



Office of the  
Medicaid Inspector  
General

ANDREW M. CUOMO  
Governor

DENNIS ROSEN  
Medicaid Inspector General

August 31, 2016

[REDACTED]  
Field Home – Holy Comforter  
2300 Catherine Street  
Cortlandt Manor, New York 10567

Re: MDS Final Audit Report  
Audit #: 13-4869  
Provider ID#: [REDACTED]

Dear [REDACTED]

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 Field Home – Holy Comforter for the census period ending July 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 January 8, 2016. 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 \$28,414.54 was calculated using the number of Medicaid days paid for the rate period January 1, 2013 through June 30, 2013 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].

[REDACTED]

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  
 FIELD HOME - HOLY COMFORTER  
 AUDIT #13-4869  
 FINDINGS BY SAMPLE NUMBER

Sample #	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	DETAILED FINDINGS							
					DISALLOW BED MOBILITY SUPPORT PROVIDED	DISALLOW TRANSFER SELF PERFORMANCE	DISALLOW TRANSFER SUPPORT PROVIDED	DISALLOW EATING SELF PERFORMANCE	DISALLOW TOILET USE SELF PERFORMANCE	DISALLOW TOILET USE SUPPORT PROVIDED	DISALLOW SPECIAL TREATMENTS, PROCEDURES	DISALLOW PHYSICAL THERAPY
1	RMB	RMB	1.22	1.22								1
2	IA1	IA1	0.61	0.61								
3	CC1	CC1	0.98	0.98								
4	RHC	RHC	1.40	1.40								
5	PE1	PE1	0.79	0.79								
6	CC1	CC1	0.98	0.98	1							
7	SSA	SSA	1.03	1.03								
8	RMB	RMB	1.22	1.22								
9	RMB	RMB	1.22	1.22								
10	CB1	CB1	0.86	0.86						1		
11	RHC	RHC	1.40	1.40								
12	RMC	RMC	1.27	1.27				1				
13	RMC	RMC	1.27	1.27								
14	PE1	PE1	0.79	0.79								
15	IB1	IB1	0.78	0.78			1					
16	RMA	CA1	1.17	0.77								1
17	CC2	CB2	1.12	0.91	1					1		

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 FIELD HOME - HOLY COMFORTER  
 AUDIT #13-4869  
 FINDINGS BY SAMPLE NUMBER

Sample #	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	DETAILED FINDINGS								
					DISALLOW BED MOBILITY SUPPORT PROVIDED	DISALLOW TRANSFER SELF PERFORMANCE	DISALLOW TRANSFER SUPPORT PROVIDED	DISALLOW EATING SELF PERFORMANCE	DISALLOW TOILET USE SELF PERFORMANCE	DISALLOW TOILET USE SUPPORT PROVIDED	DISALLOW SPECIAL TREATMENTS, PROCEDURES	DISALLOW PHYSICAL THERAPY	
18	RHC	RHC	1.40	1.40									
19	CA1	CA1	0.77	0.77									
20	CC1	CC1	0.98	0.98									
21	SSB	SSB	1.06	1.06									
22	CB1	CB1	0.86	0.86									
23	RHC	RHC	1.40	1.40									
24	SSC	SSC	1.12	1.12									
25	PE1	PD1	0.79	0.72		1		1					
26	RMA	PA1	1.17	0.46					1			1	
<b>TOTALS</b>					<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>2</u>	<u>2</u>	<u>1</u>	<u>3</u>	

**OFFICE OF THE MEDICAID INSPECTOR GENERAL  
FIELD HOME – HOLY COMFORTER  
AUDIT #13-4869  
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*

**Bed Mobility Support Provided**

In 1 instance, documentation did not support resident was a 2+ person physical help at least once. 17

**Transfer Self-Performance**

In 1 instance, documentation did not support resident required total assist every time. 6

**Transfer Support Provided**

In 1 instance, documentation did not support resident was a 2+ person physical help at least once. 25

**Eating Self-Performance**

In 1 instance, documentation did not support resident required supervision one or more times. 15

**Toilet Use Self-Performance**

In 2 instances, documentation did not support resident required total assist every time. 12, 25

Toilet Use Support Provided

In 1 instance, documentation did not support resident was a 2+ person physical help at least once. 17

In 1 instance, documentation did not support resident was a one person physical help at least once. 26

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 1 instance, documentation did not support the number of days with MD exams during the look back period. 10

In 1 instance, documentation did not support the number of days with MD orders during the look back period. 10

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 O0400-0700*

Physical Therapy

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

In 2 instances, documentation did not support medical necessity for therapy and/or therapy was not reasonable for resident condition. 16, 26

RUGS-II Classifications Overturned

In 4 instances, the RUG classifications were overturned. 16, 17, 25, 26

*10 NYCRR §86-2.10, Volume A-2*

OFFICE OF THE MEDICAID INSPECTOR GENERAL

FIELD HOME - HOLY COMFORTER

AUDIT #13-4869

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 #16**

Disallowance A 00400C 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:**

Facility Comment: The facility sent in a history of the resident's PT services prior to the current services claimed. The facility detailed her evaluation and findings leading to her need for physical therapy.

OMIG Response: The MDS Assessment Reference Date (ARD) is 07/25/12. The 7-day look back period is 07/19/12 - 07/25/12.

The MDS claimed 5 days, 171 minutes of Physical Therapy (PT).

Documentation Submitted by the Facility and Reviewed:

- MD order dated 7/19/12
- Initial PT Evaluation
- OMIG Finding Sheet

ADL levels were independent for this resident prior to the ARD. The documentation provided did not support the medical necessity for skilled PT services.

The Nursing Progress Report notes dated 07/05/12 thru 07/25/12 do not contain documentation that licensed nursing staff evaluated, assessed, and observed the resident had a decline in ADL's.

Section G of the MDS documentation dated 07/25/12 shows independent ADL levels were baseline for this resident

The record did not have documentation of any physician evaluations of the resident and there were no physician progress notes for the resident.

The Physical Therapy Initial Evaluation/Treatment Plan dated 07/19/12 documented the resident refused therapy and it was discontinued on 6/29/12. Staff approached her again less than three weeks later for therapy during the ARD.

Documentation does not support the following MDS Manual's coding instructions for Physical Therapy: (Section O)

- *Code only medically necessary therapies that occurred after admission/re-admission to the nursing home.*
- *The 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.*
- *The services must be provided with the expectation that the condition of the patient will improve materially in a reasonable and predictable period of time and the services must be reasonable and necessary for treatment of the resident's condition.*

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.*

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

## Sample #26

Disallowance A O0400C 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:**

Facility Comment: The facility sent in the initial PT evaluation.

OMIG Response: The MDS Assessment Reference Date (ARD) is 04/27/12. The 7-day look back period is 47/21/12 - 04/27/12.

The MDS claimed 5 days, 186 minutes of Physical Therapy (PT).

Documentation Submitted by the Facility and Reviewed:

- Initial PT evaluation

ADL levels were supervision and set up help for this resident prior to the ARD. The documentation provided did not support the medical necessity for skilled PT services.

Documentation does not support the following MDS Manual's coding instructions for Physical Therapy: (Section O)

- *Code only medically necessary therapies that occurred after admission/re-admission to the nursing home.*
- *The 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.*
- *The services must be provided with the expectation that the condition of the patient will improve materially in a reasonable and predictable period of time and the services must be reasonable and necessary for treatment of the resident's condition.*

**Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as family-funded services) shall not be counted in item O0400 therapies, even when performed by a therapist or assistant.**

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.*

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