



**Office of the  
Medicaid Inspector  
General**

**ANDREW M. CUOMO**  
Governor

**DENNIS ROSEN**  
Medicaid Inspector General

October 14, 2016

[REDACTED]  
Clifton Springs Hospital and Clinic Extended Care  
2 Coulter Road  
Clifton Springs, New York 14432

Re: MDS Final Audit Report  
Audit #: 14-3960  
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 Clifton Springs Hospital and Clinic Extended Care for the census period ending January 25, 2013. 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 August 1, 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 \$24,566.04 was calculated using the number of Medicaid days paid for the rate period July 1, 2013 through December 31, 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]

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   
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Division of Medicaid Audit  
Office of the Medicaid Inspector General



OFFICE OF THE MEDICAID INSPECTOR GENERAL  
 CLIFTON SPRINGS HOSPITAL AND CLINIC EXTENDED CARE  
 AUDIT 14-3960  
 CALCULATION OF AUDIT IMPACT

RATE TYPE	DECREASED IN DIRECT COMPONENT OF RATE*	MEDICAID DAY	IMPACT
Part B Eligible/Part B D Eligible	\$2.10	11,262	\$23,650.20
Non-Medicare/Part D Eligible	\$2.12	432	\$915.84
Total			<u>\$24,566.04</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  
 CLIFTON SPRINGS HOSPITAL AND CLINIC EXTENDED CARE  
 AUDIT #14-3960  
 ERRORS BY SAMPLE NUMBER

Sample #	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	<i>Disallow bed mobility self performance</i>	<i>Disallow bed mobility support provided</i>	<i>Disallow transfer self performance</i>	<i>Disallow eating self performance</i>	<i>Disallow toilet use self performance</i>	<i>Disallow toilet use support provided</i>	<i>Disallow active disease diagnosis</i>	<i>Disallow occupation therapy</i>	<i>Disallow Dementia Add On</i>
1	PE1	PD1	0.79	0.72	1				1				
2	PC1	PC1	0.66	0.66					1			1	
3	RMX	SE2	1.96	1.37						1	1		
4	PE1	PE1	0.79	0.79									
5	SE2	SSA	1.37	1.03	1	1	1	1					
6	PD1	PD1	0.72	0.72									
7	PE1	PD1	0.79	0.72	1			1	1				
8	PE1	IA1	0.79	0.61	1	1	1	1					
9	IA1	IA1	0.61	0.61									
10	RMC	RMC	1.27	1.27									
11	PE1	PE1	0.79	0.79									
12	IA1	IA1	0.61	0.61									
13	PD1	PD1	0.72	0.72									
14	IA1	IA1	0.61	0.61									
15	PE1	PE1	0.79	0.79									
16	SSB	SSB	1.06	1.06									
17	IA1	IA1	0.61	0.61									
<b>Totals</b>					<u>3</u>	<u>1</u>	<u>2</u>	<u>2</u>	<u>3</u>	<u>2</u>	<u>1</u>	<u>1</u>	<u>1</u>

**OFFICE OF THE MEDICAID INSPECTOR GENERAL  
CLIFTON SPRINGS HOSPITAL AND CLINIC EXTENDED CARE  
AUDIT #14-3960  
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 Self-Performance**

In 1 instance, documentation did not support resident required total assist every time. 7

In 1 instance, documentation did not support resident required weight bearing assist three or more times. 8

In 1 instance, documentation did not support resident required non weight bearing assist three or more times. 5

**Bed Mobility Support Provided**

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

**Transfer Self-Performance**

In 1 instance, documentation did not support resident required total assist every time. 8

In 1 instance, documentation did not support resident required non weight bearing assist three or more times. 5

**Eating Self-Performance**

In 2 instances, documentation did not support resident required supervision one or more times. 5, 8

**Toilet Use Self-Performance**

In 2 instances, documentation did not support resident required total assist every time. 7, 8

In 1 instance, documentation did not support resident required non weight bearing assist three or more times. 5

**Toilet Use Support Provided**

In 2 instances, documentation did not support resident was a 2+ person physical help at least once. 1, 7

**Active Disease Diagnosis**

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 the diseases coded relate to the resident's functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death. MDS 3.0 manual guidelines will be followed when examining the medical records.

*42 CFR §483.20 (b) (xvii)*  
*MDS Manual 3.0 I0100-18000*

In 1 instance, documentation did not support Dementia as a physician documented diagnosis in the past 60 days. 2

In 1 instance, documentation did not support Dementia as an active diagnosis during the 7 day look back. 2

**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*

Occupational Therapy

In 1 instance, documentation did not support evaluation/reassessment for therapy. 3

In 1 instance, documentation did not support an order for therapy. 3

In 1 instance, documentation did not support medical necessity for therapy and/or therapy was not reasonable for resident condition. 3

Physical Therapy

In 1 instance, documentation did not support evaluation/reassessment for therapy. 3

In 1 instance, documentation did not support an order for therapy. 3

In 1 instance, documentation did not support medical necessity for therapy and/or therapy was not reasonable for resident condition. 3

Dementia Add-on

In 1 instance, documentation did not support the diagnosis of Alzheimer's/dementia required for the add-on. 2

*10 NYCRR §86-2.40 (z)(1)*

**RUGS-II Classifications Overturned**

In 5 instances, the RUG classifications were 1, 3, 5, 7, 8  
overturned.

*10 NYCRR §86-2.10, Volume A-2*

**OFFICE OF THE MEDICAID INSPECTOR GENERAL  
CLIFTON SPRINGS HOSPITAL AND CLINIC EXTENDED CARE  
AUDIT # 14- 3960  
ANALYSIS OF PROVIDER RESPONSE**

Sample #	Finding	Provider Response	Accepted/Denied	Explanation
#3	O0400B Occupational Therapy.  O0400C Physical Therapy.	<ul style="list-style-type: none"> <li>• Pg. 26 of MDS 3.0</li> <li>• PT initial Evaluation</li> <li>• OT initial Evaluation</li> <li>• Physician Orders</li> </ul>	Denied	<p>MDS with ARD 12/7/12, has no order to evaluate and treat Physical Therapy and Occupational Therapy.</p> <p>See MDS Manual - section O.</p>