NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

January 31, 2018

CERTIFIED MAIL/RETURN RECEIPT

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The Grove at Valhalla Rehab & NC
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RE: In the Matter of The Grove at Valhalla Rehabilitation and Nursing Center

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,

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:nm
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of

The Grove at Valhalla
Rehabilitation and Nursing Center
Provider #01876604

from determinations to recover Medicaid Program overpayments.

Decision After Hearing

#13-4876

Before: William J. Lynch
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York 10007
March 8, 2017
Record closed: August 16, 2017

Parties: New York State Office of the Medicaid Inspector General
217 Broadway, 8th Floor
New York, New York 10007
By: Mara Pandolfo, Esq.

The Grove at Valhalla Rehabilitation and Nursing Center
61 Grasslands Road
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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. 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 The Grove at Valhalla Rehabilitation and Nursing Center (the Appellant), previously known as Hebrew Home of Westchester, in which the OMIG concluded that the Appellant had received Medicaid Program overpayments. The Appellant requested a 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 witnesses:	Rachel Forward, Hospital Nursing Services Consultant
OMIG exhibits:	1 - 14m
Appellant witnesses:	[redacted]
Appellant exhibit:	A
ALJ exhibits:	I, II

A transcript of the hearing was made (pages 1-230). Each party submitted post hearing briefs and replies, and the record was closed on August 16, 2017.

SUMMARY OF FACTS

1. At all times relevant hereto, The Grove at Valhalla Rehabilitation and Nursing Center, previously known as Hebrew Home of Westchester, was 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 Valhalla, New York.

2. In December 2013, the OMIG commenced two audits (#13-4876 and #13-4877) to review the Appellant's documentation in support of its Minimum Data Set (MDS) submissions used to determine its reimbursement from the Medicaid Program. (Exhibit 2.)

3. This appeal is limited to Audit #13-4876 which reviewed the MDS submissions related to the Appellant's census period ending January 25, 2012, which affected the rate period July 1 through December 31, 2012. (Exhibit 7.)

4. On October 20, 2015, the OMIG issued a draft audit report which determined that the Resource Utilization Group (RUG) categories assigned to 12 of the 28 samples in the review were not accurate. The OMIG recalculated the Appellant's Medicaid reimbursement rate accordingly and stated that the Appellant had been overpaid by Medicaid in the amount of $50,765.56. (Exhibit 7; Transcript page 55.)

5. On December 7, 2015, the Appellant responded to the draft audit report with additional documentation supporting its claim. The OMIG reviewed and considered this documentation. (Exhibit 8; Transcript page 56-57.)

6. On September 27, 2016, the OMIG issued a final audit report which determined that the RUG categories assigned to eight of the samples in the review were not accurate (down from 12 in the draft audit). The final audit report advised the Appellant

that the OMIG intended to recover Medicaid Program overpayments in the amount of $25,841.44. (Exhibit 9; Transcript page 58.)

7. By letter dated November 2, 2016, the Appellant requested an administrative hearing to appeal the final audit report. (Exhibit 10.)

8. At the hearing, the Appellant limited the appeal to contesting the OMIG's findings concerning five of the eight samples, specifically the samples for Resident 1, 10, 20, 25 and 28. (Transcript page 186.)

9. Resident 1's MDS submission for the audit period had an assessment review date (ARD) of [redacted], 2011. The lookback period for activities of daily living (ADL) reported on the MDS was [redacted] through [redacted] (Exhibit 11, sample 1, page 4; Transcript page 100.)

10. Appellant reported a RUG category [redacted] which required an ADL score between [redacted]. The OMIG auditors reduced the reported scores in all categories of ADLs as well as Special Treatments or Procedures, and Resident 1's RUG category was changed to [redacted] with an ADL score between [redacted]1. (Exhibit 9, page 4; Transcript pages 105-106.)

11. The Appellant provided the following documentation in support of its reported RUG category for Resident 1: nurses' notes (one within the lookback period which indicated that the Resident returned from the hospital via [redacted] with [redacted] ambulance attendants), a daily MDS ADL flow sheet from outside the lookback period, a care plan, and a copy of section G of the MDS code sheet. (Exhibit 8, pages 6-14; Transcript pages 103-104.)

12. Resident 10's MDS submission for the audit period had an ARD of [redacted], 2011. The lookback period for ADLs reported on the MDS was [redacted] through [redacted] (Exhibit 11, sample 10; Transcript page 129.)

13. Appellant reported a RUG category [redacted] which required an ADL score between [redacted]. The OMIG auditors reduced the ADL score for Eating from level [redacted] to level [redacted] and Resident 10's RUG category was changed to [redacted] with an ADL score of [redacted]. (Exhibit 9, page 4; Transcript pages 136-137.)

14. The Appellant provided the following documentation in support of its reported RUG category for Resident 10: a single nurse's note within the lookback period, a daily MDS ADL flow sheet from outside the lookback period, a care plan, and a copy of section G of the MDS code sheet. (Exhibit 11, pages 19-22; Transcript pages 129-134.)

15. Resident 20's MDS submission for the audit period had an ARD of [redacted] 2012. The lookback period for ADLs reported on the MDS was [redacted] through [redacted] (Exhibit 11, sample 20; Transcript pages 153-154.)

16. Appellant reported a RUG category [redacted] which required an ADL score between [redacted]. The OMIG auditors reduced the reported scores in all categories of ADLs, and Resident 20's RUG category was changed to [redacted] with an ADL score of [redacted] (Exhibit 9, page 5; Transcript pages 155-159.)

17. The Appellant provided the following documentation in support of its reported RUG category for Resident 20: nurses' notes from the lookback period (only two notes referenced ADLs), and a care plan. (Exhibit 8, pages 30-33; Transcript pages 156-160.)

18. Resident 25's MDS submission for the audit period had an ARD of [redacted], 2011. The lookback period for ADLs reported on the MDS was [redacted] through [redacted] (Exhibit 11, sample 25; Transcript page 171.)

19. Appellant reported a RUG category [redacted] which required an ADL score of [redacted] The OMIG auditors reduced the reported scores in the ADL categories of Transfer, Eating and Toilet Use, and Resident 25's RUG category was changed to [redacted] with an ADL score of [redacted] (Exhibit 9, page 5; Transcript page 175.)

20. The Appellant provided the following documentation in support of its reported RUG category for Resident 25: a care plan. (Exhibit 8, p. 37; Transcript pages 173-175.)

21. Resident 28's MDS submission for the audit period had an ARD of [redacted] 2012. The lookback period for activities of ADLs reported on the MDS was [redacted] through [redacted] (Exhibit 11, sample 28; Transcript page 179.)

22. Appellant reported a RUG category [redacted] which required an ADL score of [redacted]. The OMIG auditors reduced the reported scores in all categories of ADLs, and Resident 28's RUG category was changed to [redacted] with an ADL score of [redacted] (Exhibit 9, page 5; Transcript pages 181-182.)

23. The Appellant provided the following documentation in support of its reported RUG category for Resident 28: a single nurse's note within the lookback period, a care plan, and a copy of section G of the MDS code sheet. (Exhibit 8, pages 43-46; Transcript pages 179-180.)

ISSUE

Has the Appellant established that the OMIG's Final Audit Report determinations to correct the RUG categories of five residents and recover the resulting Medicaid overpayments was 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 (CMS) RAI Version 3.0 Manual.

Not all nursing home residents require the same level of care, some requiring more costly attention. 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. (Transcript page 35). 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 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. 42 CFR 483.20; 10 NYCRR 86-2.37, 415.11. 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. 10 NYCRR 86-2.37, 415.11.

Section G of the CMS RAI Manual provides instructions for assessing residents' need for assistance with activities of daily living (ADLs), gait and balance, and decreased range of motion. Each resident's RAI evaluates the resident as of a specific assessment review date (ARD). The resident's ADL status for a seven day "look back" period before the ARD is reviewed and "coded" at that level of care. CMS RAI Manual, page G-3. The facility's CMI, and consequently its reimbursement, for an entire six-month rate period

will be calculated accordingly whether or not the resident ADL status changes during the rate period.

Detailed instructions for conducting the ADL assessment include:

Steps for Assessment

1. Review the documentation in the medical record for the 7-day lookback period.

2. Talk with direct care staff from each shift that has cared for the resident to learn what the resident does for himself during each episode of each ADL activity definition as well as the type and level of staff assistance provided. Remind staff that the focus is on the 7-day look-back period only.

3. When reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, determine the level of assistance required for moving the resident to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed.

   To clarify your own understanding and observations about a resident's performance of an ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific. See page G-9 for an example of using probes when talking to staff. CMS RAI Manual, page G-3.

The ADL assessment is coded by assigning numerical ADL scores to the resident's functional abilities in accordance with an algorithm set forth in the manual. CMS RAI Manual, page G-6.

Regarding documentation, MDS reporting requirements set forth in the CMS RAI Manual do not supersede or replace Medicaid documentation requirements in Department and federal regulations. For Medicaid reimbursement purposes, 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) and 517.3. Federal regulations pertinent to this case require:

The [RAI] assessment must include at least the following:

> (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
>
> (xviii) Documentation of participation in assessment. 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)(1).

To the extent that additional documentation requirements are imposed in connection with MDS reporting, such as completion of the RAI form itself, they are specified in CMS RAI Manual. Documentation requirements in general are addressed in the CMS RAI Manual as follows:

> 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.

DISCUSSION

The final audit report stated that the reason for the disallowances was a failure to produce the documentation required by Section G of the CMS RAI Manual and 42 CFR 483.20(b), and the report's findings affected the RUG categories assigned to eight residents in the audit sample. These findings lowered the residents' individual CMI scores, leading to a reduction in the facility's overall CMI and consequently the direct component of its

rate. The Appellant limited this appeal to contesting the OMIG's findings concerning five of the eight samples. Therefore, the sole issue for this hearing is whether the Appellant has established that the OMIG incorrectly changed the RUG categories reported on the MDS for those five residents.

Appellant first contended that the CMS RAI Manual did not impose any documentation requirement for ADL assessments. However, the CMS RAI Manual specifically states that nursing homes can determine how the assessment information is documented while remaining in compliance with the Federal regulations and the instructions of the Manual. CMS RAI Manual, page 1-6. The fact that the CMS RAI Manual permits a nursing home to determine how the assessment information is documented means that Manual requires documentation, and in order to remain in compliance with the Federal regulations at 42 CFR 483.20(b), the documentation must include summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS.

While not conceding that any documentation was required, the Appellant argued that the facility's documentation was in compliance with the CMS RAI Manual by providing, either during the audit or in response to the draft audit report, some combination of at most four types of documents for the five sample residents. These documents included copies of section G of the MDS code sheets, MDS ADL flow sheets from outside the lookback period, nurses' notes, and care plans. (Findings of Fact 11, 14, 17, 20 and 23.) However, none of these materials documents a performance of the assessments as required by the CMS RAI Manual.

The Appellant initially contended that a copy of section G of the MDS code sheet was in and of itself sufficient documentation because a registered nurse signed an attestation in Section Z0400 of the MDS assessment which certified that the information used to complete the assessment was accurately collected in accordance with the applicable Medicaid requirements. The OMIG witness testified that this document was unacceptable because "[t]here must be additional documentation in the clinical record that supports the number that was placed on the MDS." (Transcript pages 134, 162.) I agree. The Appellant failed to establish how the attestation complies with the requirements for documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS as required by 42 CFR 483.20(b)(1)(xvii). For example, the assessment requires information to be gathered from all shifts. 42 CFR 483.20(b)(1)(xviii). The Appellant's documentation fails to reflect such information.

For the same reason, a care plan is insufficient to establish summary information regarding the assessment of a resident's ADLs during the seven-day lookback period. The OMIG's witness testified the Appellant's documentation was not found acceptable because "the care plan is developed after the MDS process is completed" and is by name and definition a plan. Instructions for the MDS specify that "the focus is on the 7-day look-back period only." CMS RAI Manual, page G-3. The care plan is not evidence of "what the resident actually did during those seven days of lookback period." (Transcript, pages 119-120, 156, 160, 173-175, 180.)

The Appellant also submitted MDS ADL flow sheets and notes in the residents' medical records in its attempt to establish that the OMIG's findings were incorrect. The OMIG witness testified that documentation of a resident's ADL performance which was

not during the lookback period was not acceptable. (Transcript page 103-104, 132.) The OMIG's position in this regard is also correct. The whole thrust of the assessment is limited to a review of a defined period of time which is limited by the CMS RAI Manual to a seven-day lookback period.

Finally, the Appellant failed to establish that one or two notes in a resident's medical record regarding ADL self-performance was sufficient documentation to support the reported RUG category on the MDS. The CMS RAI Manual requires the person completing the assessment "to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (ie., not only how well the evaluating clinician sees the resident, but how the resident performs on other shifts as well)." CMS RAI Manual, page G-4. With this information, a facility must then apply the "Rule of Three," to determine the coding of a resident's level of self-performance of ADLs based upon the occurrence of an activity and whether the activity occurred at least three times during the seven-day lookback period. CMS RAI Manual, page G-6. The Appellant failed to provide documentation capturing the Resident's self-performance over the seven-day lookback period which would serve as a basis for applying the "Rule of Three" in any of the five samples. (Transcript page 157-158).

In summation, the Appellant argued that the OMIG's audit and related findings were arbitrary and capricious because the OMIG had adopted a position that a disallowance was required if the Appellant did not have a singular document – an ADL flow sheet. To the contrary, the record suggests that the OMIG was open to accepting any documentation which complied with the CMS RAI Manual and the Federal regulations. The fact that OMIG deemed the MDS ADL flow sheets as sufficient in certain instances to establish the

reported RUG score does not mean that the OMIG was unwilling to accept some other document. Based on my review of the record, the Appellant failed to offer any other type of documentation which minimally complied with the requirements of the CMS RAI Manual and the Federal regulations. As such, the Appellant has failed to establish that the OMIG's audit findings were incorrect.

DECISION: The OMIG's determination to recover overpayments based upon the MDS audit findings for Residents 1, 10, 20, 25 and 28 is affirmed.

This decision is made by William J. Lynch, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Albany, New York
January 30, 2018

William J. Lynch
Bureau of Adjudication