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## Department of Health

KATHY HOCHUL  
Governor

JAMES V. McDONALD, MD, MPH  
Commissioner

JOHANNE E. MORNE, MS  
Executive Deputy Commissioner

December 9, 2024

**CERTIFIED MAIL/RETURN RECEIPT**

Ian Oliveros-Nikol, Esq.  
NYS OMIG  
800 North Pearl Street  
Albany, New York 12204

Julie Corpuz, VP of Clinical Reimbursement  
East Neck Nursing and Rehabilitation Center  
134 Great East Neck Road  
West Babylon, New York 11704

**RE: In the Matter of East Neck Nursing and Rehabilitation Center**

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,

A handwritten signature in blue ink that reads "Natalie J. Bordeaux".

Natalie J. Bordeaux  
Chief Administrative Law Judge  
Bureau of Adjudication

NJB:nm  
Enclosure

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of

**East Neck Nursing and  
Rehabilitation Center**  
Provider #0087644

from a determination to recover  
Medicaid Program overpayments.

**Decision After  
Hearing**

Audit#19-6824

Before: Jeanne T. Arnold  
Administrative Law Judge

Hearing date: May 8, 2024  
May 22, 2024  
By videoconference  
Record closed: July 22, 2024

Parties: New York State Office of the Medicaid Inspector General  
800 North Pearl Street  
Albany, New York 12204  
By: Ian Oliveros-Nikol, Esq.

East Neck Nursing and Rehabilitation Center  
134 Great East Neck Road  
West Babylon, New York 11704  
By: Julie Corpuz  
Vice President of Clinical Reimbursement

**JURISDICTION**

The New York State Department of Health (Department) acts as the single state agency to supervise the administration of the Medical Assistance (Medicaid) Program in New York. Public Health Law (PHL) § 201(1)(v); Social Services Law (SSL) § 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

East Neck Nursing and Rehabilitation Center

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 (FAR) for East Neck Nursing and Rehabilitation Center (Appellant) for the census period ending July 26, 2017, determining that the Appellant 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, Auditor  
OMIG exhibits: 1-23  
Appellant witness: Tanvi Fadia, Rehabilitation Director  
Appellant exhibits: A-P

Transcripts of the hearing were made. (T 5/8/24 1-186; T 5/22/24 1-204.) The record closed on July 22, 2024, after the submission of post hearing briefs.

### **SUMMARY OF FACTS**

1. The Appellant is a residential health care facility (RHCF) in West Babylon, 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 July 26, 2017. These MDS submissions were used to determine the Appellant's reimbursement from the Medicaid Program for the rate period January 1 through June 30, 2018. (Exhibit 4.)

3. The OMIG first issued a Draft Audit Report (DAR) to the Appellant on January 6, 2022. (Exhibit 2.) The DAR indicated that the Appellant has been overpaid \$247,832.55 by the Medicaid Program. The Appellant responded to the DAR and submitted additional documentation (including Exhibits 7, 9, 11, 13, 15, 17, 19, 21), resulting in the OMIG Final Audit Report (FAR) dated March 30, 2023, identifying overpayments in the Appellant's Medicaid reimbursement totaling \$70,809.30. (Exhibit 4.) The overpayments were the result of a recalculation of the Appellant's Medicaid reimbursement rate to reflect the audit findings.

4. The OMIG's audit findings included a determination that Resource Utilization Group (RUG) categories assigned to eight of the Appellant's residents (**Samples 1, 11, 16, 18, 25, 27, 30, and 39**) were not accurate because the Appellant's records failed to document the categories assigned for the residents' conditions. (Exhibit 4, attachment B.)

5. By letter dated May 2, 2023, the Appellant requested an administrative hearing to challenge the audit findings and overpayment determination. (Exhibit 5.)

6. The Appellant reported all eight residents' RUG category as RHC. The audit corrected the Sample 1, 11, 16, 18, 25, 27 and 30 RUG category to PD1, and the Sample 39 category to CB1, on the grounds that the medical basis and specific need for physical therapy (PT) and occupational therapy (OT) during the week before the assessment reference date (ARD) were not fully and properly documented in the residents' records. (Exhibit 4, pp 1389-91, 1396-1403.)

**ISSUE**

Has the Appellant established that the OMIG's audit determination to recover Medicaid overpayments attributable to the disallowance of physical and occupational therapy reported for the Sample 1, 11, 16, 18, 25, 27, 30 and 39 residents 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 MDS. MDS submissions to the Department's Bureau of Long Term Care Reimbursement (BLTCR) are used to classify residents into numerically scored RUG categories to calculate a nursing home's "case mix index" (CMI). The facility's CMI, 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 NY2d 273 (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. (Exhibit 1.)

Each resident's RAI evaluates the resident as of a specific ARD set by the facility. (Exhibit 1, p 31.) Occupational and physical therapies are reported by the number of minutes of therapy provided in a seven day "look back" before the ARD. (Exhibit 1, pp

484-485.) 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**

After audit, the OMIG changed the RUG categories of sample residents 1, 11, 16, 18, 25, 27 and 30 from “RHC,” wherein residents are receiving high rehabilitation of at least 325 minutes per week for five days per week to “PD1,” wherein residents are not receiving rehabilitation, and in Sample 39 to “CB1,” wherein residents are classified as clinically complex but also are not receiving rehabilitation. (Exhibit 4, pp 1389-1391.) The sample residents were reclassified because the OMIG auditor found that the Appellant facility failed to document the medical necessity for the PT and OT rehabilitation the sample residents were receiving during the look back weeks. At issue here then is the interpretation of what constitutes, for MDS reporting and Medicaid reimbursement purposes, documentation of “medically necessary therapies.” CMS RAI Manual, page O-17.

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.

(Exhibit 1, p 485.) Medical care, services or supplies ordered or prescribed 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). Here, the OMIG auditor required more than just therapists' evaluations followed by physician orders signing off on the therapists' recommendations for PT and OT to satisfy MDS standards. The auditor also looked for some documentation of why the sample residents were referred for a therapist's evaluation to begin with or some justification during the look-back week confirming that the therapy was medically necessary. *See Beth Abraham Center for Rehabilitation and Nursing, Decision After Hearing, Audit#20-2752 (March 22, 2024).*

OMIG's interpretation of the RAI Manual and regulations, to require facilities to produce interdisciplinary documentation in the residents' medical records -- including information about the day-to-day status of the residents to establish the medical basis and specific need for therapy services -- is entitled to deference. *Elderwood at Grand Island v Zucker*, 188 AD3d 1580, 1581 (4<sup>th</sup> Dept 2020), *lv denied* 36 NY3d 910 (2021); *Elderwood at Cheektowaga v Zucker*, 188 AD3d 1578, 1579 (4<sup>th</sup> Dept 2020); *Elderwood at Amherst v Zucker*, 188 AD3d 1568, 1569 (4<sup>th</sup> Dept 2020).

OMIG determined that for all the sample residents, there was insufficient documentation in their medical records to support the reason PT and OT referrals were made. Additionally, OMIG disallowed the ordered therapies because records that were

produced showed conflicting documentation between nursing and therapy, illustrating a lack of interdisciplinary communication. (Exhibit 4, pp 1396-1403.)

For each sample resident, in addition to the therapist evaluations, discharge summaries, and physician orders, the Appellant provided a nursing note which prompted the ensuing PT and OT evaluations and various nursing records. (Exhibits 7, 9, 11, 13, 15, 17, 19, 21.) The Appellant argues that this is enough interdisciplinary documentation to prove medical necessity for PT and OT during the look back periods pursuant to the MDS and Medicaid requirements. The OMIG, however, contends that the nursing notes are pro forma and/or verbatim copies and that the other, more specific nursing records, including charts documenting the sample residents' activities of daily living (ADLs) and progress in the floor ambulation program (FAP), when submitted, do not match either the associated nursing note and/or the therapists' evaluations and subsequent physician orders.

The OMIG auditor testified that because the PT and OT evaluations of all the sample residents indicate that the residents were referred by nursing, the first place she looked in performing the audit was to the nursing notes. The nursing notes for four of the resident samples, 1, 11, 27 and 30 were, word for word, identical. Each one reads:

Resident continues to be noted by nursing staff, with decline in her ability to perform her FAP on the unit and her ADLs. CNA [Certified Nurse Assistant] reports that resident continues to require increased assistance with transfers from her w/c [wheelchair] to and from her bed and/or toilet. She continues to require more assistance to complete her FAP as well as ambulate with RW [rolling walker] to and from the bathroom, with increased assistance and more rest periods during ambulation. She also continues to require more assist from staff for dressing. Referred to OT/PT to restore PLOF [prior level of function].

(Exhibit 7, p 1465; Exhibit 9, p 1597; Exhibit 17, p 2047; Exhibit 19, p 2175.) The auditor testified that it is highly unlikely that different residents in the Appellant facility would have identical needs. (T 5/8/24, pp 58-59, 115, 130.) Although the nursing notes for the other resident samples, 16, 18, 25, and 39, are not identical, they similarly report the same alleged areas of decline, including ambulation, transfers, toileting and dressing. (Exhibit 11, p 1703; Exhibit 13, p 1803; Exhibit 14, p 1866; Exhibit 21, p 2306.)

In each instance, the therapists' evaluations reported prior levels of function (PLOF) in these areas and the residents' current levels as identified by the therapists. The Appellant produced no documentation substantiating the prior levels that the therapists recorded, when those prior levels were assessed, or what period they refer to. Thus, the OMIG auditor looked to other documents, including the nurse-authored FAP records and ADL charts, to verify if the claimed PLOFs were accurate and/or to substantiate the pro forma nurses' notes produced for the audit by the Appellant. (T 5/8/24, pp 37.)

For each sample detailed below, OMIG contends that the audit did not produce adequate documentation of decline prior to the PT and OT evaluations and treatment, which led to the auditor's conclusions that the referrals to therapy were not warranted and that the therapists' contemporaneous assessments were made up or exaggerated to provide a basis for medical necessity for the PT and OT. (T 5/8/24, p 145, 158.)

The Appellant's overall argument for each sample detailed below was that that the nursing data, including the ADL and FAP charts, alone could not demonstrate the sample residents' decline indicated by the nursing notes. The Appellant argued, in each instance, that there was documentary proof that the sample residents' conditions improved *after* therapies and that this is evidence that in fact the therapies were medically necessary. The

Appellant also argued that the therapies were necessary to maintain current conditions, as is recognized in federal regulations that provide “a patient may need skilled services to prevent further deterioration or preserve current capabilities” (43 CFR 409) and the RAI Manual’s recognition that “[r]ehabilitation...therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.” (Exhibit 1, p 485.)

### **Sample 1**

The ARD for the Sample 1 resident (Resident 1) was [REDACTED] 2017. The Appellant reported the resident’s RUG category as [REDACTED]. The audit corrected it to [REDACTED] on the grounds that the medical basis and specific need for 5 days/175 minutes of PT and OT during the week before the ARD were not fully and properly documented in the resident record. (Exhibit 4, pp 1389, 1396.)

On [REDACTED], 2017, Resident 1, age [REDACTED] and diagnosed with [REDACTED] and a [REDACTED], was referred for both PT and OT evaluations to restore her PLOF. (Exhibit 6, p 1412; T 5/8/24, pp 36-37.) This was pursuant to the nursing note, also used for samples 11, 27, and 30, “written” that day, indicating a decline in Resident 1’s ability to perform her FAP and ADLs, including transfers, toileting and dressing. (Exhibit 7, p 1465.)

### **Physical Therapy**

A facility physical therapist evaluated Resident 1 on [REDACTED], 2017, and recommended restorative PT five to six times weekly for four weeks, which a physician ordered and certified as a medically necessary plan of treatment on [REDACTED] four days after the ARD and the resident’s discharge date from the therapy on [REDACTED] (Exhibit 7, pp

1499, 1505.) This is the PT that was reported in the MDS look back week of [REDACTED]

[REDACTED]

Ambulation

Resident 1's [REDACTED] 2017 FAP required her to ambulate [REDACTED] feet with a rolling walker, assist of one, with wheelchair to follow. The nursing chart indicates "yes," that Resident 1 performed this task every day in [REDACTED] during the 3:00 to 11:00 PM shift, except for three days when the resident refused. The OMIG auditor testified that because nurses indicated that Resident 1 completed her FAP daily, this revealed that there was no decline in her ambulation, contrary to the nurse's note. (T 5/8/22, pp 38-40; Exhibit 7, p 1533.)

Additionally, the OMIG auditor stated that the PT evaluation conflicts with the FAP. Whereas the FAP demonstrates Resident 1's ability to ambulate [REDACTED] feet, the therapist's evaluation recorded her PLOF as only [REDACTED] feet, and that she currently could ambulate only [REDACTED] feet. The OMIG auditor testified that she could not verify a decline in Resident 1's ability to complete the FAP because there is no documentation to support the therapy evaluation assertion that the resident was ever going [REDACTED] or [REDACTED] feet. (T 5/8/24, p 42.)

Appellant's Regional Rehabilitation Director Tanvi Fadia testified that there is a difference between everyday nursing assessments and PT screens and evaluations. While the FAP chart, relied on by the OMIG auditor, was completed by a simple "yes" that the task was completed, it did not describe the gait, balance, strength or perhaps how many breaks were needed to complete the ascribed [REDACTED] feet. (T 5/22/24, pp 13-16.) The nurse's note dated [REDACTED] detailed more than a decline in functional mobility, but a decline with

the resident's ability to safely ambulate, and the need for increased assistance from caregivers relating to decreased endurance. (Exhibit 7, p 1465.)

At evaluation, the therapist observed Resident 1 ambulate only █ feet with Contact Guard Assistance (CGA) with a rolling walker. (Exhibit 7, p 1501.) The goal for the therapy then was for the resident to improve to █ feet with supervision using the rolling walker. After only one week in PT, the resident was able to ambulate █ feet using the rolling walker. The discharge report notes that the goal of █ feet was surpassed to █ feet with supervision. (Exhibit 7, p 1506.) There is no explanation why, if the resident was already walking █ feet every day in █ per FAP, PT was medically necessary for one week between █ and █

#### Transfers

Resident 1's █ ADL chart showed that the resident was able to transfer at levels ranging from '█ (limited assistance or CGA) to '█ (extensive assistance or "hands on" assistance to transfer). (Exhibit 7, p 1531; T 5/8/24, pp 42-43.) The OMIG auditor stated that the █ ADL Transfer chart did not demonstrate a decline in the resident's ability to transfer prior to commencement of therapy services (T 5/8/24, p 43-44) and, therefore, the Appellant did not document why PT was necessary for the resident's transferring. After one week, the PT discharge note details that the resident still requires an "assist of one" but only supervision, or a Level █ Yet a review of the resident's ADL charts, for both █ and █ 2017, reveal levels █ and █ and no level █ (Exhibit 7, pp 1531, 1529.)

The PT progress report that discharged the resident on █, after "maximum" potential was reached, documents that the resident had gains in █ body strength,

██████████ in standing, body mechanics during transfers, and gait pattern during ambulation with improved ██████████ strength, decreasing fall risk and need for assistance. (Exhibit 7, pp 1505-1507.) A Physiatry Consultation, dated ██████████ -- six days after PT had ended -- recommended that the resident be discharged to the maintenance program and that her FAP include instructions of ambulation at ██████ feet, detailing that the resident "has made progress in therapy and reached her maximum potential." (Exhibit 7, p 1467.) Yet neither of these reports indicate what specifically the resident was referred for as her FAP was already at ██████ feet throughout all of ██████████

The Appellant has not demonstrated documentation of medical necessity substantiating that PT was reasonable and necessary.

### **Occupational Therapy**

A facility occupational therapist evaluated Resident 1 on ██████████, 2017 and recommended restorative OT five to six times weekly for four weeks, which a physician ordered and certified as a medically necessary plan of care on ██████████ four days after the ARD and the date the resident was discharged from therapy. (Exhibit 7, pp 1510, 1516.) This is the OT that was reported in the MDS look back week of ██████████.

### **Toileting**

The OMIG Auditor reviewed the resident's ██████████ ADL chart for toileting, which documented that the resident had a mix of "██████████ (extensive assistance) and ██████████ (limited assistance), and the auditor did not see any decline in the resident's ability to perform toileting prior to therapy. Although the OT evaluation detailed that the resident's PLOF required assist of one, supervision, or level ██████████ for toileting and ambulation to and from the

bathroom, the [REDACTED] ADL chart never showed a Level [REDACTED] for toileting and no decline in toileting was supported in the documentation. (T 5/8/24, pp 47-48; Exhibit 7, p 1532.)

### Dressing

The Auditor testified that the [REDACTED] ADL chart revealed that the resident is a [REDACTED] level, whereas the occupational therapist detailed that the resident was an “Assist of one, supervision” or a “level [REDACTED] (Exhibit 7, p 1533.) The OMIG auditor concluded that the therapist wanted to make the resident look worse than she was to support the medical necessity for therapy despite that there was no decline. (T 5/8/24, p 50.) The Appellant contended that the ADL chart does not differentiate between [REDACTED] body dressing and, whereas Resident 1 improved in [REDACTED] body dressing, she did not improve in [REDACTED] body dressing, which would account for why her ADL level remained stagnant at a [REDACTED]” level. (Exhibit 7, p 1517 T 5/22/24, p. 30.) Perhaps true, but there was no documentation of same in the resident’s record and thus no proof of a decline to substantiate an OT referral.

In sum, the Appellant documentary proof from the qualified therapists and physicians does not correlate with the documents from the nursing administration and the Appellant did not meet its burden of proving medical necessity for Resident 1 to receive both PT and OT during the one-week look back period.

### Sample 11

The ARD for the sample 11 resident (Resident 11) was [REDACTED] 2017. The audit corrected the resident’s RUG category from [REDACTED] to [REDACTED] on the grounds that the medical basis and specific need for 5 days/175 minutes of OT and PT during the week before the



ARD were not fully and properly documented in the resident record. (Exhibit 4, pp 1389, 1397.)

On [REDACTED] 2017, Resident 11, age [REDACTED] and diagnosed with [REDACTED] was referred for both PT and OT evaluations to restore her PLOF. (Exhibit 9, p 1625; T 5/8/24, 58-59.) This was pursuant to a nursing note that day – the identical note to those used for samples 1, 27 and 30 -- indicating a decline in Resident 11's ability to perform her FAP and ADLs including transfers, toileting and dressing. (Exhibit 9, p 1597.)

### **Physical Therapy**

A facility physical therapist evaluated Resident 11 on [REDACTED] 2017 and recommended restorative PT five to six times weekly for four weeks, which a physician ordered and certified as a medically necessary plan of treatment. (Exhibit 9, pp 1625-1626.) This is the PT that was reported in the MDS look back week of [REDACTED] Resident 1 was discharged from PT on [REDACTED] 2017, the same day as the ARD, after three weeks of therapy. (Exhibit 9, p 1631.)

### **Ambulation**

The OMIG auditor testified that she could not verify that Resident 11 was experiencing a decline in her ability to perform the FAP prior to the nursing note and PT commencing on [REDACTED] 2017. (T 5/8/22, p 59.) Resident 11's FAP was for her to ambulate [REDACTED] feet with a rolling walker, assist of one, with wheelchair to follow, twice daily. The chart indicates "yes," that Resident 11 performed this task twice every day in [REDACTED] 2017. The OMIG auditor testified this revealed that there was no decline in Resident 11's ability to perform her FAP, contrary to the nurse's note. (T 5/8/22, p 60; Exhibit 9, p 1650.)

Additionally, the PT evaluation conflicts with the FAP. Whereas the FAP documented that Resident 11 ambulated only █ feet, the therapist noted that the Resident's PLOF was █ feet, and she currently could ambulate █ feet. (Exhibit 9, pp 1626-1627.) The █-feet assessment is the therapist's own contemporaneous assessment; however, the Appellant produced no documentation substantiating the PLOF -- of █ feet -- recorded by the therapist. (T 5/8/24, p 62.)

While the Appellant introduced the █ 2017 FAP chart (Exhibit B, p 109) as well as Resident 11's Kardex Report, which indicated that commencing █, 2017, her FAP should be amended to █ feet (Exhibit C), the Appellant admitted that these documents were not submitted to the OMIG, in response to the DAR, and were never considered for the FAR. (T 5/22/24, pp 106-107.) The Appellant also could not explain the drastic discrepancy in the FAP distances.

#### Transfers

Concerning transfers, the OMIG auditor testified that she did not note that the resident declined in her ability to transfer anytime in █ 2017. She testified that she looked at the █ chart which showed that the resident transferred at the level █ (extensive assistance). (T 5/8/24, pp 62-64; Exhibit 9, p 1648.) Although the therapist noted that the resident's PLOF with respect to transfers was limited assistance, or a level █", the Appellant did not produce any evidence that the resident was ever at that level. Additionally, Resident 11's █ ADL chart reveals that the resident remained at the █ level, despite that the PT discharge indicates that the resident improved to require supervision only. The Appellant did not explain the discrepancy.

The resident's clinical record produced by the Appellant for the OMIG audit failed to document the medical necessity for PT for Resident 11 during the look back week.

### **Occupational Therapy**

A facility occupational therapist evaluated Resident 11 on [REDACTED] 2017 and recommended restorative OT five to six times weekly for four weeks, which a physician ordered and certified, also on [REDACTED], as a medically necessary plan of care. (Exhibit 9, pp 1636-1637.) This is the OT that was reported in the MDS look back week of [REDACTED] [REDACTED] Resident 1 was discharged from OT on [REDACTED] 2017, the same day as the ARD, after three weeks of therapy. (Exhibit 9, p 1642.)

### **Toileting**

The OMIG auditor testified that the resident's [REDACTED] ADL chart for toileting documented that the resident required consistent extensive assistance, or [REDACTED]" and did not document any decline in the resident's ability to perform toileting prior to therapy. (T 5/8/24, p 65; Exhibit 9, p 1647.) The OT evaluation, on the other hand, detailed that the resident's PLOF required limited assistance, or level [REDACTED] (T 5/8/24, p 65; Exhibit 9, p 1638.) The auditor concluded that since the [REDACTED] ADL chart never showed a level [REDACTED] for toileting and no decline in toileting was supported in the documentation, the Occupational Therapist made the resident appear worse than she was to support the need for therapy. (T 5/8/24, p 65-66.) Resident 11's [REDACTED] ADL chart reveals that the resident continued at the [REDACTED]" level. (Exhibit 9, p 1651.) The OT discharge, on the other hand, indicates that the resident improved to supervision, a level [REDACTED] (Exhibit 9, p 1643.) The Appellant neither documented nor explained any reason for the discrepancy.

Dressing

The OMIG auditor was unable to verify the resident's ability in dressing because the Appellant facility did not produce the [REDACTED] 2017 dressing ADL chart. The [REDACTED] ADL dressing chart detailed that Resident 11 consistently received extensive assistance, or level [REDACTED]." (T 5/8/22, pp 66-67; Exhibit 8, p 1568.) The auditor could not verify any decline in the resident's ability to dress. (T 5/8/22, pp 67-68.)

The Appellant failed to offer sufficient documentation of the reason for either the PT or OT referrals, records to support the nurse's note dated [REDACTED] 2017, or proof to explain the conflicting documentation between nursing and therapy. Further, while the PT and OT for Resident 11 lasted three weeks, there is no interim documentation to verify that progress was being made in the therapy, justifying the continuation of such therapies into the look back week of [REDACTED] *Compare Beth Abraham Center for Rehabilitation and Nursing*, Decision After Hearing, Audit#20-2752 (March 22, 2024).

Sample 16

The ARD for the Sample 16 Resident (Resident 16) was [REDACTED] 2017. The audit corrected the resident's RUG category from [REDACTED] to [REDACTED] on the grounds that the medical basis and specific need for 5 days/175 minutes of OT and PT during the week before the ARD were not fully and properly documented in the resident record. (Exhibit 4, pp 1389, 1398.)

On [REDACTED], 2017, Resident 16, age [REDACTED] and diagnosed with [REDACTED], [REDACTED], and [REDACTED], was referred by nursing note for PT and OT evaluations due to a decline in functional mobility, ADLs, and need for

increased assistance with ambulation, transfers, toileting, and dressing “to restore PLOF.”

(Exhibit 11, p 1703.)

### **Physical Therapy**

A facility physical therapist evaluated Resident 16 on [REDACTED] 2017 and recommended restorative PT for five to six times weekly for four weeks, which a physician ordered on [REDACTED] and certified as a medically necessary plan of treatment. (Exhibit 11, p 1716.) This is the PT that was reported in the MDS look back week of [REDACTED] PT commenced with the look-back week and ended on [REDACTED] 2017, the exact ARD. (Exhibit 11, pp 1722-1726.)

### **Ambulation**

The OMIG auditor testified that she could not verify that Resident 16 was experiencing a decline in her ability to perform the FAP prior to the nursing note and PT commencing in late [REDACTED] 2017. (T 5/8/24, p 75.) Resident 16’s [REDACTED] 2017 FAP was for her to ambulate [REDACTED] feet with a rolling walker, assist of one, with wheelchair to follow. The chart indicates “yes,” that Resident 16 performed this task twice daily. The OMIG auditor testified this revealed that, contrary to the nurse’s note, there was no decline in Resident 16’s ability to perform her FAP. (T 5/8/24, p 75; Exhibit 11, p 1738.)

Additionally, the OMIG auditor stated that the PT evaluation conflicts with the FAP. Whereas the FAP documents Resident 16’s ability to ambulate [REDACTED] feet, the therapist indicated that the Resident’s PLOF was [REDACTED] feet, the [REDACTED]. (T 75-76; Exhibit 11, p 1717.) The auditor could not verify a decline in this resident’s ability to complete the FAP because Resident 16 “was [REDACTED] before. She was [REDACTED] during and after therapy.” (T 5/8/24, p 77.) The PT evaluation and the PT discharge summary

also conflict with each other as the evaluation indicates that the resident's PLOF was [REDACTED] feet (Exhibit 11, p 1717), whereas the discharge summary indicates that the resident's baseline was in fact established on the date of the assessment, or on [REDACTED], at [REDACTED] feet. (Exhibit 11, p 1723.)

The Appellant argues that Resident 16 improved because of PT. The Appellant submitted the resident's Kardex report, dated [REDACTED] 2017, the date PT ended, indicating that the resident's FAP should change to [REDACTED] feet. (T 5/22/24, p 53; Exhibit E.) The Appellant's Director of Rehabilitation also testified the therapist worked with Resident 16 on gait training with an increased emphasis on quality of gait, correcting the sequencing of the gait using an assistive device, and increasing the safety weight shift during mobility. (T 5/22/24, p 49; Exhibit 11, p 1724.) Although the PT goal for Resident 16 of increasing her ambulation from [REDACTED] to [REDACTED] feet was met pursuant to the PT discharge plan, the Appellant failed to prove that the resident's actual FAP increased to [REDACTED] feet as the [REDACTED] 2017 FAP still indicates [REDACTED] feet. (Exhibit 11, p 1739.) The Kardex report was not submitted for the audit and simply reiterated the finding of the therapist's discharge summary but there was no documentation that the resident ever performed her FAP at [REDACTED] feet.

#### Transfers

Concerning transfers, the OMIG auditor testified that the Appellant's records did not document that the resident declined in her ability to transfer anytime in [REDACTED] 2017. The auditor looked at the [REDACTED] ADL chart, which showed that the resident was able to transfer at level "[REDACTED]" (extensive assistance or "hands on" assistance to transfer) and "[REDACTED]" (limited assistance or "contact guard assistance") during the 7:00 AM to 3:00 PM

shift. (T 5/8/24, p 78; Exhibit 11, p 1744.) The [REDACTED] Transfer chart did not demonstrate a decline in the resident's ability to transfer prior to commencement of therapy services. (T 5/8/24, pp 78, 81.) Only on one occasion, [REDACTED] during the 7:00 AM to 3:00 PM shift, the resident transferred by herself with no assistance, level [REDACTED] but it appears as a fluke. (Exhibit 11, p 1744.) According to the therapist, the resident's prior level of transfer was with "assist of one supervision" which in ADL terms is a "level [REDACTED] but because the ADL chart for [REDACTED] 2017 does not indicate any level [REDACTED] the therapist apparently simply made it up to justify medical necessity. (T 5/8/24, pp 78-79.) While the PT discharge notes that the resident no longer requires "contact guard assistance" but supervision (level [REDACTED] the [REDACTED] 2017 ADL chart for transfers continues to detail that the resident required mostly limited or extensive assistance (levels [REDACTED] and [REDACTED] (Exhibit 11, p 1740.) The records provided for the audit are inconsistent.

The Appellant did not provide documentation to meet its burden of proving that PT services were medically necessary for Resident 16 during the look back week.

### **Occupational Therapy**

A facility occupational therapist evaluated Resident 16 on [REDACTED], 2017, and recommended OT five to six times weekly for four weeks, which a physician ordered and certified as a medically necessary plan of care on [REDACTED], 2017. (Exhibit 11, p 1727.) This is the OT that was reported in the MDS look back week of [REDACTED] OT was given only during the look back week and ended on [REDACTED] 2017, the ARD. (Exhibit 11, pp 1733-1737.)

### Toileting

The [REDACTED] 2017 ADL chart for toileting indicates that Resident 16 required extensive assistance from one person every day on the 3:00-11:00 PM shift. On the 7:00 AM-3:00 PM shift, the resident required only supervision on three days, limited assistance on 22 days, and extensive assistance on 5 days. (Exhibit 11, p 1743.) The OMIG auditor found that a decline was not documented because the resident's level remained entirely consistent on the later shift and consistently inconsistent on the earlier shift. (T 5/8/24, p 83.) The [REDACTED] ADL chart is consistent with the [REDACTED] ADL chart (Exhibit 11, 1740.) The therapist's notes detail that the resident's PLOF was "supervision," at evaluation the resident was CGA (or limited assistance), and by discharge, after one week, back to supervised. (Exhibit 11, pp 1729, 1733.) However, again, the therapist had no proof of the PLOF but their own notes. While the Appellant highlights the nursing note dated [REDACTED] which mentions toileting, the OT evaluation and discharge summaries, the [REDACTED] 2017 ADL chart and Kardex report (T 5/22/24, p 50; Exhibit 11, pp 1728, 1729, 1733, 1735; Exhibits D, E), this does not equate to documentation of a decline in Resident 16's ability to toilet *prior* to being referred to OT.

### Dressing

The Appellant did not submit the [REDACTED] 2017 ADL chart for dressing and, therefore, the OMIG auditor testified that there was no documentation of a decline in the resident's ability to dress. (T 5/8/24, p 84.) Again, the Appellant relies on the scant nursing note dated [REDACTED] which mentions dressing, as well as the OT evaluation and discharge summaries, the [REDACTED] 2017 ADL chart and Kardex report (T 5/22/24, p 50; Exhibit 11, pp 1728, 1729, 1731, 1733, 1735; Exhibits D, E), yet none of this equates to a



documented decline in the resident's everyday ability to dress leading to the OT referral. While the Appellant again contended that because the resident's [REDACTED] body dressing improved to supervision -- but the [REDACTED] body did not -- this accounts for why the [REDACTED] ADL chart documents the resident remaining at level [REDACTED] assistance after OT, there is no note to this effect. (T 5/22/24, p 50; Exhibit 11, pp 1731, 1733; Exhibit D.) The nursing staff did not document this alleged fact contemporaneously yet wants this to be considered at the time of audit.

Therefore, the Appellant failed to meet its burden to produce sufficient documentation that OT was medically necessary during the look back week.

#### **Sample 18**

The ARD for the sample 18 resident (Resident 18) was [REDACTED] 2017. The audit corrected the Appellant's reported resident RUG category from [REDACTED] to [REDACTED] on the grounds that the medical basis and specific need for 5 days/185 minutes of OT and 5 days/175 minutes of PT during the week before the ARD were not fully and properly documented in the resident record. (Exhibit 4, pp 1390, 1399.)

On [REDACTED], 2017, Resident 18, age [REDACTED] and diagnosed with [REDACTED] and [REDACTED] was referred by nursing note for PT and OT evaluations due to a decline in functional mobility, ADLs, and need for increased assistance with transfers, FAP, toileting, and dressing with [REDACTED] balance, including risk of fall and to restore PLOF. (Exhibit 13, p 1803.)

#### **Physical Therapy**

A facility physical therapist evaluated Resident 18 on [REDACTED] 2017 and recommended restorative PT five to six times weekly for four weeks, which a physician

ordered and certified as a medically necessary plan of treatment on [REDACTED] (Exhibit 13, p 1824.) This is the PT that was reported in the MDS look back week of [REDACTED]. Resident 18 received therapy for just over one week that coincided with the look back week, and was discharged from PT on [REDACTED] 2017, the exact ARD. (Exhibit 13, pp 1836-1841.)

#### Ambulation

The OMIG auditor could not verify that Resident 18 was experiencing a decline in his ability to perform the FAP prior to PT in [REDACTED] 2017 because the Appellant did not provide the resident's FAP for either [REDACTED] or [REDACTED] 2017. Any decline noted by the therapist, therefore, could not be verified. (T 5/8/24, pp 89-90.)

The Appellant submitted a Physiatry Consultation, dated [REDACTED] 2017, which details that the Resident 18 declined in function secondary to [REDACTED] ([REDACTED] [REDACTED]), and his [REDACTED] diagnosis, and had good rehabilitation potential. (T 5/22/24, p 57; Exhibit 13, p 1805.) The Appellant also relied on the PT discharge summary, which indicates that gait training was performed with facilitation of swing phase and emphasis on [REDACTED], increasing Resident 18's safety to get back and forth to the bathroom. (T 5/22/24, p 59; Exhibit 13, p 1837.) The Appellant also introduced fall scale reports, which were not submitted as part of the audit. (T 5/22/24, pp 63-65.) The first, dated [REDACTED] 2017, reports a score of [REDACTED] which is a [REDACTED] fall risk. (Exhibit F.) The second, dated [REDACTED] the same day as discharge from PT, reports a score of [REDACTED] representing only a [REDACTED] risk of fall. (Exhibit G.) The Appellant did not explain why, if the resident was found to be a fall risk in early [REDACTED] he was not referred to therapy until [REDACTED].

### Transfers

Concerning transfers, the OMIG auditor testified that the Appellant again did not submit an [REDACTED] ADL tracker and, therefore, she could not verify the medical necessity for PT concerning transfers because she did not have a baseline and so had no way to verify a decline in the resident's ability to transfer. (T 5/8/24, pp 90-91.) The PT discharge records that the resident was evaluated at CGA and improved through therapy to set up assistance with improved sit to stand transfers, to maintain [REDACTED] allowing toilet transfers with only set up assistance from nursing. (Exhibit 13, p 1839.)

Here, while there is evidence that Resident 18's fall risk decreased *from the beginning of* [REDACTED] to [REDACTED] and his ability to ambulate and transfer improved per the therapist's discharge report, the Appellant did not meet its burden to demonstrate through documentation why the resident was sent to therapy on [REDACTED], three days before the physiatry consult was ever even completed, and almost three months after he was found to be a [REDACTED] fall risk. The Appellant did not have documentation supporting the pro forma nursing note referring Resident 18 for PT and submitted no relevant ADL charts for [REDACTED] or [REDACTED] 2017.

### Occupational Therapy

A facility occupational therapist evaluated Resident 18 on [REDACTED] 2017 and recommended restorative OT five to six times weekly for four weeks, which a physician ordered and certified as a medically necessary plan of treatment by electronic signature on [REDACTED]. (Exhibit 13, p 1830.) This is the OT that was reported in the MDS look back week of [REDACTED]. Resident 18 was discharged from OT on [REDACTED], 2017, the exact

ARD, after just over one week of therapy that coincided with the look back week. (Exhibit 13, pp 1842-1846.)

#### Toileting

Concerning toileting, the OMIG auditor testified that the Appellant did not submit an [REDACTED] ADL tracker and, therefore, she could not verify the medical necessity for OT concerning toileting because she did not have a baseline and so had no way to verify a decline in the resident's ability. (T 5/8/24, pp 92-95.) Resident 18 was evaluated at CGA at OT evaluation and completed OT at supervision level. His improvement was noted in his transfers to toilet and ability to clothe himself ([REDACTED] after toileting. (Exhibit 13, pp 1843-1844.)

#### Dressing

The Appellant likewise did not submit the [REDACTED] 2017 ADL chart for dressing. However, the Appellant relies on the psychiatry consultation which details the need for therapy due to the resident's diagnosis of [REDACTED] and the nursing note, which specifically mentions dressing as well as the OT evaluation and discharge summaries, the [REDACTED] 2017 ADL chart and Kardex report, both of which were not produced for the audit. (Exhibit 13, pp 1728, 1729, 1731, 1733, 1735; Exhibits D, E.) The [REDACTED] body dressing improved from limited assistance to contact guard assistance, level [REDACTED] to level [REDACTED] from evaluation on [REDACTED] to discharge on [REDACTED] according to the therapist. (T 5/22/24, p 61; Exhibit 13, p 1842-1846.) While the Appellant detailed alleged improvement, during therapy, the Appellant failed to produce documentation substantiating any decline in dressing and toileting as stated in the pro forma nursing note dated [REDACTED]

The Appellant did not offer sufficient documentation to support the medical necessity of OT during the look back week as it did not produce any relevant documentation of the resident's levels of functioning prior to the OT referral.

### **Sample 25**

The ARD for the sample resident 25 (Resident 25) was [REDACTED] 2017. The Appellant reported the resident's RUG category as [REDACTED] and the audit corrected it to [REDACTED] on the grounds that the medical basis and specific need for 5 days/175 minutes of OT and PT during the week before the ARD were not fully and properly documented in the resident record. (Exhibit 4, pp 1390, 1400.) On [REDACTED], 2017, Resident 25, age [REDACTED] and diagnosed with [REDACTED], was referred by nursing note for PT and OT evaluations due to a decline in functional mobility, transfers, FAP and ADLs, and need for increased assistance from staff. (Exhibit 14, p 1867.)

### **Physical Therapy**

A facility physical therapist evaluated Resident 25 on [REDACTED] 2017 and recommended restorative PT five to six times weekly for four weeks, which a physician ordered and certified as a medically necessary plan of treatment. (Exhibit 15, p 1938.) This is the PT that was reported in the MDS look back week of [REDACTED] Resident 25 was given one week of therapy that coincided precisely with the look back week, and was discharged from PT on [REDACTED] 2017, the exact ARD. (Exhibit 15, pp 1944-1947.)

### **Ambulation**

The OMIG auditor testified that she could not verify that Resident 25 was experiencing a decline in his ability to perform the FAP prior to the nursing note and the coinciding PT evaluation both on [REDACTED]. (T 5/8/24, pp 102-103.) Resident 25's FAP

shows that he completed his task to walk [REDACTED] feet with rolling walker and wheelchair to follow twice daily in [REDACTED] 2017 without decline. (T 5/8/24, pp 103-104; Exhibit 15, p 1961.) The physical therapist noted that Resident 25's PLOF included completing [REDACTED] feet with CGA and rolling walker, but the OMIG auditor found this was not credible because it was completely inconsistent with all the other facility records and not supported by any records. (T 5/8/22, pp 104-105; Exhibit 15, p 1939.)

Resident 25's [REDACTED] ADL chart reveals that the FAP's goal distance remained at [REDACTED] feet even after discharge from therapy, which refutes the discharge report that claimed improvement to [REDACTED] feet. (Exhibit 15, pp 1944, 1972.) Although the Appellant introduced a Kardex report purporting to indicate that, as of [REDACTED] 2017, the resident's FAP was to be [REDACTED] feet with a rolling walker, there was no proof that this ever was implemented by nursing (Exhibit K) and the Appellant did not produce the Kardex report during the audit.

The Appellant contends that the therapist worked on Resident 25's gait, training to normalize the gait pattern, adjustment of center of mass and training to correct the hand and foot placement. The Appellant's Director of Rehabilitation testified that it was not distance but quality of gait that was improved and that locomotion in unit improved from Level [REDACTED] to Level [REDACTED] on or around [REDACTED], 2017 (T 5/22/24, pp 74-75, 79-81; Exhibit 15, p 1945), yet PT ended as early as [REDACTED]. Further, the Appellant's burden was not to show improvement after therapy but documentation supporting therapy in the first instance.

### Transfers

Concerning transfers, the OMIG auditor found no records to document that the resident declined in his ability to transfer anytime in [REDACTED] 2017. The auditor testified that she looked at the [REDACTED] chart which showed that the resident transferred at the level [REDACTED]" (extensive assistance) every shift for the entire month. (T 5/8/24, p 106; Exhibit 15, p 1964.) The physical therapist noted that Resident 25's PLOF with respect to transfers was CGA, or a level [REDACTED] but there is no evidence anywhere that he was ever at that level. The auditor stated that this is evidence again that nursing and PT assessments did not match, and the alleged declines were not validated. (T 5/8/24, p 107.)

The Appellant's witness relied on the PT discharge summary which records that gains were made in the resident's [REDACTED] extremity strength, which improved the sit to stand transfers. (T 5/22/24, p 75; Exhibit 15, p 1946.)

The Appellant also argued that medical necessity for the treatment was demonstrated by a doctor's note, dated [REDACTED] 2017, that Resident 25 "had [REDACTED] and was on [REDACTED] two hundred milligrams, and [REDACTED] and patient was on [REDACTED] (T 5/22/24, p 72.) This note did not even mention therapy and does not explain how the resident's medical diagnosis affected his ambulatory and ADL needs.

The Appellant did not establish interdisciplinary medical necessity for PT.

### **Occupational Therapy**

The nurse's note dated [REDACTED] 27 also sparked the OT evaluation that very same day. The therapist recommended restorative OT for five to six times weekly for four weeks, and a physician ordered and certified "the need for these medically necessary services furnished under this plan of treatment" by electronic signature on [REDACTED] 2017.

(Exhibit 15, p 1948.) This is the OT that was reported in the MDS look back week of [REDACTED] Resident 25 was given one week of therapy that coincided precisely with the look back week, and was discharged from OT on [REDACTED] 2017, the exact ARD. (Exhibit 15, pp 1954-1957.)

#### Toileting

The OMIG auditor testified that Resident 25's [REDACTED] ADL chart for toileting documented that he required consistent extensive assistance, or "[REDACTED]," and there was no documented decline in his ability to perform toileting prior to therapy. (T 5/8/24, p 108; Exhibit 15, p 1964.) The OT evaluation recorded that the resident's PLOF required limited assistance, or level [REDACTED] (T 5/8/24, p 109; Exhibit 15, p 1948.) Since the [REDACTED] ADL chart never showed a Level [REDACTED] for toileting, no decline in toileting was supported in the documentation. The OMIG auditor again testified that the OT evaluation appeared to be another attempt to make a resident appear worse than he was to support the need for therapy. (T 5/8/24, p 109.)

The Appellant did not submit any documentary evidence or make any attempt to explain the discrepancy between nursing and therapy records.

#### Dressing

The OMIG auditor testified similarly concerning dressing. The [REDACTED] ADL chart revealed that the resident is a "[REDACTED]" level, except for once when he was a "[REDACTED]" (T 5/8/24, p 110; Exhibit 15, p 1961.) The evaluation for OT detailed that the resident was "[REDACTED] body dressing with limited assist" which is a Level [REDACTED] (T 5/8/24, p 110; Exhibit 15, p 1949.) The auditor found no evidence of decline and no documentation supporting that the resident was ever a Level [REDACTED] (T 5/8/24, p 110-111.)



Although the Appellant contended that Resident 25 improved from modified assistance to minimum assistance, but that it was reported consistently in the ADL chart at the '████' level (T 5/22/24, p 78), it is the Appellant's burden to document a clear decline necessitating the OT received during the look back week and, here, the Appellant did not do so.

The Appellant failed to produce interdisciplinary documentation to support the medical necessity of OT for Resident 25 during the look back week.

### **Sample 27**

The ARD for the Sample Resident 27 (Resident 27) was █████ 2017. The Appellant reported the resident's RUG category as █████ and the audit corrected it to █████ on the grounds that the medical basis and specific need for 5 days/175 minutes of OT and PT during the week before the ARD were not fully and properly documented in the resident record. (Exhibit 4, pp 1390, 1401.) On █████ 2017, Resident 27, age █████ and diagnosed with █████ and █████, was referred by nursing note for PT and OT evaluations due to a decline in functional mobility, ADLs, and need for increased assistance with ambulation, transfers, toileting, and dressing "to restore PLOF." (Exhibit 17, p 2047.) This nursing note was used, word for word, to refer three other residents, samples, 1, 11, and 30, for therapy.

### **Physical Therapy**

A facility physical therapist evaluated Resident 27 on █████, 2017 and recommended restorative PT for five to six times weekly for five weeks, which a physician ordered and certified as a medically necessary plan of treatment. (Exhibit 17, pp 2067-2068.) This is the PT that was reported in the MDS look back week of █████-

Resident 27 was discharged from PT on 2017, the exact ARD, after three weeks of therapy. (Exhibit 17, pp 2073-2078.)

#### Ambulation

The OMIG auditor testified that she could not verify that Resident 27 was experiencing a decline in her ability to perform the FAP prior to the nursing note on and the PT evaluation on as the Appellant did not submit an ADL chart for 2017. (T 5/8/24, p 116.) Resident 27's 2017 FAP shows that she completed her task to walk feet with rolling walker and wheelchair to follow twice daily in without decline. (T 5/8/24, pp 116-117; Exhibit 17, p 2093.) The physical therapist noted that Resident 27's PLOF included completing feet with CGA and rolling walker, but the auditor found this was not credible because it was inconsistent with the other evidence, there was no documentary proof of it, and the resident is years old and feet is the . (T 5/8/22, pp 117-118; Exhibit 17, p 2068.) The 2017 FAP chart indicates that Resident 27's FAP continued at feet, even after PT had ended. (T 5/8/24 p 125; Exhibit 17, p 2111.)

Although the Appellant introduced a Kardex report which indicates that, as of 2017, the resident's FAP was to be feet with a rolling walker, there was no evidence that this ever was implemented by nursing, and it was not submitted as part of the audit. (Exhibit M.)

#### Transfers

Concerning transfers, the OMIG auditor could not verify a decline because the Appellant did not provide 2017 ADL charts for this resident. (T 5/8/24, p 119.) The auditor reviewed on the 2017 ADL chart and there was no

documentation of decline in the resident's ability to transfer. (T 5/8/24, p 120.) Although the physical therapist reported that the resident's PLOF before evaluation was a level ■ there was no documentation of this, and the therapist did not say from where that number was derived. (T 5/8/24, p 121.) The Appellant relied on the PT discharge summary which states that gains were made in the resident's ability to transfer, to supervision (T 5/22/24, p 84, 92; Exhibit 17, pp 2075-2076), but again there is no proof of how the resident arrived at therapy to begin with.

The ■ ADL chart and the PT evaluation indicate that Resident 27 was able to transfer on some days with only supervision and, on other days, required extensive assistance. From ■, there were three days during the 3:00-11:00 PM shift that the resident was a Level ■ requiring only supervision with transfers, but the other days and times, was a Level ■ Throughout ■ the mix of Level ■ and Level ■ continued inconsistently. (Exhibit 17, p 2096.)

The Appellant has not demonstrated through interdisciplinary documentation a medical need for PT for Resident 27.

### **Occupational Therapy**

A facility occupational therapist evaluated Resident 27 on ■, 2017 and recommended OT five to six times weekly for four weeks, which a physician ordered and certified as medically necessary treatment. (Exhibit 17, pp 2079-2080.) This is the OT that was reported in the MDS look back week of ■ Resident 27 was discharged from OT on ■ 2017, the exact ARD, after three weeks of therapy. (Exhibit 17, pp 2085-2088.)

### Toileting

The OMIG auditor testified that she reviewed the resident's [REDACTED] ADL chart from [REDACTED] for toileting and the resident required extensive assistance, or [REDACTED]" except for four days on the evening shift. (T 5/8/24, pp 121-122; Exhibit 17, p 2096.) Although the OT evaluation indicated that the resident's PLOF was a level [REDACTED] the auditor did not see proof of this and could not verify a decline in the resident's ability to perform toileting tasks prior to therapy. (T 5/8/24, p 122; Exhibit 17, p 2080.) On the date of the evaluation, the therapist noted that the resident's current level was CGA, which required assistance of one person to be on the ready to help. (Exhibit 17, p 2081.) The Appellant's witness testified that, over the course of therapy, the resident improved to supervised, which also required someone to be present but only for set up and observation. (T 5/8/24, p 84; Exhibit 17, p 2086.) The Appellant however did not submit therapy notes detailing any progress of the resident during therapy, thus not documenting the medical necessity for the therapy during the look back week.

The [REDACTED] ADL toileting chart and the OT evaluation indicate that Resident 27 was able to toilet on some days with only supervision and, on other days, required extensive assistance. Throughout [REDACTED] the mix of Level [REDACTED] in toileting needs continued inconsistently before, during and after OT. (Exhibit 17, p 2096.)

### Dressing

The OMIG auditor testified that the Appellant never provided [REDACTED] ADL dressing charts for Resident 27 and, therefore, the auditor did not have a documented baseline, and there was no evidence of decline. (T 5/8/24, p 123.) The Appellant's

witness testified that the resident improved to supervised from CGA. (T 5/8/24, p 84; Exhibit 17, p 2086.)

The [REDACTED] ADL dressing chart and the OT evaluation indicate that Resident 27 was able to dress on some days with only supervision and, on other days, required extensive assistance. Throughout [REDACTED] the mix of Level [REDACTED] in toileting needs continued inconsistently before, during and after OT. Further, while the [REDACTED] ADL chart does indicate Level [REDACTED] on several days, it also continued to demonstrate inconsistencies, with many Levels [REDACTED] (Exhibits 17, p 2092; Exhibit L.)

The Appellant has not demonstrated through interdisciplinary documentation a medical need for OT or PT for Resident 27. Although Resident 27 participated in therapies for three weeks, here, the Appellant did not submit progress notes which may or may not have substantiated continued therapies into the look-back week, which ended on the exact date of the ARD.

### **Sample 30**

The ARD for the Sample 30 Resident (Resident 30) was [REDACTED] 2017. The Appellant reported the resident's RUG category as [REDACTED] and the audit corrected it to [REDACTED] on the grounds that the medical basis and specific need for 5 days/175 minutes of OT and PT during the week before the ARD were not fully and properly documented in the resident record. (Exhibit 4, pp 1390, 1402.)

On [REDACTED] 2017, Resident 30, age [REDACTED] and diagnosed with [REDACTED] [REDACTED] and with a history of falls, was referred for both PT and OT evaluations to restore her PLOF by the same nursing note, word for word, as the notes for sample residents 1, 11 and 27. (Exhibit 19, p 2175.)

### Physical Therapy

A facility physical therapist evaluated Resident 30 on [REDACTED], 2017 and recommended restorative PT for five to six times weekly for four weeks which a physician ordered and certified as a medically necessary plan of treatment. (Exhibit 19, p 2204.) This is the PT that was reported in the MDS look back week of [REDACTED]. Resident 30 was discharged from PT on [REDACTED] 2017, the exact ARD, after three weeks of therapy. (Exhibit 19, pp 2210-2215.)

### Ambulation

The OMIG auditor could not verify that Resident 30 was experiencing a decline in her ability to perform the FAP. (T 5/8/24, p 131.) Resident 30's [REDACTED] 2017 [REDACTED] is [REDACTED] feet with rolling walker, assist of one, wheelchair to follow and every day during [REDACTED] the resident was able to complete same. (T 5/8/22, p 131-132; Exhibit 18, p 2144.) Resident 30's [REDACTED] 2017 FAP shows that she completed her task to walk [REDACTED] feet with rolling walker and wheelchair to follow, without decline. (Exhibit 19, p 2216.) The therapist noted that Resident 30's PLOF included completing [REDACTED] feet with rolling walker and supervision, but this does not represent a decline. (T 5/8/22, pp 132-133; Exhibit 19, p 2205.)

The Appellant introduced a Kardex report which indicates that, as of [REDACTED] 2017, the resident's FAP was to be [REDACTED] feet with a rolling walker, but there was no proof that this ever was implemented by nursing. (Exhibit N.) In any event, the Kardex report was not submitted as part of the audit. While the Appellant contends that the therapist worked with the resident and ambulation was better with decreased assistance (T 5/22/24, p 92; Exhibit 19, p 2212), no decline was documented prior to PT intervention.

### Transfers

Concerning transfers, the OMIG auditor could not verify a decline because the resident's [REDACTED] 2017 ADL chart documents instead that the resident remained consistent at a Level [REDACTED] or extensive assistance, for the entire month. (T 5/8/24, p 133.)

On [REDACTED] and [REDACTED], the resident was a Level [REDACTED] on the 7:00 AM to 3:00 PM shift. (Exhibit 18, p 2148.) At the beginning of [REDACTED] during the six days prior to the nursing note and start of therapy, the resident was a Level [REDACTED] and did not show a decline. (T 5/8/24, p 134; Exhibit 18, p 2157.) Although the physical therapist noted that the resident's PLOF with respect to transfers was a level [REDACTED] there is no evidence of this, and the alleged decline was not documented. (T 5/8/24, p 135-136; Exhibit 19, p 2205.) The therapist's evaluation noted the resident's level to be CGA. (Exhibit 19, p 2206.) The Appellant cited the PT discharge summary which details that gains were made in the resident's transfers from limited assistance to supervision. (T 5/22/24, p 92; Exhibit 19, p 2210.) However, there is only the therapist's contemporaneous observation and no interdisciplinary documentation that the resident's level of transferring changed either, before, during or after PT.

The Appellant has not demonstrated through interdisciplinary documentation a medical need for PT for Resident 30.

### **Occupational Therapy**

A facility occupational therapist evaluated Resident 30 on [REDACTED], 2017 and recommended restorative OT five to six times weekly for four weeks, which a physician ordered and certified as a medically necessary plan of treatment. (Exhibit 19, p 2193.) This is the OT that was reported in the MDS look back week of [REDACTED] Resident

30 was discharged from OT on [REDACTED] 2017, the exact ARD, after three weeks of therapy. (Exhibit 19, pp 2199-2203.)

#### Toileting

The OMIG auditor reviewed the resident's ADL chart from both [REDACTED] 2017 and [REDACTED] 2017 for toileting, which documented that the resident required extensive assistance, or "[REDACTED]" every day. (T 5/8/24, pp 136-137; Exhibit 18, pp 2147, 2156.) Although the OT evaluation indicated that the resident's PLOF was a level [REDACTED] limited assist of one, CGA, the OMIG auditor did not see proof of this and could not verify a decline in the resident's ability to perform toileting tasks prior to therapy. (T 5/8/24, p 138; Exhibit 18, p 2134.) The auditor also testified that this is an example of nursing and rehabilitation not talking to each other which has a negative effect on the resident. (T 5/8/24, p 139.) The Appellant's witness testified that the resident improved, yet no improvement is documented. (T 5/22/24, p 92; Exhibit 19, p 2200.)

#### Dressing

The OMIG auditor testified that the resident's ADL chart from both [REDACTED] 2017 and [REDACTED] 2017 for dressing, and the resident required extensive assistance, or [REDACTED] every day. (T 5/8/24, pp 139-140; Exhibit 18, pp 2149, 2153.) The auditor did not see any evidence of decline. (T 5/8/24, p 140.) Although the OT evaluation indicated that the resident's PLOF was a level [REDACTED] limited assist of one, CGA, the auditor did not see proof of this and could not verify a decline in the resident's ability to perform dressing tasks prior to therapy. (T 5/8/24, p 141-142; Exhibit 18, p 2134.) The Appellant's Director of Rehabilitation testified that because there was a pain in the resident's [REDACTED] on rest



and activity, the [REDACTED] body dressing did not improve after OT (T 5/22/24, p 93) but did not indicate where this was documented to justify the referral to OT.

The Appellant has not demonstrated through interdisciplinary documentation a medical need for OT or PT for Resident 30. Like for Residents 11 and 27, here Resident 30 was in therapies for three weeks, but did not submit any progress notes during the course of the therapies which may have justified the medical necessity for the therapies continuing into the week before the ARD, the date the therapies ended.

### **Sample 39**

The ARD for the Sample 39 Resident (Resident 39) was [REDACTED] 2017. The Appellant reported the resident's RUG category as [REDACTED] and the audit corrected it to [REDACTED] on the grounds that the medical basis and specific need for 5 days/185 minutes of OT and 5 days/175 minutes of PT during the week before the ARD were not fully and properly documented in the resident record. (Exhibit 4, pp 1391, 1403.)

On [REDACTED] 2017, Resident 39, age [REDACTED] and diagnosed with [REDACTED] [REDACTED] after [REDACTED] from a [REDACTED] was referred by nursing note for both PT and OT evaluations due to a decline in functional mobility and transfers, FAP, ADLs and dressing and with an increased fall risk. (Exhibit 21, p 2306.)

### **Physical Therapy**

A facility physical therapist evaluated Resident 39 on [REDACTED], 2017 and recommended restorative PT for five to six times weekly for four weeks on [REDACTED]. A physician ordered and certified "the need for these medically necessary services furnished under this plan of treatment" by electronic signature on [REDACTED] (Exhibit 21, p 2329.) This is the PT that was reported in the MDS look back week of [REDACTED]

Resident 39 was discharged from PT on [REDACTED] 2017, the exact ARD, having received only one week of therapy that coincided with the look back week, given in accordance with a treatment plan that was not approved by a physician until five days after the therapy ended. (Exhibit 21, pp 2335-2339.)

#### Ambulation

The OMIG auditor could not verify that Resident 39 was experiencing a decline in her ability to perform the FAP (T 5/8/24, p 149.) Resident 39's [REDACTED] 2017 FAP is [REDACTED] feet with rolling walker, assist of one, wheelchair to follow and every day during [REDACTED] the resident was able to complete same. (T 5/8/22, p 149; Exhibit 21, p 2356.) The auditor testified that the decline that the nurses wrote about, therefore, could not be verified. (T 5/8/24, p 149-150.) The physical therapist noted that Resident 39's PLOF was [REDACTED] feet but did not say when that was or where this information came from. On the date of the evaluation, [REDACTED] [REDACTED] the resident was able to walk only [REDACTED] feet, but on the same day, nurses verified [REDACTED] feet, per the FAP. (T 5/8/22, pp 150; Exhibit 21, p 2331.)

The Appellant noted that the resident had a psychiatry consultation on [REDACTED] due to a [REDACTED], or [REDACTED] and the consultant found that rehabilitation would be helpful for the resident because of pain and a decline in function (T 5/22/24, p 95; Exhibit 21, p 2308), yet this was after therapy already had commenced. The Appellant's Director of Rehabilitation testified that the resident's gait pattern was normalized with correction of [REDACTED] [REDACTED] [REDACTED] (T 5/22/24, p 98.) The Appellant introduced the [REDACTED] 2017 ADL charts concerning walking in room and corridor which demonstrate that these two activities commenced after PT ended (Exhibit O, p 154), and a

Kardex report dated [REDACTED] 2017 (Exhibit N), but the charts and Kardex report were not produced at audit and do not demonstrate a decline in function prior to the therapy referral.

#### Transfers

Concerning transfers, the OMIG auditor could not verify a decline because the resident's [REDACTED] 2017 ADL chart details that the resident remained consistent at a Level "[REDACTED]," or extensive assistance, for the entire month. (T 5/8/24, p 151-152; Exhibit 21, p 2359.) The physical therapist noted that the resident's PLOF with respect to transfers was a level [REDACTED] but the OMIG auditor pointed out that there is no evidence of this and so, the alleged decline not validated. (T 5/8/24, p 152-153; Exhibit 21, p 2331.) The therapist noted that the resident commenced PT able to transfer with minimum assistance with a rolling walker for support but needed only CGA at discharge after only one week. (Exhibit 21, p 2335.) However, any alleged benefit of therapy documented by the therapist does not justify the medical need for the initial referral to therapy.

The Appellant has not demonstrated through interdisciplinary documentation a medical need for PT for Resident 39.

#### **Occupational Therapy**

A facility occupational therapist evaluated Resident 39 on [REDACTED] 2017 and recommended restorative OT for five to six times weekly for four weeks, and a physician ordered and certified "the need for these medically necessary services furnished under this plan of treatment" by electronic signature again on [REDACTED]. (Exhibit 21, p 2341.) This is the OT that was reported in the MDS look back week of [REDACTED]. Resident 39 was discharged from OT on [REDACTED], 2017, the exact ARD, having received only one week

of therapy that coincided with the look back week, given in accordance with a treatment plan that was not approved by a physician until five days after the therapy ended. (Exhibit 21, pp 2347-2351.)

#### Toileting

The OMIG auditor reviewed the resident's ADL chart from [REDACTED] 2017 for toileting, which documented that the resident required extensive assistance, or "[REDACTED]" every day. (T 5/8/24, pp 154-155; Exhibit 21, p 2358.) Although the OT evaluation indicated that the resident's PLOF was a level [REDACTED] limited assist of one, CGA, the auditor did not see proof of this and could not verify a decline in the resident's ability to perform toileting tasks prior to therapy. (T 5/8/24, p 154-155; Exhibit 21, p 2342.) While the therapist noted that the resident improved in therapy from minimum assistance to CGA (T 5/22/24, p 98; Exhibit 21, p 2348), again any such alleged improvement during the very week of look back does not justify the need for that initial referral to therapy.

#### Dressing

The OMIG auditor testified that resident's [REDACTED] ADL chart for dressing documented that the resident required extensive assistance, or [REDACTED] every day. (T 5/8/24, pp 157; Exhibit 21, p 2355.) The auditor did not see any evidence of decline. (T 5/8/24, p 157.) Although the OT evaluation indicated that the resident's PLOF was a level [REDACTED] supervision, the auditor did not see proof of this and could not verify a decline in the resident's ability to perform dressing tasks prior to therapy. (T 5/8/24, p 157-158; Exhibit 21, p 2342.)

While the Appellant relies on the fact that the resident's [REDACTED] body dressing improved from minimum assistance to CGA over the course of the one week of OT (T

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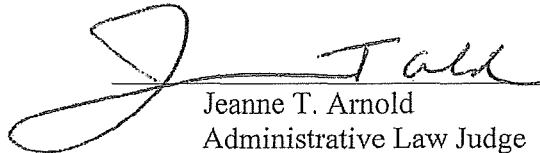
5/22/24, p 98), there is no documentation of same. The ADL chart did not show a decline prior to therapy. (Exhibit 21, p 2348.)

The Appellant did not prove through interdisciplinary documentation that there was a medical necessity for Resident 39 to receive both PT and OT during the one-week look back period.

**DECISION:**

The OMIG's determination to recover overpayments based upon the MDS audit findings that skilled therapies for Sample 1, 11, 16, 18, 25, 27, 30 and 39 residents were not documented to be reasonable and necessary for the sample residents' medical conditions is affirmed.

DATED: Rochester, New York  
December 9, 2024



Jeanne T. Arnold  
Administrative Law Judge