

**STATE OF NEW YORK  
DEPARTMENT OF HEALTH**

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In the Matter of the Appeal of:

**HIGHLAND NURSING HOME**

Provider ID# 00565119,

Appellant,

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

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**Decision  
After Hearing**

Audit # 13-4391

Before:

Jude B. Mulvey  
Administrative Law Judge

Sean D. O'Brien  
Administrative Law Judge

Held at:

New York State Department of Health  
Regional Office  
217 South Salina Street  
Syracuse New York 10007

Hearing Date:

May 17, 2017

Record closed September 14, 2017

Parties:

Office of the Medicaid Inspector General  
584 Delaware Avenue  
Buffalo, New York 14120

By: Kendra Vergason, Esq.

Highland Nursing Home, Inc.  
182 Highland Road  
Massena, New York 13662

By: Elizabeth Kaneb, President

**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) Section 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) Section 31.

OMIG issued a final audit report for Highland Nursing Home, Inc. (Appellant) in which OMIG concluded that Appellant had received Medicaid Program overpayments. Appellant requested a hearing pursuant to SSL Section 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: Mary Gaudron, R.N.

OMIG exhibits: 1-12

Appellant exhibits: A-J

Appellant witnesses: [REDACTED], Medical Records  
[REDACTED], Director of Nursing

ALJ exhibit: I

A transcript (T), pages 1-88, of the hearing was made. Each party submitted a post hearing brief and reply brief. The record was closed on September 14, 2017. The assigned Administrative Law Judge, Jude B. Mulvey, subsequently left state employment and a new Administrative Law Judge, Sean D. O'Brien, was assigned to review the record and to issue a decision on the submitted record.

**SUMMARY OF FACTS**

1. At all times relevant hereto, Appellant was a residential health care facility enrolled as a provider in the Medicaid Program.
2. In 2013 OMIG commenced Audit #13-4391 to review Appellant's documentation in support of its Minimum Data Set (MDS) submissions used to determine its reimbursement from the Medicaid Program.
3. The audit reviewed MDS submissions related to Appellant's July 2012 census used to determine reimbursement from the Medicaid Program for the rate period January 2013 through July 2013. OMIG reviewed records for a sample of twenty facility residents. On March 31, 2016, OMIG issued a draft audit report that included findings for one of the samples resulting in an estimated rate adjustment of \$11,113.72. (OMIG Ex 4).
4. On April 12, 2016, Appellant submitted a response to the draft audit report. On August 31, 2016, OMIG issued a final audit report that identified overpayments in the amount of \$ 11,029.44. On September 22, 2016, Appellant requested a hearing to review the overpayment determination. (OMIG Ex 4; OMIG Ex 5; OMIG Ex 6; OMIG Ex 8).
5. At issue for this hearing were the findings for audit Sample Number 19 (Sample #19). OMIG determined the Resource Utilization Group (RUG) category assigned for that sample was not accurate because Appellant's records failed to support the number of days with physicians' orders coded on the Minimum Data Set (MDS) assessment. (T 25-30 and OMIG Ex 6).

6. Sample #19 was initially assigned a RUG-III classification of CA2 in the Clinically Complex Category. OMIG disallowed MDS item O0700: Physician Orders because Appellant did not document four days of physician orders during the look back period. (OMIG Ex 6 and T 28-35). This resulted in the reclassification of Sample #19 to the RUG-III Impaired Cognition Category IB2 (OMIG Ex 6).

7. Appellant does not dispute the four days coded in MDS item O0700 for physician order changes was inaccurate and not supported by the documentation in the patient's record. (OMIG Ex. 5 p. 1).

8. With its response to the draft audit findings the Appellant submitted documentation for two physician's exams and three days of physician order changes (T. 55-63 and OMIG Ex 5 and Appellant Ex C). Per the OMIG's witness the provided documentation would have supported a determination of clinically complex. (T 63).

### **ISSUE**

Has Appellant established that OMIG's audit determinations for the RUG categories for Sample # 19 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). These kinds of costs are allowed if they are incurred and the amount is reasonable. The facility's costs are reimbursed by means of a per diem rate set by the Department based on the data reported by the facility. (PHL Section 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 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 Section 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)).

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 the 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. 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. (CMS RAI Manual, page 1-5). The MDS has other uses, however, including Medicare and Medicaid reimbursement.

Patients are assigned into a RUG-III category through completion of the MDS assessment tool. The MDS is part of the Resident Assessment Instrument (RAI) set by the Centers for Medicare and Medicaid Services for conducting federally mandated assessments (42 CFR Sections 483.20 and 483.315). The MDS represents the patient's clinical status based on the Assessment Reference Date (ARD). (42 CFR Section 483.20 (g) and (h); RAI MDS 3.0 Manual Version). Each RUG category is assigned a numerical value based upon the resources necessary to care for that type of patient with a greater value assigned to categories that require more resources.

### **DISCUSSION**

Mary Guadron, an OMIG Hospital Nursing Services Consultant, testified on behalf of OMIG. She reviewed the subject audit, but was not part of the OMIG audit team. Ms. Guadron stated "...we [OMIG] found that there were only three days of [physician] order changes not four..." and one day of physician exams. (T 25). Ms. Guadron went on to testify, "...we reviewed the medical record that the facility provided, and we found only three days of physician orders changes...". (T 29). She also stated Appellant responded and agreed there were only three days of order changes. (T 29).

Per 42 CFR 483.20(b)(1)(g), "[t]he assessment must accurately reflect the resident's status." Due to Appellant's inaccurate coding and lack of documentation the OMIG auditors did not find the reported RUG category for Sample #19 was adequately supported.

Ms. Guadron explained, that, "...this one change had an audit impact." (T33). In particular, "...this change according to the Medicaid days resulted in eleven thousand twenty-nine dollars and forty-four cents." (T 33).

On cross examination Ms. Gaudron testified Appellant did provide evidence of a second physician exam which would have qualified this resident for the reported RUG category. (T 45). However, Appellant failed to submit a correction to DOH to maintain the category and because it did not submit a correction the incorrect coding remains (T 45-46).

Appellant acknowledges the error in coding, but argues OMIG should have allowed Appellant to correct the error as part of the audit process. However, Ms. Guadron testified that only DOH could accept the correction and OMIG only audits and reports as to what the errors are. "...[T]hat they [the facility] are supposed to make the correction and then if DOH would accept it they [DOH] would have to say." (T 43). She further explained, "[t]he facilities are notified that they can make corrections to DOH and they can also submit additional documentation to support what they claimed." (T 57).

Appellant admits the error in reporting four physician orders instead of what its documentation shows is three physician orders and two physician examinations. (T 31, T 43-44, T 55 and T 80-81, Appellant's Brief at page 2). However, Appellant argues that this error should be disregarded by OMIG because the documentation it produced establishes the RUG category reported for the resident (Sample#19) was accurate and supported by the documentation it produced in response to the draft audit report. To deny the appeal will "unjustly enrich" DOH. (Appellant Brief at page 4).



At the hearing, the Administrative Law Judge asked Ms. Guadron if the documentation submitted by the Appellant in response to the draft audit report i.e. the documentation of the three physician orders and two physician exams was enough to support the determination of “clinically complex” for RUG category CA2 for Sample #19. (OMIG 5 and T 62-63). Ms. Guadron admitted that it would be enough if the Appellant had made the correction to the MDS report before this audit was conducted. (T 63).

It is fundamental that the information provided to the government by a facility provider be “...true, accurate and complete.” (18 NYCRR 504.3 (h)). What Appellant received due to its admitted error was an overpayment in government monies. “An overpayment includes any amount not authorized to be paid...whether paid as the result of ...fraud, abuse or **mistake**.” (emphasis added) (18 NYCRR 518.1(c)). The federal regulations also emphasize the importance of accurate information, “[t]he assessment must accurately reflect the resident’s status.” (42 CFR 483.20(b)(1)(g)).

In the present case, the supporting documentation for Sample #19 as discovered by the subject audit was admittedly inconsistent with the information reported on the MDS report (T. 80-81, Appellant’s Brief at page 2) OMIG is tasked to audit Medicaid providers to ensure accurate and correct reporting by Medicaid providers for proper payments to be made. Appellant admitted its error and subsequently provided information to OMIG auditors to support the reported RUG category (T 54-57).

As stated by Ms. Gaurdron during cross examination it was incumbent upon the Appellant to submit the correction for acceptance by DOH and not to the OMIG auditors who do not have the authority to accept corrections. (T 43-47, T 49, T 54-57).

The burden is on the Appellant to demonstrate by substantial evidence the findings by the OMIG were incorrect. (18 NYCRR 519.18 (h)). Appellant has offered no evidence to overturn the audit's findings and determinations. Instead, Appellant has made arguments that it should be simply be allowed to correct its admitted error on the MDS assessment for Sample #19. (Appellant's Brief at page 3).

The Appellant's Medical Records representative, [REDACTED], in her testimony did not provide any information as to what record keeping practices are in place to ensure Appellant's Medicaid support records are maintained in proper order. (T 67-80). In addition, [REDACTED] could not identify how the documentation for Sample #19 was missed initially by Appellant. (T 80-81).

The MDS Correction Policy in effect for the 2012 puts responsibility on Appellant to ensure MDS data is accurate (OMIG Ex 13, CMS RAI Manual page 5-1 (April 2012) ). "OMIG does not make corrections for data entry errors made by the facility." (OMIG Ex. 6 at Attachment D). What is at issue is not whether corrections could be made, but rather if the original information as provided to the OMIG auditors established the accuracy of the data reported on the MDS for Sample #19. The OMIG auditors correctly determined the documentation was insufficient and therefore the disallowance of MDS item O700 Physician Orders for the Audit Sample #19 is appropriate and recovery for overpayments is authorized.

**DECISION**

1. OMIG's determination to recover overpayments based upon the findings of Audit #13-4391 is affirmed.
2. This decision is made by Sean D. O'Brien, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Albany, New York  
May 8, 2019

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SEAN D. O'BRIEN  
Administrative Law Judge

TO:

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