
Queensbury, New York 12804

Phyllis Goldstein, Director of Corporate Appeals
Centers Health Care
4770 White Plains Road
Bronx, New York 14070

RE: In the Matter of Warren Center for Rehabilitation and Nursing aka Warren Operations Associates, LLC

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,

Natalie J. Bordeaux

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB:nm
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of

WARREN CENTER FOR
REHABILITATION AND NURSING
(AKA WARREN OPERATIONS ASSOCIATES, LLC),

DECISION

Medicaid # 00473794

Audit # 18-9191

for a hearing pursuant to Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR)

Before: Tina M. Champion
Administrative Law Judge

Held At: Videoconference via WebEx

Date of Hearing: July 1, 2020
Record closed September 30, 2020

Parties: New York State Office of the Medicaid Inspector General
By: Richard Chasney, Assistant Attorney
800 North Pearl Street
Albany, New York 12204

Warren Center for Rehabilitation and Nursing
aka Warren Operations Associates, LLC
42 Gurney Lane
Queensbury, New York 12804
By: Phyllis Goldstein, Director of Corporate Appeals
Centers Health Care
4770 White Plains Road
Bronx, New York 14070

JURISDICTION

Pursuant to New York State Public Health Law (PHL) § 201(1)(v) and New York State Social Services Law (SSL) § 363-a, the Department of Health (Department) acts as the single state agency to supervise the administration of the medical assistance program (Medicaid) in New York State. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority pursuant to PHL §§ 30, 31 and 32 to pursue administrative enforcement actions against any individual or entity that engages in fraud, abuse, or unacceptable practices in the Medicaid program and to recover improperly expended Medicaid funds.

The OMIG determined to recover Medicaid overpayments made to Warren Center for Rehabilitation and Nursing, aka Warren Operations Associates, LLC, (Appellant) for the census period ending January 25, 2016. Appellant requested a hearing to challenge the overpayment determination pursuant to SSL § 145-a and 18 NYCRR 519.4.

HEARING RECORD

OMIG Exhibits:
1 – Excerpts from CMS RAI Version 3.0 Manual v1.13 – October 2015
2 – Audit Notification Letter
3 – Entrance & Exit Conferences
4 – Draft Audit Report
5 – Provider Response Extension
6 – Provider Response to Draft Audit Report
7 – Final Audit Report
8 – Sample #1
9 – Excerpts from CMS RAI Version 2.0 Manual – December 2008
10 – Hearing Request
11 – Notice of Hearing
12 – Notice of Prehearing Conference
13 – Statement of Prehearing Conference Amended

Appellant Exhibits: None

OMIG Witnesses: Lloyd Clark, Health Care Surveyor 2

Appellant Witnesses: None

Transcript: Pages 1 – 82

Post-hearing Briefs: September 30, 2020

FINDINGS OF FACT

1. The Appellant is a residential health care facility that was enrolled as a provider in the New York State Medicaid Program at all relevant times herein. (Tr. 13.)

2. The OMIG performed a field audit to review the Appellant's documentation in support of its Minimum Data Set (MDS) submission that is used to calculate its reimbursement rate from the Medicaid Program. The scope of the audit was for the census period ending on January 25, 2016, which affects the rate period of July 1, 2016 through December 31, 2016. (OMIG Exs. 2, 3, 4 & 7; Tr. 13-14.)

3. The OMIG issued a Draft Audit Report on September 11, 2019, in which it preliminarily determined that the Resource Utilization Group (RUG) category assigned to one of twelve patients reviewed was not supported by documentation that minimally complied with requirements of federal regulations, state regulations, and Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (CMSRAI 3.0). Specifically, for the one patient with the incorrect RUG category, three activities of daily living (ADLs) were disallowed because of insufficient supporting documentation. (OMIG Ex. 4.)

4. The OMIG preliminarily identified a resulting overpayment in the amount of $7,643.88. (OMIG Ex. 4.)

5. The Appellant responded to the Draft Audit Report by letter dated October 28, 2019, and provided additional documentation. (OMIG Ex. 6.)

6. The OMIG considered the Appellant's response and determined that the additional documentation also did not minimally comply with federal regulations, state regulations, and the CMSRAI 3.0. (Tr. 14-15.)

7. The OMIG issued a Final Audit Report on December 9, 2019, in which the determination of a $7,643.88 overpayment was unchanged. (OMIG Ex. 7; Tr. 14-15.)

8. By letter dated December 16, 2019, the Appellant timely requested a hearing to review the OMIG's overpayment determination. (OMIG Ex. 10.)

ISSUE

Has the Appellant established that the OMIG's determination to recover overpayments in the amount of $7,643.88 was not correct?

APPLICABLE LAW

Medicaid providers are subject to audit and claim review by the Department. (18 NYCRR 504.8[a].) "When the department has determined that any person has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, it may require repayment of the amount determined to have been overpaid." (18 NYCRR 518.1[c].) Overpayments include "any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake." (18 NYCRR 518.1[c].)

Federal regulations require that residential health care facilities make a comprehensive assessment of a resident's needs, using the Resident Assessment Instrument (RAI) specified by the State. (42 CFR 483.20[b]; see also 10 NYCRR 86-2.37.) This assessment must include 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][xvii].) New York State uses the RAI as published by the Centers for Medicare and Medicaid Services (CMS) to determine a facility's Medicaid rate of payment. (10 NYCRR 86-2.40[m][1].)

Residents of residential health care facilities require varying levels of care and associated cost. The MDS is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in the Medicaid program. (Ex. 1 at p. 5.) Resident-assessment requirements for the MDS are specified in federal regulations, and further detailed in CMSRAI 3.0. (42 CFR 483.20; 10 NYCRR 86-2.40[m][1].) MDS data is also used by New York State to determine Medicaid reimbursement. (10 NYCRR

86-2.40[m][1]; Ex. 1 at 5-6.)

New York State residential health care facilities assess residents and submit the information on the MDS to the Department of Health's Bureau of Long Term Care Reimbursement (BLTCR). (10 NYCRR 86-2.37[a].) BLTCR uses each facility's MDS data to classify each of the facility's residents into a RUG classification. (10 NYCRR 86-2.40[m].) RUG classifications used by BLTCR are defined in the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 2.0 User's Manual (CMSRAI 2.0). (Exs. 1 at p. 10, 9 at p. 3; Tr. 47-48.) Each RUG classification has an associated case mix index number. (10 NYCRR 86-2.10[a][5].) The higher the case mix index number of a resident, the greater the level of care required by the resident. Accordingly, the higher the average case mix index of a facility's residents, the higher a facility's rate of reimbursement. (Matter of Elcor Health Servs. v Novello, 100 NY2d 273, 276-277 [2003]; 10 NYCRR 86-2.10; 10 NYCRR 86-2.40[m].)

Part of New York State's MDS is an assessment of each resident's need for assistance with ADLs such as bed mobility, eating, and transfer. (10 NYCRR 415.11[a].) CMSRAI 3.0 sets the minimum requirements for ADL assessments. (Ex. 1 at 11-51; *see also* 10 NYCRR 86-2.40[m][1].) Each resident must be evaluated as of a specific assessment reference date (ARD) that is chosen by the facility within the required timeframe for ADL assessments. (Ex. 1 at 8-9; Tr. 32.) The facility must assess each episode of a resident's ADL activity for each ADL type within a seven-day look-back period from the selected ARD, and assign numerical ADL codes on the MDS for both ADL self-performance and ADL support-provided, based on coding rules required by the RAI 3.0 Manual. (Ex. 1 at 11-51; Tr. 32.)

In challenges to an OMIG's overpayment determination, the Appellant has the burden of showing that the OMIG's determination "was incorrect and that all claims submitted and denied were due and payable under the program, or that all costs claimed were allowable." (18 NYCRR 519.18[d][1].)

DISCUSSION

In this audit, OMIG disallowed three self-performance ADL codes – bed mobility, transfer, and eating – for sample number one, which resulted in the entire overpayment in this audit. (Exhibit 7 at 4, 7.) All three disallowances were because the Appellant coded a self-performance ADL on the MDS submission for which it failed to provide documentation that minimally complied with federal regulations, state regulations, and the RAI 3.0 Manual. (Exhibit 7 at 4-8.)

The Appellant selected sample number one's ARD as January 5, 2016, resulting in December 30, 2015 through January 5, 2016 as the seven-day look-back period. (Exhibit 8 at 1; Tr. 41-42.) The Appellant's documentation for sample number one during the audit, and in response to the draft audit report, consisted of (1) a patient care plan for dates subsequent to the seven-day look-back period; (2) an ADL function sheet for dates prior to the seven-day look-back period; (3) an ADL tracker sheet that included only one day of the seven-day look-back period; (4) nurse notes that included one note within the seven-day look-back period; and (5) an MDS pain assessment. (Exs. 6, 8; Tr. 48-70.)

ADL self-performance coding requirements are detailed in the RAI 3.0 Manual. (10 NYCRR 86-2.40[m][1].) The coding rules include the "rule of three," which requires that an ADL self-performance activity occurs at least three times within the seven-day look-back period for a facility to code a level of care value of 1, 2, 3 or 4. Further, in order to code a level of care value of 4, every occurrence within the seven-day look-back period must have required full staff performance, meaning that the resident was totally dependent on staff to perform the activity. (Ex. 1 at 11, 16, 17; Tr. at 31-33, 53-54.)

In order to apply the rule of three to determine the appropriate ADL self-performance code to report on the MDS, the RAI 3.0 Manual states that residential health care facilities "must first note which ADL activities occurred, how many times each ADL activity occurred, what type and what level of support was required for each ADL activity over the entire 7-day look-back period." (Ex. at 16.) If a residential health care facility's documentation does not include what

type and level of support was provided to a resident for an ADL self-performance activity during the 7-day look-back period on at least three occurrences, it cannot be used when applying the rule of three for MDS coding.

For the 7-day look-back period of the resident at issue, the Appellant coded a 3 for self-performance of bed mobility, a 4 for the self-performance of transfer, and a 2 for self-performance of eating. The OMIG asserts that the Appellant's documentation shows only two occurrences of self-performance of bed mobility, two of self-performance of eating and two of self-performance of transfer rather than the required three documented occurrences for each self-performance category. The OMIG argues that the codes used by the Appellant should therefore be disallowed and coded as a 0.

At hearing, the Appellant acquiesced that the documentation does not meet the requirements. The Appellant's representative, Phyllis Goldstein, stated "in all honesty, we do not have the rule of three. It's just not there. In terms of actual nursing documentation in the nurse. C.N.A. documentation which is what OMIG was looking at. I looked for it, it doesn't exist." (Tr. 75.) However, the Appellant argues that even though it did not meet the rule of three, the records provided indicate that the resident at issue would likely have needed the levels of care the Appellant coded on the MDS. This is an argument that the detailed ADL coding rules are essentially optional and meaningless.

The OMIG's witness, Lloyd Clark, credibly testified that a resident's self-performance level of care can change from shift to shift. He also credibly testified that information in a resident's record does not always correlate with the actual levels of care provided. These changing levels and discrepancies between a resident's record and actual self-performance underscore the importance of documenting what self-performance activities actually occurred during the designated look-back period, which look-back period was based on the ARD chosen by the Appellant. An assumption of what the likely level of care would have been based on a resident's

other records in this matter is insufficient. The Appellant has not met its burden to show that the OMIG's determination was incorrect.

DECISION

The OMIG's determination to recover Medicaid Program overpayments from Warren Center for Rehabilitation and Nursing in the total amount of $7,643.88, inclusive of interest, is affirmed.

Albany, New York
September 7, 2023

Tina M. Champion
Administrative Law Judge