

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

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| In the Matter of the Appeal of | : | |
| | : | |
| Huntington Living Center | : | Decision After |
| Provider #01206220 | : | Hearing |
| | : | |
| from a determination by NYS Office of the | : | |
| Medicaid Inspector General to recover | : | |
| Medicaid Program overpayments. | : | #14-3980 |
| | : | |

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
259 Monroe Avenue
Rochester, New York 14607
May 3, 2017
Record closed: June 16, 2017

Parties: New York State Office of the Medicaid Inspector General
584 Delaware Avenue
Buffalo, New York 14202
By: Kendra A. Vergason, Esq.

Huntington Living Center
Karol Prayne, Administrator
369 East Main Street
Waterloo, New York 13165
By: Karen Donovan

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 Huntington Living 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: Patricia Murphy, R.N.

OMIG exhibits: 1-9

Appellant witness: [REDACTED] rehabilitation supervisor

Appellant exhibit: A

A transcript of the hearing was made. (Transcript, pages 1-139.) The record remained open for post hearing submissions until June 16, 2017. The OMIG submitted a brief, the Appellant did not.

SUMMARY OF FACTS

1. Huntington Living 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 Waterloo, New York.

2. 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 July 1 through December 31, 2013. The OMIG requested records for a sample of forty facility residents from its January 2013 census. (Exhibit 6.)

3. The OMIG determined that the resource utilization group (RUG) category assigned to one of the residents (resident 19) was not accurate because the Appellant's records failed to document the need for physical therapy (PT) services ordered and provided to the resident. The OMIG recalculated the Appellant's Medicaid reimbursement rate accordingly.

4. The Appellant's MDS submission assigned resident 19 to RUG category "RMC." (Exhibit 8, page 1.) Assignment to this category meant he required skilled therapy at a minimum of 150 minutes per week. Pursuant to 10 NYCRR 86-2.40(m)(8), the OMIG reclassified the resident's RUG category from "RMC," which has a case mix index (CMI) score of [REDACTED] to "PD1," which has a CMI score of [REDACTED]. (Exhibit 2, page 4; Exhibit 7.)

5. On October 17, 2016, the OMIG issued a final audit report that identified overpayments in the Appellant's Medicaid reimbursement resulting from the recalculation 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 \$21,203.12. (Exhibit 2.) The total overpayment included amounts attributable to the change in RUG category and reduction in CMI score for resident 19.

6. Resident 19's MDS submission had an "assessment review date" (ARD) of [REDACTED] 2012. The seven day "look back" period for physical therapy reported on the MDS was [REDACTED], 2012.

7. On [REDACTED], 2012, facility staff documented a telephone order for "PT eval & treat, if indicated." The order does not document a reason for the evaluation. (Exhibit 8, page 12; Transcript, pages 50-51.)

8. The evaluation was done on [REDACTED] 2012, stating a diagnosis of [REDACTED] [REDACTED] [REDACTED] [REDACTED]. The evaluating therapist recommended a [REDACTED] week course of PT. (Exhibit 8, pages 14-15; Transcript, pages 105-107.)

9. The resident's facility physician approved the recommendation, and on [REDACTED] ordered [REDACTED] weeks of PT, [REDACTED] times and [REDACTED] minutes per week. (Exhibit 8, pages 13, 15; Transcript, page 107.)

10. Progress notes for the period [REDACTED] show a consistent functional status throughout the therapy. (Exhibit 8, pages 4-11.) The resident record contains no documentation of any observed functional deficit before the evaluation was performed. (Transcript, page 129.)

11. On [REDACTED] 2012, after [REDACTED] days of PT, another evaluation was completed. The resident was found to be at "baseline status." He was discharged from PT. (Exhibit 8, pages 19-20; Transcript, pages 111-12.)

ISSUE

Has the Appellant established that the OMIG's MDS audit determination to recover Medicaid overpayments attributable to the claimed physical therapy needs of resident 19 is 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), 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 7.) 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, page 11.)

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 9), 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 audit report included findings about several of the forty residents reviewed, but only one of the findings is in dispute. (Exhibits 2, 3; Transcript, page 13.) The sole issue for this hearing is whether the Appellant's records document that physical therapy (PT) services provided to resident 19 were reasonable and necessary for treatment of the resident's condition. The OMIG does not dispute that these services were ordered by a physician, and were provided as reported. (Exhibit 8, page 13; Transcript, pages 20-21.) The OMIG's criticism is that the resident record failed to document the medical necessity for the PT. 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.

A physician's order dated [REDACTED], 2012, [REDACTED] week before the ARD and authorizing a [REDACTED] week course of physical therapy, constituted documentation of the required order for the therapy. (Exhibit 8, page 13.) The OMIG auditors looked for documentation to support the medical necessity for the PT during the seven day "look back" period [REDACTED], 2012. (Transcript, pages 32-33.)

Resident 19 had been evaluated for physical therapy on [REDACTED], 2012, [REDACTED] months before the [REDACTED] 2012 PT under review. The earlier evaluation had determined he was at his "baseline" level and not in need of skilled PT. (Exhibit A; Transcript, page 101.) There is no documented evidence of any functional difficulty after the [REDACTED] 2012 evaluation that found no need for PT, and the evaluation under review

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)(xviii).

No evidence of this described process, however, is documented in resident 19's record. (Transcript, page 114.) There is no recorded staff communication, and a chart review, if it was done in connection with the evaluation, would have revealed nothing other than the previous evaluation (Exhibit A) that found no need for PT. Progress notes fail to mention anything pertinent to a need for PT. (Transcript, pages 59, 130.) The telephone order for the evaluation does not document a reason for it or how it came about. (Exhibit 8, page 12.) The documentation in this instance does not reflect compliance with the requirements of 42 CFR 483.20(b)(xviii) or the CMS RAI Manual to establish either the reason for the evaluation or the need for therapy. nor is it even consistent with the Appellant's own self described assessment process.

The Appellant argues that the discharge of the resident after ten visits with no further need for the therapy documents it was successful and "shows the medical necessity." (Transcript, pages 113, 131.) There is little indication, however, that this therapy did effect a change in the resident's functioning. The therapy began on [REDACTED] and the staff began making chart entries documenting the resident's ADL functioning on [REDACTED]. His ADL scores on [REDACTED] (with a higher score indicative of lower functioning) were:

| | Self performance | Support |
|------------|------------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] |

(Exhibit 8, page 5.)

On [REDACTED], the last day ADL functioning was documented, those scores were:

Self performance Support



(Exhibit 8, page 11.)

█ shift evaluations in between these dates recorded similar scores. (Exhibit 8, pages 5-11.) On █, on this documentation of essentially no change in functioning, and no improvement, the resident was discharged from PT on the grounds he was at “baseline status.” (Exhibit 8, page 20.) This “baseline status” is where the resident was at the beginning of the PT.

The Appellant is apparently aware that timing therapy to coincide with a resident’s ARD, rather than observed and documented clinical indications, can distort the facility’s case mix index for an entire rate period. █ observed:

We do certainly understand that there are those facilities that do report a high-amount of therapy throughout the process of rate-setting, the M.D.S. and the case-mix cycles. However in the case of Huntington Living Center, we’re not one of those facilities. (Transcript, page 16.)

█ █ assertion was not directly challenged by the OMIG, but the documentation issue remains. There is no contextual support in this resident record suggestive of a need for PT. All that this resident’s record shows is that, just before the ARD, indeed precisely when the look back period for that ARD commenced, the Appellant, with no documented reason, began a course of PT. The PT achieved essentially no results, and was discontinued immediately after the ARD.

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, and which achieves no discernable result. 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 – in this case of a resident whose “performance can be variable depending on mood... ? reliability as historian” (Exhibit 8, page 15) - is a reasonable application of Medicaid reimbursement requirements.

DECISION: The OMIG’s determination to recover overpayments based upon the MDS audit findings for resident 19 is 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