



Office of the  
Medicaid Inspector  
General

ANDREW M. CUOMO  
Governor

DENNIS ROSEN  
Medicaid Inspector General

August 24, 2016

██████████  
Little Neck Care Center  
(aka Little Neck Nursing Home)  
260-19 Nassau Boulevard  
Little Neck, New York 11362

Re: MDS Final Audit Report  
Audit #: 13-4456  
Provider ID#: ██████████

Dear ██████████

This is the final audit report of findings with regard to the Office of the Medicaid Inspector General's (OMIG) Minimum Data Set (MDS) audit of Little Neck Care Center (aka Little Neck Nursing Home) for the census period ending January 25, 2012. In accordance with 18 NYCRR §517.6, this final audit report represents the OMIG's final determination on issues found during OMIG's review.

We received your response to our draft audit report dated September 29, 2015. Your comments have been considered (see Attachment D) and the findings in the final audit report remain identical to the draft audit report.

The Medicaid overpayment of \$38,609.76 was calculated using the number of Medicaid days paid for the rate period July 1, 2012 through December 31, 2012 and the change in the direct component of your Medicaid rate as calculated by the Department of Health's Bureau of Long Term Care Reimbursement (BLTCR). The calculation of this overpayment is detailed in Attachment A. BLTCR will adjust your Medicaid rates for the relevant rate period to reflect the change in the direct component. The findings explanation, regulatory references, and applicable adjustment can be found in the attachments following Attachment A.

The Provider has the right to challenge this action and determination by requesting an administrative hearing within 60 days of the date of this notice. If the Provider wishes to request a hearing, the request must be submitted in writing to:

General Counsel  
Office of Counsel  
New York State Office of the Medicaid Inspector General  
800 North Pearl Street  
Albany, NY 12204

Questions regarding the request for a hearing should be directed to Office of Counsel, at ██████████.

[REDACTED]

Page 2  
August 24, 2016

In accordance with 18 NYCRR 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply along with your hearing request a signed authorization permitting that person to represent you at the hearing; you may call witnesses and present documentary evidence on your behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

Should you have any questions regarding the above, please contact [REDACTED]  
[REDACTED].

[REDACTED]

Division of Medicaid Audit  
Office of the Medicaid Inspector General

[REDACTED]

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
LITTLE NECK CARE CENTER  
AUDIT # 13-4456  
CALCULATION OF AUDIT IMPACT

RATE TYPE	DECREASED IN DIRECT COMPONENT OF RATE*	MEDICAID DAYS	IMPACT
Part B Eligible/Part B D Eligible	\$2.47	14,258	\$35,217.26
Non-Medicare/Part D Eligible	\$2.50	1,357	\$3,392.50
Total			<u>\$38,609.76</u>

\*Rounded to nearest 1/100th New York State Department of Health Bureau of Managed Long Term  
Care Rate Setting / FFS

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 LITTLE NECK CARE CENTER  
 AUDIT #13-4456  
 FINDINGS BY SAMPLE NUMBER

Sample #	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	DETAILED FINDINGS				
					DISALLOW TRANSFER SELF PERFORMANCE	DISALLOW TOILET USE SELF PERFORMANCE	DISALLOW SPECIAL TREATMENTS, PROCEDURES	DISALLOW SPEECH THERAPY	DISALLOW PHYSICAL THERAPY
1	RMA	CA1	1.17	0.77					1
2	RMB	PC1	1.22	0.66			1		
3	CC1	CC1	0.98	0.98					
4	PA1	PA1	0.46	0.46					
5	IB1	IB1	0.78	0.78					
6	CB1	CB1	0.86	0.86					
7	SSA	SSA	1.03	1.03					
8	RVC	RVC	1.53	1.53					
9	CC1	CC1	0.98	0.98	1	1			
10	CC1	CC1	0.98	0.98	1				
11	IB1	IB1	0.78	0.78					
12	PC1	PC1	0.66	0.66					
13	RHC	RHC	1.40	1.40					
14	RHC	RHC	1.40	1.40					1
15	CB1	CA1	0.86	0.77	1				
16	CB1	IB1	0.86	0.78	1	1	1		
17	CB1	CB1	0.86	0.86					
18	CA1	CA1	0.77	0.77					

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 LITTLE NECK CARE CENTER  
 AUDIT #13-4456  
 FINDINGS BY SAMPLE NUMBER

Sample #	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	DETAILED FINDINGS				
					DISALLOW TRANSFER SELF PERFORMANCE	DISALLOW TOILET USE SELF PERFORMANCE	DISALLOW SPECIAL TREATMENTS, PROCEDURES	DISALLOW SPEECH THERAPY	DISALLOW PHYSICAL THERAPY
19	CB1	PD1	0.86	0.72			1		
20	CB1	CB1	0.86	0.86					
21	CB1	CB1	0.86	0.86					
22	CA1	CA1	0.77	0.77					
TOTALS					4	2	2	1	2

**OFFICE OF THE MEDICAID INSPECTOR GENERAL  
LITTLE NECK CARE CENTER  
AUDIT #13-4456  
MDS DETAILED FINDINGS**

**MDS FINDINGS****SAMPLE SELECTION****Functional Status-ADL Self-Performance and Support**

If the provider is unable to produce the supporting documentation for the patient, the service will be disallowed and the Case Mix will be adjusted. A repayment schedule will be developed.

Documentation must indicate an assessment was done to evaluate the need for assistance with activities of daily living (ADL's), altered gait and balance, and decreased range of motion (ROM). MDS 3.0 manual guidelines will be followed when examining the medical records.

*42 CFR §483.20 (b) (xvii)  
MDS Manual 3.0 G0100-0900*

**Transfer Self-Performance**

In 2 instances, documentation did not support resident required total assist every time. 9, 10

In 2 instances, documentation did not support resident required weight bearing assist three or more times. 15, 16

**Toilet Use Self-Performance**

In 1 instance, documentation did not support resident required total assist every time. 9

In 1 instance, documentation did not support resident required weight bearing assist three or more times. 16

**Special Treatments, Procedures, and Programs**

If the provider is unable to produce the supporting documentation for the patient, the service will be disallowed and the Case Mix will be adjusted. A repayment schedule will be developed.

The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specific time periods. MDS 3.0 manual guidelines will be followed when examining the medical records.

*42 CFR §483.20 (b) (xv)*  
*MDS 3.0 Manual O0100-0300, O0600-0700*

In 2 instances, documentation did not support the number of days with MD orders during the look back period. 16, 19

### Skilled Therapy

If the provider is unable to produce the supporting documentation for the patient, the service will be disallowed and the Case Mix will be adjusted. A repayment schedule will be developed.

The qualified therapist, in conjunction with the physician and nursing staff, is responsible for determining the necessity for and the frequency and duration of the therapy provided to residents. Rehabilitation (i.e., via Speech-Language Services, and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy helps the residents to attain or maintain their highest level of well-being and improve their quality of life. MDS 3.0 manual guidelines will be followed when reviewing the documentation provided by the facility.

*42 CFR §483.20 (b) (xvii)*  
*MDS 3.0 Manual O0400-0500*

### Speech-Language Pathology

In 1 instance, documentation did not support medical necessity for therapy and/or therapy was not reasonable for resident condition. 2

### Physical Therapy

In 1 instance, documentation reflected incorrect individual/concurrent/group minutes. 14

In 1 instance, documentation did not support medical necessity for therapy and/or therapy was not reasonable for resident condition. 1

**RUGS-II Classifications Overturned**

In 5 instances, the RUG classifications were 1, 2, 15, 16, 19 overturned.

*10 NYCRR §86-2.10, Volume A-2*

**OFFICE OF THE MEDICAID INSPECTOR GENERAL**  
**LITTLE NECK CARE CENTER**  
**AUDIT #13-4456**

All OMIG disallowances were accepted by the Facility except for those shown below. The following details the disposition of the draft report disallowances after consideration of the Facility's draft audit report response comments.  
.....

**Sample #1**

Disallowance B O0400 Physical Therapy

**Based on information and documentation provided by the facility, the following disallowance was not reversed and will be included in the Final Report:**

Disallowance B O0400C Physical Therapy

**Facility Comment:**

The facility stated that the auditor was incorrect in stating there was no significant change in function. Furthermore, the nurse's notes detailed one fall and that the resident needed assistance in getting up and he feels weak at times. The facility described the resident's medical condition. The facility references CMS and DOH items that are looked at during survey (f Tags).

**OMIG Response:**

The MDS Assessment Reference Date (ARD) is 12/07/11  
The 7-day look back period is 12/01/11 – 12/07/11  
The MDS claimed 5 days, 171 minutes of Physical Therapy.

*Documentation submitted and reviewed:*

Portions of documentation originally reviewed by OMIG (monthly order dated 11/24/11 with diagnosis highlighted, nursing note of 11/28/11 highlighted one fall, rehab page dated 11/29/11 that does not designate whether the resident is a new admission or a re-evaluation with prior functioning highlighted, rehabilitation consultation sheet dated 11/29/11 with no highlights).

- F-323 Clinical Implications of Falls
- NYC and DOH memos on Fall Preventions in Nursing Homes
- Falls in Nursing Home – article from Internal Medicine
- Best Practices for Fall Reduction – article from American Nurse Today

Nursing note of 11/28/11 indicated resident now had a bed alarm and there were no further complaints. Note of 11/30/11 notes an order for PT. No other nursing notes during the ARD addressing any issues with mobility or any other complaints related to the one fall of 11/25/11 at 11:30PM

Rehabilitation consultation of 11/29/11 states the following: PT observed the resident on the unit and there was no significant change in function, Resident reported feeling weak at times. Resident has no complaints of pain at this time. PT will request an MD order for a PT evaluation second to fall on 11/25/11.

**ASSESSMENT:**

**Documentation provided does not support the MDS Manual, Section O:**

- 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.

**Documentation does not support the MDS Manual's coding instructions for Physical Therapy:**

- Only medically necessary therapies that occurred after admission/re-admission to the nursing home should be coded.
- Services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

**Disposition:** The draft report finding is unchanged and will be included in the final report.

**Sample #2**

Disallowance A O0400A Speech Therapy

**Based on information and documentation provided by the facility, the following disallowance was not reversed and will be included in the Final Report:**

Disallowance B O0400C Physical Therapy

**Facility Comment:**

The auditor did not dispute that the therapy occurred, rather took issue that there was not a significant increase in cognition. The facility placed the resident on ST to improve cognition,

memory, reasoning, sequencing, orientation and problem solving. The BIMS score was increased by 3 points after therapy. The facility referenced the RAI manual V1.07 effective October 2011, Section 0-26. Also mentioned was CMS's specific initiatives for dementia care.

*Documentation submitted and reviewed:*

- Section O-RAI Manual (October 2011 version)
- CMS transmittal AB 01-135
- CMS Memorandums on dementia care initiatives
- BIMS –section C for this resident

**OMIG Response:**

The MDS Assessment Reference Date (ARD) is 12/08/11.

The 7-day look back period is 12/02/11 – 12/08/11.

Resident received speech therapy for cognition from 9/9/11 through 12/9/11 – the first day after the ARD was completed.

Initial evaluation showed the resident had a decreased ability to answer 'yes/no' questions, to understand 'why' questions, and automatic responses to days of the week questions. There is no interdisciplinary documentation to indicate whether there was a decline or improvement in cognition.

BIMS score of 12 was recorded on 9/12/11. BIMS score of 15 was recorded on 12/8/11, the last day of the ARD. Section C0200, C0300 remained unchanged. C0400 recall improved from 1 after cuing to a 2 no cuing required. The resident could recall sock, blue, and bed.

**ASSESSMENT:**

**Documentation provided does not support the MDS Manual, Section O:**

- 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.

**Documentation does not support the MDS Manual's coding instructions for Physical Therapy:**

- Only medically necessary therapies that occurred after admission/re-admission to the nursing home should be coded.
- Services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

**Disposition:** The draft report finding is unchanged and will be included in the final report.

## Sample #15

Disallowance G0110B transfer self-performance.

**Based on information and documentation provided by the facility, the following disallowance was not reversed and will be included in the Final Report:**

Disallowance G0110B transfer self-performance.

### **Facility comment:**

The facility felt that the auditor only accepted the CNA accountability record for her review. The facility felt that the RAI User Manual assessment steps should be taken into consideration when coding the MDS.

### *Documentation submitted and reviewed:*

No documentation other than the justification sheet provided by the facility.

### **OMIG Response:**

The MDS Assessment Reference Date (ARD) is 11/30/11

The 7-day look back period is 11/24/11 – 11/30/11

## **ASSESSMENT**

**The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria as follows:**

- Documentation for ADL Self-Performance must describe what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days, according to a performance-based scale.
- The responsibility of the person completing the assessment is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day."
- ADL self-performance coding options are intended to reflect real world situations where slight variations in self-performance are common.
- Must follow instructions for the Rule of Three for extensive assistance with transfer
- No documentation that would support a Rule of 3 for extensive assistance with transfer.

**Disposition:** The draft report finding is unchanged and will be included in the final report.

## Sample #16

Disallowance G0110B transfer self-performance

Disallowance G0110I Toilet use Self Performance

Disallowance O0700 Physician Orders

**Based on information and documentation provided by the facility, the following disallowance was not reversed and will be included in the Final Report:**

**Facility comment:**

The facility felt that the auditor only accepted the CNA accountability record for her review. The facility felt that the RAI User Manual assessment steps should be taken into consideration when coding the MDS. The facility further felt that the physician orders claimed were acceptable.

*Documentation submitted and reviewed:*

No documentation to review other than the justification sheet provided by the facility.

**OMIG Response:**

The MDS Assessment Reference Date (ARD) is 11/01/11.

The 7-day look back period is 10/26/11 – 11/01/11.

Physician orders and visit start on 10/19/11-11/1/11.

**ASSESSMENT**

**The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria as follows:**

- Documentation for ADL Self-Performance must describe what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days, according to a performance-based scale.
- The responsibility of the person completing the assessment is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day."
- ADL self-performance coding options are intended to reflect real world situations where slight variations in self-performance are common.
- Must follow instructions for the Rule of Three for extensive assistance with transfer
- No documentation that would support a Rule of 3 for extensive assistance with transfer.

**The MDS Manual states that orders written to increase the resident's RUG classification and facility payment are not acceptable.**

- The order of 10/24/11 is a transfer out of bed order. The transfer out of bed order is not considered a new order but as routine (nursing, medical) care.
- The order of 10/21/11 is for a flu vaccine order, which is an activation of a yearly order for all residents who can receive the vaccine. It is not for a specific resident. This order should be captured under O0250 and not as a physician order.

**The MDS Manual states that a sliding scale dosage schedule written to cover different dosages depending on lab values does not count as an order change, because a different dose is administered based on the sliding scale guidelines.**

**Disposition:** The draft report finding is unchanged and will be included in the final report.

**Sample #19**

Disallowance O0700 Physician Orders

**Based on information and documentation provided by the facility, the following disallowance was not reversed and will be included in the Final Report:**

**Facility comment:**

The facility felt that the order for the flu vaccine should be counted as one of the two orders claimed.

*Documentation submitted and reviewed:*

No additional documentation other than justification sheet provided by the facility.

**OMIG Response:**

The MDS Assessment Reference Date (ARD) is 11/11/11.

The 7-day look back period is 11/05/11 – 11/11/11.

Physician orders and visit start on 10/29/11-11/11/11.

**ASSESSMENT**

**The documentation does not support the MDS Manual 3.0 as follows:**

**The MDS Manual states that orders written to increase the resident's RUG classification and facility payment are not acceptable.** The orders of 10/21/11 and 11/03/11 are flu vaccine orders, an activation of a yearly order for all residents who can receive the vaccine; it is not for a specific resident. These orders should be captured under O0250 and not as physician orders.

**Disposition:** The draft report finding is unchanged and will be included in the final report.