STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

November 4, 2009

CERTIFIED MAIL/RETURN RECEIPT

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NYS Department of Health
Office of the Medicaid Inspector General
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RE: In the Matter of Metropolitan Jewish Geriatric 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,

James F. Horan

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH

IN THE MATTER
OF THE REQUEST OF

METROPOLITAN JEWISH GERIATRIC CENTER
Audit #06-7420
Medicaid ID #00309031

for a Hearing Pursuant to Part 519 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York ("NYCRR") to Review a Determination to Recover Medicaid Overpayments.

DECISION AFTER HEARING

Before: William J. Lynch
Administrative Law Judge

Held At: NYS Department of Health
90 Church Street
New York, New York 10007
April 16, 2009
May 4 and 29, 2009
June 9 and 24, 2009

Record closed: September 8, 2009

Parties: NYS Office of the Medicaid Inspector General
By: Barry S. Mandel, Esq.
New York State Department of Health
Office of the Medicaid Inspector General
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Metropolitan Jewish Geriatric Center
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JURISDICTION

The Metropolitan Jewish Geriatric Center ("Appellant") requested this hearing pursuant to Section 519.4 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York ("NYCRR") to appeal from a determination of the New York State Department of Health Office of the Medicaid Inspector General ("the OMIG") to recover alleged overpayment of reimbursement by the Medical Assistance for Needy Persons Program ("Medicaid Program"), plus interest.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Administrative Law Judge in arriving at a particular finding. Conflicting evidence, if any was considered and rejected in favor of the cited evidence.

1. Appellant is a 510 bed skilled nursing facility located at 4915 10th Avenue, Brooklyn, New York. It is certified to operate a residential health care facility under Article 28 of the Public Health Law. Appellant received Medicaid reimbursement as Provider # 00309031. (Not contested).

2. The OMIG is an independent entity within the New York State Health Department ("Department"). One of the OMIG's functions is to undertake civil and administrative enforcement actions against individuals or entities engaging in fraud, abuse or other illegal, improper or unacceptable practices within the Medicaid Program. (Not contested).

3. By letter dated July 31, 2006, the OMIG began an audit of Appellant's bed reserve billings to Medicaid for service dates from January 1, 2002 through December 31, 2004.

The OMIG instructed Appellant to submit documentation solely related to the daily patient activity and reserved bed-holds. (OMIG Ex. 18; T. 431-434).

4. Appellant provided this information to the OMIG. (OMIG Ex. 25A; T. 438-440).

5. The OMIG's auditor testified that some 20-30 disallowances were made based upon the documentation received for the audit period. (T. 459).

6. By letter dated May 18, 2007, the OMIG expanded the scope of its audit and instructed Appellant to submit documentation "supporting the hospital discharge planning coordinator's determination that the recipient was expected to return to [Appellant's facility] within 15 days from the hospital admission date." (OMIG Ex. 19, T. 247-248).

7. Specifically, the OMIG asked Appellant to produce written documentation from the hospital generated by the fourth day of hospitalization indicating that person was not expected to require hospitalization beyond fifteen days in all instances where Appellant had billed for a reserved bed while a resident was hospitalized. (T. 461).

8. By letter dated October 11, 2007, the OMIG advised Appellant that the only documentation that should be submitted in response to the audit request was "written dated documents that verify the expected length of stay and/or anticipated discharge dates associated with the client's hospital stay." Further, the OMIG indicated that "[t]he records [Appellant] submits should be specific in addressing the hospital's determination of an anticipated length of stay and/or expected discharge date for each client." (OMIG Ex. 22).

9. In a draft audit report issued on June 10, 2008, the OMIG disallowed Medicaid reimbursement in instances where a bed hold exceeded fifteen days and the Appellant had failed to produce documentation from the hospital (T. 254-255). Then the OMIG recomputed the daily census totals and disallowed any other bed hold initiated on that date if the vacancy rate exceeded five percent as a result of the first disallowance (T. 487-490).

10. Under the Health Care Assessment Program, residential health care facilities licensed under Article 28 of the Public Health Law must pay a six percent assessment on monthly cash receipts effective April 1, 2002. New York Medicaid reimburses nursing homes for the portion of the assessment that applies to days on which Medicaid is the primary payer for a resident. In its report, the OMIG determined that the six percent reimbursement Appellant had received related to the disallowed bed holds was a Medicaid overpayment. (OMIG Ex.6).

11. The OMIG also assessed interest on the overpayment from the dates of occurrence (OMIG Ex. 6).

12. The June 10, 2008 draft audit report found Appellant was required to pay $925,314,04. (OMIG Ex. 6).

13. In a revised draft audit report issued on August 27, 2008, the OMIG found that Appellant was required to pay $947,125.35. (OMIG Ex. 1).

14. By letter dated September 29, 2008, Appellant submitted a response to the OMIG's revised draft audit report and the proposed audit adjustment. (OMIG Ex. 2).

15. On October 2, 2008, the OMIG issued a Final Report of its Bed Reserve Audit of Appellant for the three-year period ending December 31, 2004. The final report did not change the findings contained in the August draft report. The OMIG disallowed 2,006 bed-hold days corresponding to 104 hospital stays of residents during the three-year period. (OMIG Ex. 3).

16. The OMIG modified its repayment demand to $927,983.20 after its review of a submission made by Appellant on October 2, 2008, which the OMIG received on October 8, 2009. (T. 49-50, 497-502).

17. By letter dated November 26, 2008, Appellant requested an administrative hearing

pursuant to 18 NYCRR § 519.7 to contest the Final Report (OMIG Ex. 4).

18. Originally codified as 18 NYCRR 360.20 and recodified in 1994 as 18 NYCRR 505.9(d), the bed hold regulations have not materially changed since the 1970s when they were first adopted. (T. 88).

19. The purpose of the bed hold regulations is to ensure that residents can return to their nursing home room and bed after a temporary hospitalization for acute medical care. (T. 84-85, 596).

20. If certain conditions are met, nursing homes must reserve a Medicaid recipient's nursing home bed while the resident is temporarily hospitalized with an acute condition "unless it is clearly evident at the time of departure to the hospital that the [resident] will not return to the originating facility in 15 days or less." (OMIG Ex. 7 at 2-127).

21. The resident must have established residency in the facility for at least thirty days prior to the hospitalization. 18 NYCRR § 505.9(d)(5)(i)(a).

22. The nursing home must have a vacancy rate of five percent or less when the resident is transferred. 18 NYCRR § 505.9(d)(5)(i)(b).

23. The nursing home resident must want to return to the facility, and the nursing home must be able to provide the level of care the resident would require upon return (T. 87).

24. When a nursing home is holding a bed for a resident, the regulations provide that the hospital discharge planning coordinator must notify the nursing home of the resident's planned discharge date by the morning of the fourth day of hospital care and confirm in writing all bed reservation telephone communications. 18 NYCRR § 505.9(d)(6)(i)(c).

25. Elliot Frost was employed in the Department's central office from 1995 through 2005. During the three-year period being audited, Mr. Frost held sole responsibility for Department's bed-hold policies and procedures. (T. 596-603).

26. During the three-year period being audited, no Department policy, communication or directive required a nursing home to obtain the written documentation which the hospital discharge planning coordinator was required to produce. (T. 631-633).

27. The record keeping requirement in the MMIS Residential Health Care Facility Provider Manual at pages 2-131 and 2-132 states:

> Facilities must record and report reserved bed days and overnight absences on all financial and statistical reports which call for patient day information. Records adequate to enable federal and state auditors to verify the number and nature of reservations must be available to such auditors and other authorized individuals.

28. Appellant did maintain these records, including census records showing the residents' bed reservation status; records of admissions and discharges indicating the movement of residents in and out of the facility; patient-account records detailing the billings that were done for each resident; and cost reports documenting its yearly number of bed reservation days. (T. 164, 173-175, 628, 661, 709).

29. Similarly, the Department advised facilities of the need "to maintain and provide the required documentation regarding the resident's medical condition and bed reservation status." (OMIG Ex. 9 at 3-4).

30. Appellant did maintain documentation of the resident's medical condition (Appellant Ex. A, B; T. 477, 539) as well as census records documenting a resident's bed reservation status. (Appellant Ex. A, B; T. 174-175).

31. Appellant maintains a full-time on-site medical staff. Patients can return from the hospital promptly because the post-acute care of most medical conditions can be managed by nursing home based physicians. (OMIG Ex. 21, T. 770-771).

ISSUES

1. Did the audit correctly determine that Appellant was required to obtain and maintain documentation of a determination by the admitting hospital that the Medicaid recipient would return to Appellant's facility within fifteen days?

2. Is the OMIG entitled to recover of an overpayment of $927,983.20 based on Appellant's alleged noncompliance with the Medicaid regulations?

ANALYSIS AND CONCLUSIONS

The final audit report disallowed Medicaid payment for 2,006 bed-hold days based upon the OMIG's finding that Appellant had violated the requirements of 18 NYCRR § 505.9(d)(6). The report found that this section of the regulations had been violated because the OMIG had not found written documentation in Appellant's records supporting a determination by the admitting hospital that the Medicaid recipient would be discharged back to Appellant's facility within fifteen days.

A plain reading of § 505.9(d)(6), however, does not support the OMIG's finding that Appellant violated this regulation when its records did not contain written documentation of the admitting hospital's determination. Section 505.9(d)(6)(i)(c) states:

> [T]he hospital discharge coordinator must notify the institution of the recipient's planned discharge date by the morning of the 4th day of hospital care. The hospital discharge planning coordinator must also notify the institution by telephone if the recipient's planned discharge date must be adjusted after the 3rd and before the 16th day of hospital care because his or her condition has changed or additional medical information has become available. The hospital discharge planning coordinator must confirm in writing all bed reservation telephone communications.

While this regulation imposes a duty on the admitting hospital to notify Appellant and to

create a written record confirming its determination regarding the recipient's planned discharge date, the regulation's plain language does not impose a duty on Appellant to obtain that documentation from the admitting hospital.

The OMIG contends in its brief, nonetheless, that § 505.9(d)(6)(i)(c) required Appellant to pursue the hospital to obtain this documentation to support its billing. Rather than explain the basis for this interpretation in its brief, the OMIG references the testimony of the director of the OMIG's Bureau of Managed Care Audit and Provider Review concerning the general requirement to maintain documentation in support of a provider's billings in order to comply with §§ 504.3(a) and 517.3(a)(1) of the regulations. The record, however, establishes that Appellant did maintain the records that a provider has historically been required to produce during an audit. (OMIG Ex. 18 and 24). Moreover, the final audit report did not base its findings on a violation of these two additional sections of the regulations.

During the audit, Appellant asserted that the admitting hospital failed to provide the required documentation, and the OMIG did not contest this assertion. Since a nursing home has no authority to force a hospital to provide documentation, what action should a nursing home take when it does not receive documentation from the hospital by the morning of the fourth day? The OMIG auditor testified during the hearing in this matter that a nursing home was required to terminate a bed-reserve for a Medicaid recipient if the documentation was not received by the morning of the fourth day following admission (T. 468-474). The consequence of this action, however, would be to penalize the Medicaid recipient who would no longer have a reserved bed due to the hospital's failure to comply with the regulation.

Section 505.9(d)(6)(iv) of the regulation lists the circumstances under which a nursing facility must terminate a bed reservation, and failure to receive a communication from the

admitting hospital is not listed as a justification for termination. The MMIS Provider Manual at 2-127 does state that a nursing home can decide not to reserve a resident's bed when a resident's condition is such that the resident will clearly require a period of hospitalization in excess of fifteen days. Once a nursing home does reserve a resident's bed, however, nothing in regulation, policy or guidance allows a nursing home to terminate the bed-reserve when a hospital fails to meet its obligation to provide documentation to the nursing home.

At the hearing, Appellant offered the testimony of Elliott Frost who oversaw bed hold policy and procedures for the Department during the three-year period of this audit. Mr. Frost credibly testified that nursing homes were only required to maintain census information and records of admissions and discharges. He specifically stated that nursing homes were not required to obtain any documentation from a hospital to confirm the expected length of a resident's hospitalization.

At the hearing, the OMIG offered conflicting testimony regarding who determined the documentation which would have been acceptable during the audit. The current health care administrator within the Department for the Medicaid bed reservation program testified that the OMIG auditors decided which documentation would be sufficient to establish a resident's expected date of return under the regulations. The OMIG's Director of the Bureau of Managed Care Audit and Provider Review, however, testified that the auditors are required to apply the Department's interpretation of the regulations during an audit.

The OMIG also offered conflicting evidence as to the documentation which would have been accepted by the auditors concerning the resident's expected date of return. The final report and the exhibits in evidence indicate that the auditors required documents supporting the hospital's determination that the resident was expected to return within 15 days, and the Department's current bed hold administrator testified that a nursing home does not

establish entitlement to payment unless and until the facility receives confirmation from the hospital sometime before the fourth morning of hospitalization. (T. 106, 183-184). On the other hand, the OMIG auditors testified at the hearing that any document would have been acceptable so long as it stated that the resident was expected to return within 15 days, even a document prepared by the nursing home of its own assessment. In addition to these two interpretations, the record contains the testimony of the Department employee responsible for the bed hold program during the years in question which indicates that nursing homes were not required to maintain any documentation regarding the expected duration of the hospitalization. While I have considered the OMIG's contention that its interpretation of this regulation was entitled to substantial deference, I see no reason for deference to the agency when as here its interpretation of the regulation is inconsistent.

The OMIG alleges that the bed-hold program in New York State is a "veritable economic boon" to nursing homes. If the OMIG believes this to be the case, it can attempt to amend the bed-hold regulations. It cannot retroactively reinterpret regulations that have not materially changed during the past several decades.

As stated above, the findings in the final audit report are based on Appellant's alleged failure to maintain written documentation that the admitting hospital was required to produce pursuant to § 505.9(d)(6)(i). Since I have determined based upon the plain language of the regulation and the testimony of Mr. Frost that Appellant was not required to obtain this documentation from the hospital, I see no reason to reach the other issues raised in the parties' briefs. Accordingly, I find that Appellant has met its burden of proof in showing that the determination of the OMIG auditors was incorrect and that the payments received were allowable.

DECISION: The Department's determination to recover $927,983.20 in alleged Medicaid overpayments is reversed.

This decision is made by William J. Lynch, who has been designated by the Commissioner of the New York State Department of Health to make such decisions.

Dated: **November 4, 2009**
Troy, New York

William J. Lynch, Esq.
Administrative Law Judge