STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **Cooperstown Center for Rehabilitation and Nursing,** Provider ID# 00356414, Appellant, from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.	:	**Decision After Hearing** Audit # 18-9205

Before: Ann Gayle
Administrative Law Judge

Held: Remotely by Cisco Webex

Hearing Date: October 6, 2020
Record closed March 1, 2021

Parties: Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

By: Richard Chasney, Esq.

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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. Social Services Law (SSL) §363-a. 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. Public Health Law (PHL) §31.

OMIG issued a final audit report for Cooperstown Center for Rehabilitation and Nursing (Cooperstown Center or Appellant) in which OMIG concluded that Appellant had received Medicaid Program overpayments. Appellant requested a hearing pursuant to SSL §22 and former Department of Social Services (DSS) regulations at Title 18 of the New York Code, Rules and Regulations (NYCRR) Section 519.4 to review the overpayment determination.

HEARING RECORD

OMIG witness:	Patricia Murphy, R.N.
OMIG exhibits:	1-13
Appellant exhibits:	None[1]
Appellant witnesses:	None

A transcript (T) of the hearing was made. Each party submitted a post hearing brief and reply brief. The record closed March 1, 2021.

[1] *OMIG's objections to Appellant's Exhibits A-D were sustained; they were marked Appellant's Exhibits A-D for identification only; pages 1-4 of Exhibit C are in evidence as OMIG's Exhibit 9. (T 35-36, 39-40)*

SUMMARY OF FACTS

1. At all times relevant hereto, Cooperstown Center for Rehabilitation and Nursing (formerly known as Focus Rehabilitation and Nursing Center at Otsego), located in Cooperstown, New York, was a residential health care facility, licensed under PHL Article 28 and enrolled as a provider in the Medicaid Program. (Ex 1; T 90)

2. In February 2019, OMIG commenced Audit #18-9205 to review Appellant's documentation in support of its Minimum Data Set (MDS) submissions used to determine its reimbursement from the Medicaid Program. A February 28, 2019 audit notification letter was sent to Appellant. An Entrance Conference and an Exit Conference were held at the Facility; the Entrance and Exit Conference Sign-in Sheets are both dated May 1, 2019. During the on-site audit, Appellant provided OMIG with documents which included a January 7, 2016 progress note for Resident 4. (Ex 1; Ex 2; Ex 11; page 6; T 82-84, 95-96)

3. The audit reviewed MDS submissions, related to Appellant's census period ending January 25, 2016, used to determine reimbursement from the Medicaid Program for the rate period July 1, 2016 through December 31, 2016. OMIG reviewed records for a sample of fifteen facility residents. On October 8, 2019, OMIG issued a draft audit report that included findings for seven of the fifteen samples which resulted in an estimated overpayment of $70,978.98. (Ex 3; T 84-85)

4. On November 20, 2019, Appellant submitted a response to the draft audit report that included documentation for several residents. The documentation for Resident 4 consisted of undated –for month and year– ADL Tracker and Toileting Sheets. Appellant explained that these documents were not previously provided because

"[d]uring the onsite audit the ADL logs...were unavailable for your review. The ADL logs are now located and are enclosed for your review" (Ex 5, page 2). (Ex 5, pages 1-2, 20-24; T 92-95)

5. The aforesaid ADL Tracker, Toileting Sheets, and [redacted] 2016 progress note was the only documentation Appellant provided for Resident 4 during the on-site audit and in response to the draft audit report. On February 24, 2020, OMIG issued a final audit report that identified overpayments in Appellant's Medicaid reimbursement resulting from the correction of its reimbursement rate to reflect the audit findings for three of the fifteen samples. OMIG advised Appellant that it intended to recover Medicaid Program overpayments in the amount of $23,532.28. On March 4, 2020, Appellant requested a hearing to review the overpayment determination. (Ex 5; Ex 6; Ex 7; T 86-88; 96)

6. Per the parties' stipulation, the only findings at issue for this hearing were Sample #4/Resident 4's monetary findings, for which OMIG auditors determined that the Resource Utilization Group (RUG) category assigned to this resident was not accurate because Appellant's records failed to support the reported special treatment and level of ADLs. OMIG disallowed four self-performance ADL codes (bed mobility, transfer, eating, and toilet use); three support-provided ADL codes (bed mobility, transfer, and toilet use); and one special treatment ([redacted] – while resident) reported by Appellant on its MDS for Resident 4. Appellant's selected Assessment Review Date (ARD) on the MDS for Resident 4 was [redacted], 2016, therefore the 7-day look-back period for ADLs was [redacted], 2016, and the 14-day look-back period for special treatments was [redacted], 2016. OMIG corrected the resident's RUG category, and Appellant's

Medicaid reimbursement rate was recalculated accordingly. (Ex 6; Ex 10; Ex 11; T 6-7, 90-91, 114-115)

Self-Performance Codes

7. The criteria for Self-Performance Codes includes the "rule of three" which requires at least three occurrences of a self-performance activity during the seven-day look-back period to code a 2 or 3 on the MDS. The exception to the "rule of three" to code an 8 for a self-performance activity on an MDS requires that the self-performance activity did not occur and/or was provided by non-facility staff throughout the entire seven-day look-back period. This requires that all shifts of the seven-day look-back period are coded an 8. (Ex 12, pages 109, 113-115; T 75-79, 103)

8. For Self-Performance ADLs, Appellant coded: 3 for transfer; 2 for eating; 3 for toilet use; and 8 for bed mobility. Appellant's documentation consisted of: a [redacted] 2016 progress note that was dated outside the seven-day look-back period and did not document any ADL self-performance occurrences; a not-dated-for-month-or-year ADL tracker, and not-dated-for-month-or-year toileting sheets that included [redacted] a [redacted] The toileting sheets did not document any ADL self-performance occurrences because emptying a [redacted] is not eligible for ADL coding purposes. OMIG nurses disallowed the self-performance ADLs for transfer (coded 3), eating (coded 2), toilet use (coded 3), and bed mobility (coded 8), and coded them as 0. A code of 0 can result in a lower Medicaid rate payment amount than any of the other ADL self-performance codes. (Ex 5, pages 21-24; Ex11; Ex 12, pages 109-115; T 91-106, 114)

Support Provided Codes

9. The criteria for Support-Provided ADL coding requires the facility to code the highest level of support value (1, 2, or 3) provided during any shift of the seven-day look-back period. To code a level of support value of 8, the ADL activity must not have occurred and/or was provided by non-facility staff, *i.e.*, not provided by facility staff throughout the entire seven-day look-back period. This requires that all shifts of the seven-day look-back period are coded an 8. (Ex 12 at 109, 117-122, 127, 140-144; T 79; 111-112)

10. For Support-Provided ADLs, Appellant coded: 3 for transfer; 3 for toilet use; and 8 for bed mobility. Appellant's documentation consisted of: a dated outside the seven-day look-back period (January 7, 2016) progress note that did not document any ADL self-performance occurrences; a not-dated-for-month-or-year ADL tracker, and not-dated-for-month-or-year toileting sheets that included emptying a catheter bag. ADL support-provided coding rules require at least one occurrence of a support-provided activity during the seven-day look-back period for Appellant to code a 3 on its MDS, and the exception to code an 8 requires that it was provided 100% of the time for the entire seven-day look-back period. OMIG nurses determined that the progress note, ADL tracker, and toileting sheets did not contain any documented occurrence of support-provided ADLs during the seven-day look-back period. Therefore, OMIG nurses disallowed the support-provided ADLs for transfer (coded 3), toilet use (coded 3), and bed mobility (coded 8), and coded each of them as 0. A code of 0 can result in a lower Medicaid rate payment amount than any of the other ADL support provided codes. (Ex 5, pages 20-24; Ex 11; Ex 12 at 109, 111-117; T 92-95, 106-114)

Special Treatment

11. The special treatment Appellant coded was that Resident 4 was treated for [redacted] while a resident at the facility. Appellant's documentation provided during the on-site audit and in response to the draft audit report, which consisted of the aforesaid progress note, ADL tracker, and toileting sheets, did not contain any information related to [redacted] during the 14-day look-back period. Therefore, OMIG nurses disallowed the special treatment of [redacted] while a resident at the facility. (Ex 5, pages 20-24; Ex 11; Ex 12, pages 167, 168, 170, 250; T 114-117)

ISSUE

Has Appellant established that OMIG's audit determinations to correct the RUG category/adjust coded assignments reported for Resident 4, 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 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 by substantial evidence that the determination of the Department was incorrect and that all costs claimed were allowable. 18 NYCRR 519.18(d)(1) and (h). The appellant may not raise any new matter not considered by the department upon submission of objections to a draft audit report. 18 NYCRR 519.18(a).

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). This version became effective in October 2015. Exhibit 12, page 1.

Not all nursing home residents require the same level of care; some require more costly intervention 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 RUG categories reflecting the level of their functional care needs, and each RUG category is assigned a numerical "case mix index" (CMI) score. (Ex 12). 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).

The 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 and 1-6; 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 are Sections G and O. Section G of the CMS RAI Manual (Ex 12) provides instructions for facilities on how and when to code for functional status, particularly ADLs. Section O of the CMS RAI Manual (Ex 12), provides instructions for facilities on how and when to identify and report special treatments, procedures and programs, including [redacted] Each resident's RAI evaluates the resident as of a specific ARD. The facility's CMI, and consequently its reimbursement rate, will be calculated accordingly for an entire six month rate period.

DISCUSSION

Appellant bears the burden of proving that OMIG's determinations were incorrect. Appellant called no witnesses to prove its case. Appellant's representative presented arguments and offered four documents into evidence, but despite being given multiple opportunities[2] to call witnesses, elected not to do so. OMIG's objections to the proffered documents were sustained pursuant to Department regulations at 18 NYCRR 517.5(b)&(c) and 519.18(a). The documents, not provided to OMIG during the on-site visit or in response to the Draft, were considered by OMIG for settlement purposes but not accepted into evidence.

[2] *...during a pre-hearing conference call held more than one week before the hearing date, the morning of the hearing before going on the record, and several times during the hearing (T 20-22, 31, 143).*

The 2018 Matter of Brooklyn Center and 2019 Matter of Palm Gardens decisions cited in Appellant's brief are distinguishable from the instant matter in large part because neither case involved MDS coding for ADLs and because witnesses testified in both of those cases. Those witnesses testified about what the documents were, when/how/why they were created, and how/why they related to the MDS entries. No witnesses were called in the instant matter; ADL coding and [redacted] treatment are distinguishable from coding for therapy and from physicians' orders for treatment.

The issue for this hearing is whether Appellant's records document/support the level of ADL and [redacted] care Appellant reported/coded on its MDS for Resident 4. OMIG's determination to change ADL levels of care to 0 in all instances was correct, and OMIG's disallowance of the special treatment of [redacted] while a resident at the facility was likewise correct. The documents provided to OMIG on-site and in response to the Draft did not support Appellant's MDS submissions. The only properly dated document, the January 7, 2016 progress note, did not document or even mention ADLs or [redacted] treatment, and it was outside the lookback period for ADLs. The ADL tracker and toileting sheets had numerical days of the month but no month or year. As Ms. Murphy testified, properly dating documents (with a month, date, and year) is "one of the first things that you learn as far as professional records." (T 95). Appellant's representative's arguments that the documents in evidence and the additional proffered documents would allow the reviewer to know the month and year of the documents due to Resident 4's brief length of stay at the Facility and that Resident 4's medical diagnoses and conditions would prove that Resident 4 required the level of care entered on the MDS are unpersuasive. As Ms. Murphy testified, residents' ADL needs change day-to-day, shift-

to-shift, and even within a shift. (T 71). It is not the auditor's responsibility to surmise what level of care residents require and what was given. It is the facility's requirement to keep accurate records.

Section G of the CMS RAI Manual, Version 3.0., addresses Functional Status. Section G0110 specifically addresses ADLs. The "Steps for Assessment" read, in part, "Review the documentation in the medical record for the 7-day look-back period." (Ex 12, page 111). The "Coding Instructions For Each ADL Activity" reads, "Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period, as a resident's ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts…" (Ex 12, page 112).

Section O0100 of the CMS RAI Manual, Version 3.0., addresses Special Treatments, Procedures, and Programs. The "Steps for Assessment" read in part, "Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days." (Ex 12, page 168). Subsection O0100J addresses [redacted] and reads, in part, "Code peritoneal or renal [redacted] which occurs at the nursing home or at another facility." (Ex 12, page 170). The January 7, 2016 Progress Note (Ex 11, page 6), which is within the 14-day ARD, makes no mention of [redacted]

OMIG's findings were consistent with the Manual's language and not arbitrary and capricious. Appellant's documentation to support the CC1 RUG classification simply did not do so. Appellant failed to prove that OMIG's determination should be reversed. OMIG's findings are affirmed.

DECISION

OMIG's determination to recover overpayments based upon the MDS audit findings is affirmed.

This decision is made by Ann Gayle, Bureau of Adjudication, who has been designated to make such decisions.

DATED: New York, New York
August 19, 2021

Ann Gayle
Administrative Law Judge

TO:

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