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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.
Executive Deputy Commissioner

March 22, 2024

CERTIFIED MAIL/RETURN RECEIPT

Ian Oliveros-Nikol, Esq.
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Phyllis Goldstein, Director of Corporate Appeals Management
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4770 White Plains Road
Bronx, New York 10470

Beth Abraham Center for Rehabilitation and Nursing
612 Allerton Avenue
Bronx, New York 10467

RE: In the Matter of Beth Abraham Center for Rehabilitation and Nursing

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: cmg
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of

Beth Abraham Center for Rehabilitation and Nursing
Provider #00310756

from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.

Decision After Hearing

#20-2752

Before: John Harris Terepka
Administrative Law Judge

Hearing date: January 11, 2024
By videoconference
Transcript received: January 23, 2024
Record closed: March 18, 2024

Parties: New York State Office of the Medicaid Inspector General
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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 Beth Abraham Center for Rehabilitation and Nursing (the Appellant) in which the OMIG concluded that the Appellant had received Medicaid Program overpayments. The Appellant requested this hearing pursuant to SSL 145-a and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the overpayment determination.

HEARING RECORD

OMIG witness:	Rachel Forward, RN, auditor
OMIG exhibits:	1-6, 8-11, 13-14
Appellant witnesses:	None
Appellant exhibits:	None

A transcript of the hearing was made. (Transcript, pages 1-143.) The record closed on March 18, 2024 after the submission of post hearing briefs.

SUMMARY OF FACTS

1. Beth Abraham Center for Rehabilitation and Nursing is a residential health care facility (RHCF) in the Bronx, New York, licensed under PHL Article 28 and enrolled as a provider in the Medicaid Program.

2. The OMIG reviewed the Appellant's documentation in support of its Minimum Data Set (MDS) submissions for residents for the census period ending January 25, 2017. These MDS submissions were used to determine the Appellant's reimbursement from the Medicaid Program for the rate period July 1 through December 31, 2017. (Exhibit 9.)

3. The OMIG's audit findings included a determination that Resource Utilization Group (RUG) categories assigned to six of the residents (Samples 3, 30, 60, 62, 63, 80) were not accurate because the Appellant's records failed to document the categories assigned for the residents' conditions. (Exhibit 9, attachment B.)

4. On May 18, 2023, the OMIG issued a final audit report that identified overpayments in the Appellant's Medicaid reimbursement in the amount of $77,915.06. (Exhibit 9.) The overpayments were the result of a recalculation of the Appellant's Medicaid reimbursement rate to reflect the audit findings.

5. By letter dated June 6, 2023, the Appellant requested an administrative hearing to challenge the audit findings and overpayment determination in connection with Sample 3. (Exhibit 10.) The Appellant's challenge to the audit findings is limited to the OMIG audit determination in Sample 3. (Transcript, pages 17-18; Appellant brief, page 1.)

6. The assessment review date (ARD) for the Sample 3 resident was [redacted], 2016. The Appellant reported the resident's RUG category as RMC. The audit corrected it to CB1 on the grounds that the medical basis and specific need for 5 days/150 minutes occupational therapy during the week before the ARD were not fully and properly documented in the resident record. (Exhibit 9, Bates pages 1728, 1739.)

7. Resident 3 was evaluated for therapy on [redacted], 2016. The therapist recommended and a physician ordered occupational therapy for six weeks, until [redacted], 2017. (Exhibit 11, Bates page 1743.) A therapy progress note after two weeks and ten therapy treatments documented resident progress in bed mobility, dressing, hygiene and general transfers, and documented that the resident's goals for bed mobility and dressing were upgraded on [redacted], 2016. (Exhibit 11, Bates page 1750.) On [redacted], 2017, the resident was discharged from therapy with goals met except for upper body dressing and transfers. (Exhibit 11, Bates pages 1752-1753.)

ISSUE

Has the Appellant established that the OMIG's audit determination to recover Medicaid overpayments attributable to the disallowance of occupational therapy reported for the Sample 3 resident 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. 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. The provider has the right to an administrative hearing to review an overpayment determination. SSL 145-a; 18 NYCRR 519.4. The provider has the burden of showing that the determination was incorrect and that all costs claimed were allowable. 18 NYCRR 519.18(d)(1).

Among the reports of providers that are used for the purpose of establishing rates of payment is the Minimum Data Set (MDS). MDS submissions to the Department's Bureau of Long Term Care Reimbursement (BLTCR) are used to classify residents into numerically scored Resource Utilization Group (RUG) categories in order to calculate a nursing home's "case mix index" (CMI). The facility's case mix index, and consequently the direct component of its reimbursement rate, is adjusted in July and January of each year for a six-month rate period. 10 NYCRR 86-2.10(a)(5)&(c); 86-2.37; 86-2.40(m)(6). The higher the CMI, the higher the reimbursement rate during that six-month period. Elcor Health Services, Inc. v. Novello, 100 N.Y.2d 273, 763 N.Y.S.2d 232 (2003).

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. The RAI Manual provides instructions for facilities on how to identify, report and code resident assessments. Special treatments, procedures and programs, including occupational and physical therapies, are detailed at Section O. (Section O of the CMS RAI Manual applicable to this audit is in the hearing record as Exhibit 1.)

Each resident's RAI evaluates the resident as of a specific assessment review date (ARD) set by the facility. CMS RAI Manual, pages 2-9, A-31. Occupational and physical therapies are reported by the number of minutes of therapy provided in a seven day "look back" before the ARD. CMS RAI Manual, pages O-15, O-16. A resident who is receiving therapy during the look back period will be coded in a RUG category with a higher numerical CMI score reflecting that care.

Department 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 Department 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).

DISCUSSION

The only audit determination at issue in this hearing is whether the occupational therapy (OT) reported for Resident 3 during the one week look back period under review was documented in the resident's medical record in compliance with Medicaid and MDS reporting requirements. This issue turns on the interpretation of what constitutes, for

MDS reporting and Medicaid reimbursement purposes, documentation of "medically necessary therapies." CMS RAI Manual, page O-17.

Resident 3 had been a resident since [redacted] 2015. (Exhibit 11, page 1.) A facility occupational therapist evaluated her on [redacted], 2016 and recommended OT five times per week for six weeks, which a physician ordered the next day. (Exhibit 11, Bates pages 1743-1748.) This is the OT that was reported on the MDS for the look back week of [redacted]. The resident was discharged from OT on [redacted] 2017, two weeks after the ARD and after four weeks of therapy. (Exhibit 11, Bates page 1752.)

The CMS RAI Manual provides, regarding therapies:

> 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. CMS RAI Manual, page O-16.

The OMIG's criticism is that the necessity for the therapy was not properly documented to have been determined "in conjunction with the physician and nursing administration" because there is no documentation in the resident record of any reason why the resident was evaluated for OT on [redacted] As the OMIG auditor testified:

> What wasn't met is, there was no documentation to support how the resident showed up on therapy... I was unable to tell why the therapist went in and saw this resident. There is no documentation to support the reason the physical therapist even saw the resident. (Transcript, page 53.)

> We didn't see nurses' notes. There were no nurses' notes submitted from [redacted] through the therapy. So almost two months... So there's no documentation for the – for the beginning of [redacted] that would document a decline. (Transcript, pages 54-55.)

The Appellant claimed in response to the draft audit report, and at the hearing, that the resident "was evaluated for therapy due to a decline reported by nursing in

functional transfers, Activities of Daily Living and overall safety concerns." (Exhibit 8, page 1; Transcript, pages 15-16.) The resident record does not substantiate these assertions. The Appellant failed to present progress notes or any other documentation reporting any issue relevant to a need for therapy on [redacted] or to substantiate the declines reported in the therapist's evaluation. It was only the [redacted], 2016 OT evaluation itself that stated there had been declines in activities of daily living (ADL).

Although the Appellant claimed that the resident's ADL record documented a decline in functional status (Transcript, pages 119-120), the documentation instead shows largely consistent ADL scoring through the entire month of [redacted] 2016. (Exhibit 8, Bates pages 1420-1425.) The OMIG auditors requested the ADL record for [redacted] the month of the evaluation and the ARD, but the Appellant did not produce it. (Transcript, pages 47, 56, 66.)

The therapist's evaluation reported prior levels of function in various categories and the resident's current levels as identified by the therapist. (Exhibit 11, Bates page 1746.) The current levels as of [redacted] are self-evidently the therapist's own contemporaneous assessment. The Appellant has produced no documentation substantiating the prior levels that the therapist recorded, when those prior levels were assessed or what time period they refer to, and no contemporaneous documentation in the resident record to support the therapist's statements about them. (Transcript, pages 69-73.)

The Appellant argues that the therapist's recommendation and physician's order must be accepted because the OMIG audit staff is not qualified to second guess them. This view that the facility is under no obligation to document anything other than the

existence of an evaluation and order to justify skilled therapies during the look back week is rejected. The courts have agreed with the OMIG's interpretation of 10 NYCRR 518.3(b) and RAI Manual to require documentation of more than just a therapist evaluation and physician's order in MDS audits. Elderwood at Cheektowaga v. Zucker, 188 A.D.3d 1578, 136 N.Y.S.3d 581 (4th Dept. 2020); Elderwood at Amherst v. Zucker, 188 A.D.3d 1568, 134 N.Y.S.3d 591 (4th Dept. 2020); Elderwood at Grand Island v. Zucker, 188 A.D.3d 1580, 135 N.Y.S.3d 208 (4th Dept. 2020), *lv. denied*, 36 N.Y.3d 910, 142 N.Y.S.3d 477 (2021).

The ARD set by the Appellant (Transcript, pages 99-100), and consequently the one week look back period under review, were used for the purpose of establishing rates of payment for six months. Because of this circumstance, it is reasonable and appropriate for the OMIG to scrutinize the documentation to substantiate the decision to provide the services when they were provided. This standard for review is consistent with Medicaid reimbursement requirements that providers fully and properly document, in the resident record, the medical basis and specific need for all medical care ordered or provided. The therapy must have some reason and must be based on some documented information about the resident to substantiate the need for it to be given during the look back period.

The OMIG auditor pointed out, regarding the Appellant's failure to produce an ADL record for [redacted] 2016: "Well, if the [redacted] A.D.L. record contained the evidence of decline, we may have changed our mind, but we did not have that." (Transcript, page 55.) The Appellant, although it also claimed there had been a decline (Exhibit 8, page 1; Transcript, pages 15-16), pointed out that a decline is not specifically required by regulation in order to justify therapy, and that federal regulations provide "a

patient may need skilled services to prevent further deterioration or preserve current capabilities." 43 CFR 409. (Transcript, page 128.)

While it may not be necessary specifically to document a decline, there is nevertheless a requirement that there be some form of documentation to support a finding of medical need for therapy at the time it is provided. A decline is not required but may, as the OMIG auditor conceded, be sufficient to support a finding of need. A reasonable and documented improvement from therapy may also be sufficient when, as the RAI Manual recognizes, "Rehabilitation.... therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life." (RAI Manual, page O-16.)

The OMIG correctly determined that the Appellant did not fully and properly document the medical basis and specific need for the OT ordered on [redacted]. The OT under review in this audit, however, was that given during the look back week of [redacted]. The OMIG did not address the Appellant's documentation for the period [redacted] up to and including the look back week, which includes a therapy progress note made after ten treatments given in the two weeks ending [redacted], 2016, the day before the ARD. (Exhibit 11, Bates pages 1750-1751.)

The therapy progress note documenting the period [redacted] through [redacted] does substantiate the need for the therapy during the look back week under review in that, as the Appellant pointed out in response to the draft audit report and at the hearing, the patient was making significant progress during this time. (Transcript, page 106; Exhibit 8, Bates page 1396.) For the two weeks since therapy began on [redacted], the note documents progress in bed mobility, self-care dressing, self-care hygiene/grooming, and

transfers. Bed mobility and dressing goals were upgraded on [redacted]. (Exhibit 11, Bates page 1750; Transcript, page 111.) After two more weeks and ten more treatments, the resident was discharged from OT on [redacted], 2017, having substantially met most of her goals. (Exhibit 11, Bates pages 1752-1753.)

The OMIG's allegations of "conflicts within the provider's documentation" of the resident's cognitive status on [redacted], 2016 prove nothing relevant to the disallowance. (OMIG brief, pages 7, 13; Transcript, pages 81-84.) The resident's cognitive status was not alleged by either party to be a factor in a determination of the resident's need for OT, nor did the OMIG explain why an "inconsistency" in the therapy evaluation's recording of cognitive status calls the appropriateness of OT for functional status into question. As the Appellant pointed out:

> So if a patient, at one point, is able to follow directions, they may not be able to follow directions at another time. That doesn't mean they cannot have therapy. (Transcript, page 132.)

While the Appellant did not document the decline that it claims prompted the original evaluation and initiation of therapy, it did document an improvement after the initiation of therapy on [redacted] that substantiates a medical basis and need for the therapy given during the look back period. Two weeks of actual therapy with significant documented progress at the end of the second week, which was one day before the ARD, substantiates that the OT was reasonable and necessary for treatment of the resident's condition during the look back period.

DECISION: The OMIG's determination to correct the RUG category reported for the Sample 3 resident, and to recover the resulting Medicaid overpayments, is reversed.

The OMIG is directed to recalculate the audit overpayment in accordance with this decision.

This decision is made by John Harris Terepka, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Rochester, New York
March 22, 2024

John Harris Terepka
Bureau of Adjudication