

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

In the Matter of the Appeal of	:	
	:	
Garden Care Center	:	Decision After
Provider #01986694	:	Hearing
	:	
from determinations to recover Medicaid Program	:	#13-4384
overpayments.	:	#13-4385
	:	

Before: William J. Lynch
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York 10007
July 13, 2017
Record closed: October 20, 2017

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

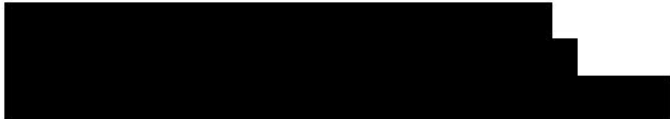
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JURISDICTION

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. 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 two final audit reports for Garden Care Center (the Appellant) in which the OMIG concluded that the Appellant had received Medicaid Program overpayments. The Appellant requested hearings pursuant to SSL 22 and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the overpayment determinations. The two requests were combined for this hearing.

HEARING RECORD

OMIG witnesses: Patricia Murphy, hospital nursing services consultant
OMIG exhibits: 1-24
Appellant witnesses: 
Appellant exhibits: A-G

A transcript of the hearing was made. (Transcript, pages 1-231.) Each party submitted post hearing briefs, and the record was closed October 20, 2017.

SUMMARY OF FACTS

1. At all times relevant hereto, Garden Care Center 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 Franklin Square, New York.

2. The OMIG commenced two audits (#13-4384 and #13-4385) 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 3.)

3. Audit #13-4384 reviewed MDS submissions related to the Appellant's January 2012 census, used to determine reimbursement from the Medicaid Program for the rate period July 1 through December 31, 2012. The OMIG reviewed records for a sample of 20 facility residents. (Exhibit 14.)

4. Audit #13-4385 reviewed MDS submissions related to the July 2012 census, used to determine reimbursement for the rate period January 1 through June 30, 2013. The OMIG reviewed records for a sample of 13 facility residents. (Exhibit 19.)

5. OMIG auditors determined that the resource utilization group (RUG) categories assigned to 26 of the residents in the reviews (residents 1, 2, 3, 4, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 18 and 20 from audit #13-4384; and residents 1, 2, 3, 4, 5, 6, 8, 9, 11, 12 from audit #13-4385) were not accurate because the Appellant's records failed to document the scores reported in the MDS submissions for the residents' needs for assistance with activities of daily living (ADL).

6. The OMIG auditors also determined that the RUG categories assigned to three of the residents reviewed (residents 15, 18 and 20 from audit #13-4384) were not supported by the Appellant's records because the Appellant failed to document that

occupational therapy (OT) services ordered and provided were medically necessary and reasonable for the residents' conditions.

7. The OMIG auditors made findings and disallowances related to special treatments, procedures and programs for four residents (resident 12 from audit #13-4384, and residents 2, 5 and 9 from audit #13-4385). The Appellant conceded these disallowances and did not challenge the findings. (Transcript, pages 68-69.)

8. The OMIG changed the residents' RUG categories and recalculated the Appellant's Medicaid reimbursement rate accordingly.

9. On September 26 and September 29, 2016, the OMIG issued final audit reports that identified overpayments in the Appellant's Medicaid reimbursement resulting from the correction 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 \$134,165.61 in audit #13-4384, and \$60,799.44 in audit #13-4385. (Exhibits 14 and 19.)

10. Resident 1's MDS submission had an assessment review date (ARD) of [REDACTED] 2012. The submission assigned her to RUG category [REDACTED] (Exhibit 16, page 3). Assignment to this category required an ADL score between [REDACTED] and [REDACTED]. The Appellant reported a score of [REDACTED]. The Appellant provided a facility record titled "ADL Assessment" which is also referred to as the "ADL tracker" for the lookback period of [REDACTED], 2012 as documentation of the reported ADL score. (Exhibit 15, page 19.)

11. Resident 15's MDS submission for the audit period had an ARD of [REDACTED] [REDACTED] 2012. (Exhibit 16, sample 15, page 445.) The lookback period for skilled therapy reported on the MDS was [REDACTED] 2011 – [REDACTED], 2012.

12. The Appellant reported a RUG category of “██████████” for resident 15. The minimum skilled therapy requirement for this category is ██████████ minutes given over ██████████ days per week. (Exhibit 10, 16.)

13. On ██████████, 2011, a nurse noted in a document titled “Medicare Part B Progress Note” that the resident “now requires ██████████ assistance with eating.” The following day, the nurse noted that the resident was “still involved in feeding but staff sometimes assists the resident to complete meals. (Exhibit 16, page 455.)

14. On ██████████, 2011, a rehab referral form was completed by a nurse and a therapist, and the therapist recommended a course of OT. (Exhibit 16, page 457.)

15. The resident’s physician signed the therapist’s recommendation and OT was commenced on ██████████, 2011, the first day of the lookback period. (Exhibit 16, page 459.)

16. Resident 15 was “instructed in feeding devices using ██████████ and instructed in ██████████ exercises and ██████████.” On ██████████ 2012, the occupational therapist discontinued OT claiming the resident demonstrated a continued ability to self-feed with tray preparation and encouragement. (Exhibit 16, page 461 of 536.)

17. On that same day, ██████████ 2012, the medication nurse on the 7-3 and 3-11 shifts of ██████████ 2012, scored Resident 15’s eating ability. The nurse on the 7-3 shift scored Resident 15’s self-performance as ██████████ meaning she required “██████████ assistance.” The nurse on the 3-11 shift scored Resident 15’s self-performance as ██████████ meaning she required “██████████ assistance.” (Exhibit 16, page 469.)

18. Resident 18’s MDS submission for the audit period had an ARD of ██████████ 2011. (Exhibit 16, sample 15, page 75 of 240.) The seven-day lookback

period for skilled therapy reported on the MDS was [REDACTED] 2011 – [REDACTED], 2011.

19. The Appellant reported a RUG category of “[REDACTED]” for resident 18. The minimum skilled therapy requirement for this category is [REDACTED] minutes given over [REDACTED] days per week. (Exhibit 10.)

20. On [REDACTED] 2011, a nurse noted in a document titled “Medicare Part B Progress Note” that the resident was “[REDACTED] to his [REDACTED] side while on wheelchair,” and required “[REDACTED] repositioning by staff.” (Exhibit 16, page 87 of 240.)

21. On [REDACTED] 2011, a rehab referral form was completed by a nurse and a therapist. The therapist recommended a course of OT. (Exhibit 16, page 95 of 240.)

22. The resident’s physician signed the therapist’s recommendation and OT was commenced on [REDACTED] 2011, the first day of the lookback period. (Exhibit 16, page 94 of 240.)

23. An occupational therapist instructed the resident in balance and weight shifting exercises to increase the resident’s ability to sit correctly in a wheelchair. The occupational therapist obtained a [REDACTED]-inch wheelchair with [REDACTED] and a [REDACTED]. OT was discontinued on the last day of the lookback period. (Exhibit 16, pages 97-110 of 240.)

24. Resident 20’s MDS submission for the audit period had an ARD of [REDACTED] [REDACTED] 2012. (Exhibit 16, sample 20, page 117 of 240.) The lookback period for skilled therapy reported on the MDS was [REDACTED] 2012 – [REDACTED] 2012.

25. The Appellant reported a RUG category of “██████” for resident 20. The minimum skilled therapy requirement for this category is █████ minutes given over █████ days per week. (Exhibit 10.)

26. On █████ 2012, a nurse noted in a document titled “Medicare Part B Progress Note” that the resident “██████ in his chair,” and requires “██████ repositioning by staff.” (Exhibit 16, page 135 of 240.)

27. On █████ 2012, a therapist recommended a course of OT for resident 20. (Exhibit 16, page 157 of 240.)

28. The resident’s physician signed the therapist’s recommendation and OT was commenced on █████ 2012, the third day of the lookback period. (Exhibit 16, page 157 of 240.)

29. An occupational therapist instructed the resident in balance and weight shifting techniques to increase the resident’s ability to sit correctly in a wheelchair. The occupational therapist obtained a █████ wheelchair and a █████, and adjusted the █████. OT was discontinued on █████, 2012, the last day of the lookback period. (Exhibit 16, pages 131 of 240.)

ISSUE

Has the Appellant established that the OMIG’s audit determinations to correct the 26 residents’ RUG categories, 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 that are used for the purpose of establishing rates of payment, and all underlying books, records, documentation and reports that 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). Where the Department's determination is based upon an alleged failure of the provider to comply with generally accepted professional or medical practices or standards of health care, the Department must establish the existence of such practice or standard. 18 NYCRR 519.18(d).

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 require 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 23.) 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. 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. CMS RAI Manual, pages 1-5, 1-6. 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, 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. 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 lookback 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 lookback 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.

Section O of the CMS RAI Manual provides instructions for facilities on how and when to identify and report special treatments, procedures and programs, including skilled therapy services that residents receive. Skilled therapies are reported by the number of minutes of therapy provided in a seven-day lookback before the ARD. CMS RAI Manual, page O-16. A resident who is receiving skilled therapy during this period will be "coded" in a RUG category that reflects the extent of the therapy. The facility's CMI, and consequently its reimbursement rate, will be calculated accordingly for an entire six-month rate period.

The standard for recognizing and “coding” 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 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), 517.3. In particular, the medical basis and specific need for all services must be fully and properly documented in the client's medical record. 18 NYCRR 518.3(b).

Federal regulations pertinent to this case require that 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 non-licensed direct care staff members on all shifts. 42 CFR 483.20(b)(1).

DISCUSSION

The OMIG's audit reports included a number of findings affecting the RUG categories assigned to residents in the audit sample. These findings lowered some residents' CMI scores, leading to a reduction in the facility's overall CMI and consequently the direct component of its rate. (Exhibits 14, 19, attachments A, B.)

The first issue in this hearing is whether the Appellant's records document support for the ADL scores reported for residents 1, 2, 3, 4, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 18 and 20 from audit #13-4384; and residents 1, 2, 3, 4, 5, 6, 8, 9, 11, 12 from audit #13-4385. The OMIG acknowledged that all 26 ADL samples from both audits were disallowed for the same reason. The OMIG also did not dispute that the Appellant had followed the same policies and procedures and submitted the same type of records for each resident. Therefore, the parties agreed to present testimony related to resident 1 from audit #13-4384, and to apply that testimony and reasoning to all ADL samples for both audits. (Transcript, page 49.)

The Appellant provided the testimony of [REDACTED], RN, BSN, MBA, who is a member of AANAC (American Association of Nurse Assessment Coordination). [REDACTED] testified that she developed the Appellant's MDS policies and procedures and personally trained the Appellant's direct care staff. [REDACTED] testimony and a document titled "CNA Assignment/Accountability Record," established that the CNA assigned to resident 1 on each shift initialed a box when assisting with certain activities including toileting and repositioning during the month of [REDACTED] but no information is documented on this form regarding other ADLs such as transfers and eating. (Exhibit 15, pages 29-30).

██████████ then testified regarding a document titled the “ADL Assessment Form,” which established that the medication nurse assigned to resident 1 on each of the three daily shifts during the 7-day lookback period recorded an ADL score in the four specific components, including bed mobility, transfers, toilet use and eating, recording both ADL self-performance and ADL support scores. The preprinted ADL Assessment Form utilized by the Appellant pursuant to policy contains separate boxes for the day nurse, evening nurse and night nurse to initial. The form also contains preprinted scoring instructions that reflect CMS RAI Manual instructions. These ADL scores were used to complete the ADL assistance section of the MDS submissions, and the ADL scores documented in the ADL Assessment Form are consistent with the scores reported on the MDS. (Transcript, pages 81, 92, 152.)

The CMS RAI Manual recognizes three ways to obtain information for the MDS report: record review, observation, and interviews with direct care staff. CMS RAI Manual, page G-3. The audit reports state: “Documentation must indicate an assessment was done to evaluate the need for assistance with activities of daily living [ADLs]...” (Exhibit 14, page 6; Exhibit 19, page 5.) The authority the OMIG cited for this standard is the federal regulation that requires:

(xvii) 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).

The OMIG auditors did not accept the ADL Assessment Form claiming that “there was no documentation to support that the direct care staff, licensed or unlicensed, was involved in the seven-day lookback period codes that were recorded.” (OMIG brief, pages 11-12.

The ADL Assessment Form utilized and maintained by the Appellant and provided to the OMIG auditors, however, documents this information. The “additional assessment” triggered during the completion of the RAI was the collection of approximately 168 numerical ADL scores by the medication nurse who was assigned to each resident on every shift during the lookback period. The ADL Assessment Form documents that these assessments were done and records “summary information.”

The OMIG’s witness testified that the Appellant’s documentation was not found acceptable and claimed:

A: [Section G of the RAI Manual] is stating they have to know each episode of each ADL activity. The only one that is going to know that is the certified nurse aide that has cared for the resident on each shift for the seven-day lookback period. Again, we consider the gold standard being the certified Nurse aides themselves filling that out and when we see that anyone other than a nurse aide fills it out, we need to see very solid documentation that the direct care staff was involved in the coding for every shift for each episode of each ADL activity. And that basically says, in a nutshell, what these disallowances are based on.

The OMIG’s position is based on the auditor’s interpretation of the Appellant’s policy and procedure for completion of the ADL Assessment Form. The policy states:

The ADL Tracking Form is utilized by the facility to capture the actual ADL self-performance and support provided to the resident within the lookback period of an MDS Assessment. The Medication Nurses are instructed to interview and/or observe the CNA (7) seven days prior to the ARD of an MDS assessment and document on the ADL tracker.

The OMIG’s witness interpreted this policy as limited to the medication nurse on the first day of the 7-day lookback period (OMIG brief, page 14; Transcript, page 57). The Appellant’s witness, however, explained that the policy applies to the medication nurse on each shift, every day of the lookback period (Transcript 106-107). Based on a plain reading of the policy and the testimony on this issue, I find that the Appellant’s explanation of the

policy is more plausible and consistent with the ADL Assessment Form completed based on observations and/or interviews made by each medication nurse on each shift of the seven-day lookback period.

The Appellant attempted, by means of the preprinted ADL Assessment Form, to simplify and streamline the documentation to the point where, for ADL scores, all that is necessary is for a nurse to fill in the numbers and sign the form. There is no good reason to conclude that the Appellant's ADL Assessment Forms do not reflect a performance of the assessments required by the CMS RAI Manual, or were not understood and intended by the Appellant to comply with minimum documentation requirements to support the MDS submissions. Therefore, the OMIG's findings related to the disallowances for the ADL scores of the 26 residents in these two audits should be reversed.

The second issue for this hearing is whether the Appellant's records document support for the occupational therapy (OT) provided to residents 15, 18 and 20 from audit #13-4384. In addition to the documentation submitted during the audit, the Appellant provided the testimony of [REDACTED], a licensed occupational therapist who holds a Master's degree in occupational therapy (Transcript, page 176.), and the testimony of [REDACTED] a physical therapist who holds a Master's degree in health policy and administration. (Transcript, page 202.)

Resident 15's seven-day lookback period for skilled therapy reported on the MDS was [REDACTED] 2011 – [REDACTED] 2012. Shortly before the commencement of the lookback period, a nurse noted in a document titled Medicare Part B Progress Note that the resident "now requires [REDACTED] assistance with eating." The following day, the nurse noted that the resident was "still involved in feeding but staff sometimes assists the resident to

complete meals. On [REDACTED] 2011, a rehab referral form was completed by a nurse and a therapist, and the therapist recommended a course of OT. The resident's physician signed the therapist's recommendation and OT commenced on the first day of the lookback period. The therapist's note states that resident 15 was "instructed in feeding devices using [REDACTED]" and instructed in [REDACTED] exercises and [REDACTED]." The OT was discontinued on the last day of the lookback period.

Regarding the documentation by the nursing staff which resulted in the assessment for occupational therapy, the OMIG's witness stated:

Well, I mean as a nurse, these are okay notes. They're nothing great. Normally an RN does not just list what the problem is, but RNs are, by law, allowed to assess. And usually, as a nurse, and someone who audits and sees a lot of nursing notes, there would be a little more involvement here of what is actually going on. And in my head I'm thinking maybe they should get a dietician involved as well. (Transcript, page 136)

Regarding the rehabilitation findings and notations by the occupational therapist, the OMIG's witness stated:

[F]rom a professional point of view...it's rather scanty for a professional occupational therapist to just be writing these one-line things for something that is going...to give the resident...the level of care that's going to elevate them to a high reimbursement level...I felt, from my own experience, [REDACTED] minutes [of occupational therapy] was a little bit excessive for the issuance of a [REDACTED], in addition to the conflicting documentation. (Transcript, pages 137-144)

The conflicting documentation discussed by the OMIG's witness was that the feeding evaluation by the occupational therapist indicated the resident needed supervision and set up for eating which would be coded as a 1, but the ADL Assessment Form completed by the medication nurses on the for the same day coded the resident's best performance as a 2 in eating, which would indicate she required limited assistance.

The Appellant's witness stated that resident 15 was a [REDACTED]-year-old female with a diagnosis of [REDACTED] who was exhibiting a [REDACTED] with [REDACTED]-[REDACTED] and that the decision to provide occupational therapy was interdisciplinary. (Transcript, pages 177-180.) She further testified that providing a [REDACTED] for [REDACTED] days did not seem excessive to her. (Transcript, page 199.) Regarding the conflicting documentation, she acknowledged that there were some [REDACTED] in the resident's feeding ability. (Transcript, page 183.)

The issue regarding documentation for resident 15's OT is whether the documentation substantiates her need for the skilled therapy. The Appellant failed to explain the conflicting information in the record for resident 15. The CNA Assignment/Accountability Record indicates the resident became [REDACTED] assistance for feeding on [REDACTED] 2011, but the reason for the referral to OT on the [REDACTED] [REDACTED] 2011 feeding evaluation claims that the resident was currently on supervision with set up for eating. In addition, the ADL Assessment Form indicates that the resident required [REDACTED] assistance on [REDACTED] 2011, but that she then required [REDACTED] assistance for some meals from [REDACTED] 2011 through [REDACTED] 2012. Due to these inconsistencies in various documents related to the resident's eating ability, resident 15's record as a whole fails to reasonably document a medical basis and specific need for OT during the lookback period. Therefore, the OMIG's disallowance for OT should be affirmed.

Resident 18's lookback period for skilled therapy reported on the MDS was [REDACTED] 2011 – [REDACTED] 2011. [REDACTED] days before the commencement of the lookback period, a nurse noted in a Medicare Part B Progress Note that the resident required [REDACTED] wheelchair repositioning. On [REDACTED] 2011, a rehab referral form was

completed by a nurse and a therapist. The therapist recommended a course of OT, the resident's physician signed the therapist's recommendation, and OT was commenced on the second day of the lookback period. An occupational therapist obtained a [REDACTED] wheelchair with [REDACTED] and a [REDACTED] and instructed the resident in balance and weight shifting exercises to increase the resident's ability to sit correctly in a wheelchair. The OT was discontinued on the last day of the lookback period.

The OMIG claimed that a skilled nursing facility is expected to provide appropriate out of bed seating devices and that instruction on usage was included. In discussing the issue of a resident 18's [REDACTED] to [REDACTED] side of wheelchair, the OMIG's witness explained:

This is something you see a lot in nursing homes with people who...are very delibilated. It's not a pretty sight and facilities...should try to correct it in the best way they can. (Transcript, page 148.)

The OMIG's witness went on to state that she "felt that the services, as I read from the manual – was a little bit excessive for this need, as far as medical necessity." She also testified, based on her nursing experience, that an occupational therapist would be called, but the resident would require a total of [REDACTED] to [REDACTED] minutes of occupational therapy. (T. 154-155) However, she acknowledged that this was a complicated resident and that it takes longer to train and retrain a resident with [REDACTED] (Transcript, pages 170-171.)

The Appellant's witness stated that the decision to provide occupational therapy was interdisciplinary because the treatment plan had been signed by a nurse, an occupational therapist and a physician. (Transcript, pages 201.) She further testified that the services provided were medically necessary. (Transcript, page 201.) Regarding the resident's medical condition, she pointed to the fact that the resident had [REDACTED] conditions which required that he remain [REDACTED] in an [REDACTED] [REDACTED] (Transcript, page 189.)

The facts related to resident 20 is very similar to the facts presented regarding resident 18. Resident 20's seven-day lookback period for skilled therapy reported on the MDS was [REDACTED] 2012 – [REDACTED] 2012. The day before the start of the lookback period, a nurse noted in a Medicare Part B Progress Note that the resident “[REDACTED] in his chair,” and requires “[REDACTED] repositioning by staff.” On [REDACTED] 2012, a therapist recommended a course of OT. The resident's physician signed the therapist's recommendation and OT was commenced on [REDACTED]. An occupational therapist instructed the resident in balance and weight shifting exercises to increase the resident's ability to sit correctly in a wheelchair. The occupational therapist obtained a [REDACTED]-[REDACTED] reclining wheelchair and [REDACTED]. OT was discontinued on the last day of the lookback period.

In discussing resident 20's OT, the OMIG's witness explained:

Wheelchair positioning...it should be a standard of care...Again, we are not saying that [residents] don't need these [OT services]. We are just saying that the amount of therapy provided to and billed for we felt was a little – was excessive. (Transcript, page 158.)

The Appellant's witness again testified about reasons that might explain why this resident needed [REDACTED] minutes of OT to correct his positioning in a wheelchair, but those reasons are not documented in the medical record.

The issue regarding both residents 18 and 20 is whether the Appellant has established that these residents needed [REDACTED] hours of OT over [REDACTED] days. The record contains a note by a nurse referring these two residents for skilled therapy to correct their positioning in their wheelchairs, an evaluation and notes by an occupational therapy, and a physician's authorization. The Appellant contends that an OMIG nurse auditor's opinion should not

outweigh the opinion of the occupational therapist who conducted the evaluation or the physician who ordered the therapy.

The Appellant had the burden of establishing that the OMIG's disallowance of these therapies was incorrect. Although the record establishes that a resident's positioning in a wheelchair is a common and ongoing issue that skilled nursing facilities must address and may require the involvement of skilled therapists, the record further establishes that providing these skilled services for 150 hours during the lookback period increases the facility's reimbursement rate for an entire six-month rate period. The Appellant provided no explanation for the coincidence of the provision of 150 hours of skilled therapy and the lookback period of these residents. The documents generated for these residents during the lookback period indicate that this therapy was authorized and provided, but the records for residents 18 and 20 as a whole fail to reasonably document a medical basis and specific need for OT of the duration provided. Therefore, the Appellant has failed to meet its burden of establishing that the determinations regarding these skilled therapies were incorrect, and the OMIG's disallowances for OT to these residents should be affirmed.

DECISION:

The OMIG is directed to recalculate the overpayment in accordance with the following:

The OMIG's MDS audit findings related to Functional Status-ADL Self Performance and Support for residents 1, 2, 3, 4, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 18, 20 and 21 from audit #13-4384 and residents 1, 2, 3, 4, 5, 6, 8, 9, 11, 12 from audit #13-4385 are reversed.

The OMIG's MDS audit findings related to Skilled Therapy for residents 15, 18 and 20 from audit 13-4384 are affirmed.

The OMIG's MDS audit findings related to Special Treatments, Procedures, and Programs for resident 12 from audit #13-4384 and residents 2, 5 and 9 from audit 13-4385 are affirmed.

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

DATED: Albany, New York
February 15, 2018

William J. Lynch
Bureau of Adjudication