

**STATE OF NEW YORK  
DEPARTMENT OF HEALTH**

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In the Matter of the Appeal of :  
: **Decision After**  
Renaissance Rehabilitation and Nursing Care Center : **Hearing**  
Medicaid ID # 00310283 :  
:   
from a determination by the NYS Office of the :  
Medicaid Inspector General to recover Medicaid :  
Program overpayments : #14-4105  
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Before: Jude Brearton Mulvey  
Administrative Law Judge

Held at: New York State Department of Health  
150 Broadway, Suite 150  
Albany, New York, 12204  
February 4, 2016  
Transcript received March 20, 2016

Parties: New York State Office of the Medicaid Inspector General  
584 Delaware Avenue  
Buffalo, New York 14221  
By: William Busler, Esq.

Mr. Raphael L. Yenowitz  


### **JURISDICTION AND APPLICABLE LAW**

The Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State. PHL 201(1)(v), SSL 363-a. Pursuant to PHL 30, 31 and 32, the Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to recover improperly expended Medicaid funds. The OMIG determined to seek restitution of payments made under the Medicaid Program to Renaissance Rehabilitation and Nursing Care Center (the Appellant). The Appellant requested a hearing pursuant to Social Services Law 22 and the former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determination.

A Medicaid Program overpayment includes any amount not authorized to be paid under the Medicaid Program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. 18 NYCRR 518.1(c). If a Department audit reveals an overpayment, the Department may require repayment of the amount determined to have been overpaid. 18 NYCRR 504.8(a)(1), 518.1. The Appellant has the burden of showing that the determination of the Department was incorrect and that all claims submitted and denied were due and payable under the program. 18 NYCRR 519.18(d).

### **SUMMARY OF FACTS**

1. Appellant Renaissance Rehabilitation and Nursing Care Center (“Appellant”) is a 120 bed nursing home located in Staatsburg, New York. It is certified to operate a residential health care facility under Article 28 of the Public Health Law. The Appellant received Medicaid reimbursement as Provider # 00310283 (Tr. 81; OMIG

Ex. 1). A provider enrolled in the Medicaid Program agrees to comply with the rules, regulations and official directives of the department. 18 NYCRR 504.3 (i).

2. The OMIG, through its contracted agent Health Management Systems (“HMS”), completed an audit of Medicaid claims paid for long-term care services for Medicaid residents who resided at Appellant’s facility for the period October 1, 2009 through November 30, 2011 (OMIG Ex. 2).

3. In a draft audit report dated July 22, 2014, the OMIG identified twelve instances in which Medicaid claims were submitted by the Appellant without being reduced by partial or full Net Available Monthly Income (“NAMI”), resulting in an aggregate overpayment of \$6,637.79. The Appellant was advised, pursuant to 18 NYCRR 517.5, that it had the right to submit documents and written arguments in opposition to the OMIG’s determination (OMIG Ex. 2).

4. By letter dated August 8, 2013, the Appellant disputed its responsibility for any overpayments, asserting that “the State cannot expect a provider to collect from a resident or from his/her family NAMI obligations that the provider was not even made aware of until months or even years after the local social services districts got around to notifying the facility” (OMIG Ex. 5). A second letter dated August 22, 2014 asserting the same argument was also sent to the OMIG (OMIG Ex. 5).

5. On June 17, 2015, after further review of the case and after considering submissions by the Appellant, the OMIG issued a Final Audit Report, informing the Appellant that the OMIG would implement its previously contemplated action to recover overpayments in the amount of \$6,637.79. The Appellant requested a hearing to review the OMIG’s determination as expressed in the Final Audit report (OMIG Ex. 1, 3 and 5).

6. The NAMI is the amount that a Medicaid recipient must contribute toward his/her care in a nursing facility. The NAMI is calculated by the local social services department (“DSS”) after consideration of the resident’s available income. The NAMI is identified in what is known as a “budget letter” from the local DSS to the Resident (Tr. 31, 38, 50; *see*, 42 CFR 435.725).

7. The NAMI must be deducted from the Medicaid claim when a nursing home provider files for payment. A provider is directed to enter the NAMI amount on the claim that is to be submitted to Medicaid for payment. A claim submitted for more than the allowed amount will result in an overpayment to the provider. The nursing home has the responsibility to collect the NAMI directly from the resident (OMIG Ex. 7; OMIG Ex. 14; *see*, 42 CFR 435.725).

8. The OMIG issues, from time to time, “Dear Administrator” letters to all nursing home administrators enrolled in the Medicaid Program. These letters are official directives with which providers must comply. A “Dear Administrator” letter dated October 26, 2001 instructs providers what to do in the event that a NAMI is not yet determined for a newly admitted resident. The “Dear Administrator” letter provides, in pertinent part, that:

*Question: What is a provider’s responsibility when the NAMI hasn’t been determined yet for newly-admitted residents? (For instance, cases where the Medicaid roster doesn’t yet identify the NAMI amount and the LDSS [Local Department of Social Services] hasn’t yet sent a budget letter to the facility. What is the facility’s responsibility to bill NAMI in this case?)*

*Answer: A provider should not bill Medicaid until they receive a budget letter from the social services district indicating the NAMI amount and effective date of the NAMI (OMIG Ex. 7 “Dear Administrator Letter”, at para. 11). (Emphasis in original)*

Resident [REDACTED]

9. Resident [REDACTED] was admitted to the Appellant's facility in [REDACTED] 2010. A NAMI budget letter was not issued at the time of his admission (OMIG Ex. 8; Tr. 51).

10. A budget letter issued by the local district in July 2011 calculated a NAMI of \$495.01 for the period June 1, 2010 through June 30, 2010. It calculated a NAMI of \$1232.01 for the period July 1, 2010 through October 30, 2011 (OMIG Ex. 8).

11. The Appellant did not deduct the \$495.01 NAMI from the claim submitted for June 2010, resulting in an overpayment of \$495.01 (OMIG Ex. 8; Tr. 51).

12. The Appellant deducted the \$1232.01 NAMI from the claims submitted for July, August and September 2010 (OMIG Ex. 8).

13. The Appellant did not deduct the \$1232.01 NAMI from the claim submitted for October 2010, resulting in an overpayment of \$1232.01 (OMIG Ex. 8; Tr. 58).

Resident [REDACTED]

14. Resident [REDACTED] was admitted to the Appellant's facility in [REDACTED] 2011. A NAMI was not issued by the local district at the time of his admission. [REDACTED] was discharged on [REDACTED] 2011 (OMIG Ex. 10; Tr. 59).

15. A budget letter was issued by the local district on November 15, 2011, after the resident's discharge. It calculated a NAMI of \$607.00 for the period April 1, 2011 through April 30, 2011 and a NAMI of \$1344.00 for the period May 1, 2011 through October 31, 2011 (OMIG Ex. 10).

16. The Appellant did not deduct the \$607.00 NAMI from the claim it submitted for April 2011, resulting in an overpayment of \$607.00 (OMIG Ex. 10; Tr. 61).

17. The Appellant deducted a \$761.00 NAMI from the claim it submitted for May 2011. Because the NAMI determination for this month was \$1,344.00, this resulted in an overpayment of \$583.00 to the Appellant (OMIG Ex. 10; Tr. 63).

18. The Appellant deducted \$1,344.00, the full NAMI amount, from the claim it submitted for June 2011 (OMIG Ex. 10).

19. The Appellant deducted a \$915.25 NAMI from the claim submitted for July 2011. Because the NAMI determination for this month was \$1,344.00, this resulted in an overpayment of \$428.75 to the Appellant (OMIG Ex. 10; Tr. 64).

20. Appellant deducted a \$761.00 NAMI from the claim submitted for August, September and October 2011. Because the NAMI determination for each month was \$1,344.00, this resulted in an overpayment of \$583.00 per month in August, September and October 2011, for a total overpayment of \$1,749.00 (OMIG Ex. 10; Tr. 65-67).

Resident [REDACTED]

21. Resident [REDACTED]. was admitted to the Appellant's facility on [REDACTED] 2011. A NAMI budget letter was not issued by the local district at the time of his admission (OMIG Ex. 9; Tr. 68).

22. A budget letter issued by the local district in October 2011 calculated a NAMI of \$717.50 for the period June 1, 2011 through May 31, 2012 (OMIG Ex. 9).

23. The Appellant did not deduct the \$717.50 NAMI from the claim submitted for June 2011, resulting in an overpayment of \$717.50 (OMIG Ex. 9; Tr. 69-70).

24. The Appellant applied a NAMI of \$742.18 to July 2011, which exceeded the correct NAMI of \$717.50 (OMIG Ex. 9).

25. The Appellant deducted a \$717.50 NAMI from the claims it submitted for the months of August, September, October and November 2011 (OMIG Ex, 9).

Resident [REDACTED]

26. Resident L.O was admitted to the Appellant's facility on [REDACTED] 2010. A NAMI budget letter was not issued at the time of her admission (OMIG Ex. 11; Tr. 71).

27. A budget letter issued by the local district in April 2011 calculated a NAMI of \$385.00 for the period August 1, 2010 through February 28, 2011 (OMIG Ex. 11).

28. The Appellant did not deduct the \$385.00 NAMI from the claim submitted for August 2010. Because Medicaid only paid \$137.50 to Appellant for [REDACTED]'s care in August 2010, the overpayment amount is \$137.50 (OMIG Ex. 11; Tr. 71-73).

29. The Appellant correctly deducted a \$385.00 NAMI from the claim it submitted for September 2010 (OMIG Ex. 11).

Resident [REDACTED]

30. Resident [REDACTED] was admitted to the Appellant's facility on [REDACTED] 2011. A NAMI budget letter was not issued by the local district at the time of her admission (OMIG Ex. 12; Tr. 74).

31. A budget letter issued by the local district in March 2012 calculated a NAMI of \$170.02 for August 2011 (OMIG Ex. 12).

32. The Appellant did not deduct the \$170.02 NAMI from the claim submitted for August 2011, resulting in an overpayment of \$170.02 (OMIG Ex. 12; Tr. 74).

Resident [REDACTED].

33. Resident [REDACTED] was admitted to the Appellant's facility in [REDACTED] 2010. A NAMI budget letter was not issued by the local district at the time of her admission (OMIG Ex. 13; Tr. 75).

34. A budget letter issued on March 28, 2012 calculated a NAMI of \$233.48 for the period May 1, 2010 through May 31, 2010 and a NAMI of \$970.48 for the period June 1, 2010 through June 28, 2010 (OMIG Ex. 13).

35. The Appellant did not deduct the \$233.48 NAMI from the claim submitted for May 2010, resulting in an overpayment of \$233.48 (OMIG Ex. 13; Tr. 75).

36. The Appellant correctly deducted a \$970.48 NAMI from the claim it submitted for June 2010 (OMIG Ex. 13).

### **ISSUE**

Was the OMIG's determination to recover Medicaid Program overpayments in the amount of \$6,337.79 from Appellant Renaissance Rehabilitation and Nursing Care Center correct?

### **DISCUSSION**

The Appellant does not dispute the NAMI amounts applicable to the residents for the months in question, and does not dispute the accuracy of the overpayment calculation based on those NAMI amounts (Tr. 15, 83). The issue raised by the Appellant is whether the failure to apply the accurate NAMI amounts when it submitted its claims should be forgiven.

Residential health care facilities such as the Appellant are reimbursed for services by the Medicaid Program for services to Medicaid recipients (Public Health Law 2808). Medicaid, however, is a payor of last resort. If a recipient has other sources that can be applied, they must be looked to by the provider before billing the Medicaid Program (42 CFR § 435.832). Medicaid recipients in nursing homes who have resources available are responsible for paying a certain amount of their nursing home costs each month. This amount, which is termed the recipient's Net Available Monthly Income (NAMI), is calculated by the recipient's local social services district (see, 42 CFR 435.725).

The amount of the nursing home's claim to Medicaid must be reduced by the individual resident's NAMI; the provider does this by correctly identifying the NAMI on its claim for reimbursement to Medicaid (OMIG Ex. 14 [UB-04 Billing Guidelines]). Failure to list the NAMI on the claim form may result in an overpayment by Medicaid (OMIG Ex. 14). The audit in this case was intended to determine whether Appellant, in submitting its claims for each recipient, properly credited the program with the recipient's correct and applicable NAMI. In each case where the NAMI was either too low or not applied, an overpayment was identified.

The Appellant does not dispute that overpayments were made in the amount sought by the OMIG:

Appellant ... first of all, let me state for the record, I am not disagreeing with the --- technically, the amount owed in the audit on paper, that is (Tr. 15).

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Appellant: ---I mean [I] agree to the amount. I agree that there were overpayments (Tr. 83).

Accordingly, because there is no dispute about the existence of a \$6,337.79 overpayment to the Appellant, the remainder of the inquiry focuses on whether the Appellant is

absolved of a duty to reimburse the Medicaid program for this amount due to the timing of the receipt of the budget letter. As previously noted, the Appellant has the burden of demonstrating a basis for this assertion. The Appellant has not sustained this burden.

The Appellant is a skilled nursing home that participates in the Medicaid Program. (*See*, SSL 364-j; Tr. 14). As such, the Appellant is obligated to comply with the rules, regulations and directives of the Medicaid Program (18 NYCRR 504.3[i]). UB-04 Billing Guidelines, a Medicaid directive, instructs providers to accurately report a resident's NAMI amount when submitting claims for payment (OMIG Ex. 14). In the event that a NAMI is not yet determined by the local district for a newly admitted resident, the nursing home "should not bill Medicaid until [the nursing home] receive[s] a budget letter ... indicating the NAMI amount and effective date of the NAMI" ("Dear Administrator" letter dated October 26, 2001, OMIG Ex. 7, at para. 11; *see also*, OMIG Ex. 14; 42 CFR 435.725).

It is undisputed that the Appellant failed to record applicable NAMI amounts in twelve instances in its claims for payment, resulting in overpayments. In defense of its actions, Appellant asserts that because the budget letters identifying the applicable NAMIs were not received for several months after admission of the resident, the Appellant should not be responsible for repayment of those NAMIs. However, the Appellant presented no evidence at the hearing, nor did it set forth any legal argument against the proposed recovery. The Appellant did not present any policies or regulations that would absolve a provider of responsibility to the Medicaid Program for overpayments where the budget letters were received several months after the resident entered the facility. Indeed, the "Dear Administrator" letter (OMIG Ex. 7) specifically

addressed this situation, and advises Medicaid providers that reimbursement of Medicaid-eligible residents should not be sought until after receipt of the budget letter.

The Appellant did not delineate any efforts to ascertain the appropriate NAMI before submission of the claims in question. As noted by the auditor testifying on behalf of the OMIG, there were other billing options available to the Appellant than the actions it took: the Appellant could have (1) identified the resident as a private-pay resident and continue to bill the resident under those terms until such time as the budget letter was received, or (2) classify the resident as “Medicaid-pending” on his/her financial history and collect an estimated NAMI amount until the budget was received (Tr. 100-101).

The evidence indicates that the Appellant sometimes chose to reduce its claims to reflect a resident’s NAMI and, other times, chose not to do so, resulting in overpayments. Contrary to the Appellant’s assertions that it could not prospectively estimate the NAMI, a review of the payment history of the six residents at issue demonstrates that in several instances, the Appellant was able to accurately calculate the applicable NAMI before receipt of the actual budget letter. For example, Resident [REDACTED] entered the Appellant’s facility on or about [REDACTED] 2011 (OMIG Ex. 9). His NAMI budget letter was not issued by the local district until October 7, 2011 (OMIG Ex. 9). The Appellant did not deduct an estimated NAMI for June 2011. The Appellant apparently estimated [REDACTED]’s NAMI as \$742.18 for July 2011 and in August 2011, it was able to determine the resident’s NAMI as \$717.50 – the exact figure calculated in the budget letter that was not received until October 2011 (OMIG Ex. 9). The Appellant has not explained why, if it was able to accurately deduct the NAMI in August, it could not have done so in June as well. In [REDACTED]’s case, while payment for June through September 2011 was made on November 14,

2011 – after the budget letter was received by the Appellant – the Appellant offered no evidence as to when the billing for August 2011 was actually submitted to Medicaid, leading to the conclusion that the Appellant was able to accurately determine the \$717.50 NAMI without a budget letter.

Similarly, Resident [REDACTED] entered the Appellant's facility on [REDACTED] 2011 (OMIG Ex. 10). His budget letter calculating a NAMI of \$1,344.00 for the period May 1, 2011 through October 31, 2011 was not received by the Appellant until November 15, 2011 (OMIG Ex. 10). Yet the Appellant reported this resident's NAMI to be \$761.00 in May, August, September and October 2011, reported the NAMI as \$915.25 in July 2011 and significantly, correctly reported the NAMI as \$1,344.00 in [REDACTED] 2011 (OMIG Ex. 10). In another instance, Resident [REDACTED] entered the Appellant's facility in June 2010 (OMIG Ex. 8). His budget letter calculating a NAMI of \$1,232.01 for the period July 1, 2010 through October 30, 2011 was not received until July 2011 (OMIG Ex. 8). Yet the Appellant accurately reported [REDACTED]'s NAMI to be \$1,232.01 in July, August and September 2010 (OMIG Ex. 8). The Appellant could not explain why, in October 2010, it was unable to calculate the accurate NAMI (Tr. 115; OMIG Ex. 8). Clearly, the Appellant did not require actual receipt of the budget letter to accurately report a resident's NAMI.

The Appellant failed to meet its burden of showing that the OMIG's determination to recover overpayments were incorrect. The recovery of \$6,337.79 is upheld.

**DECISION:** The OMIG's determination to recover Medicaid Program overpayments in the amount of \$6,337.79 is affirmed.

This decision is made by Jude Brearton Mulvey, who has been designated to make such decisions.

DATED: Menands, New York  
September 26, 2016

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Jude Brearton Mulvey  
Bureau of Adjudication