

cc: Ms. Daniels Rivera by Scan
Ms. Mailloux by Scan
Ms. Champion by Scan
Mr. Cohen by Scan
BOA by scan
SAPA File



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

August 17, 2026

CERTIFIED MAIL/RETURN RECEIPT

Timothy Osho, Esq.
NYS OMIG
800 North Pearl Street
Albany, New York 12204

Phyllis Goldstein
Corporate Appeals Specialist
University Center for Rehabilitation and Nursing
2505 Grand Avenue
Bronx, New York 10468

RE: In the Matter of the Appeal of University Center for Rehabilitation and Nursing

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 black ink that reads "Tina M. Champion".

Tina M. Champion
Interim Chief Administrative Law Judge
Bureau of Adjudication

TMC:nm
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of

University Center for
Rehabilitation and Nursing
Provider #00312249

from a determination to recover
Medicaid Program overpayments.

Decision After
Hearing

Audit#23-4177

Before: Jeanne T. Arnold
Administrative Law Judge

Hearing date: December 10, 2025
By videoconference
Record closed: January 5, 2026

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Timothy Osho
timothy.osh@omig.ny.gov

University Center for Rehabilitation and Nursing
2505 Grand Avenue
Bronx, New York 10468
By: Phyllis Goldstein
Corporate Appeals Specialist
pgoldstein@sigmahealthrehab.com

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

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 the University Center for Rehabilitation and Nursing (Appellant) for the census period ending January 31, 2018, 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:	1-8
Appellant witness:	Phyllis Goldstein, Corporate Appeals Specialist
Appellant exhibits:	none

A transcript of the hearing was made. (T 1-77.) The record closed on January 5, 2026.

SUMMARY OF FACTS

1. The Appellant is a residential health care facility (RHCF) in the Bronx, 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 January 31, 2018. These MDS submissions were used to determine the Appellant's reimbursement from the Medicaid Program for the rate periods July 1, 2018 through December 31, 2018. (Exhibit 1.)

3. The OMIG first issued a Draft Audit Report (DAR) to the Appellant on May 16, 2024. (Exhibit 4.) The DAR indicated that the Appellant has been overpaid \$47,896 by the Medicaid Program. The Appellant responded to the DAR and submitted additional documentation (Exhibit 5), resulting in the OMIG Final Audit Report (FAR) dated July 10, 2025, identifying overpayments in the Appellant's Medicaid reimbursement totaling \$41,017.90. (Exhibit 6.) 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 three of the Appellant's residents (Samples 3, 9 and 10) were not accurate because the Appellant's records failed to document the categories assigned for the residents' conditions. (Exhibit 6, attachment B.)

5. The Appellant reported the resident's RUG categories as follows: Sample 3 at an **RHC** level which means that **R**ehabilitation is required at a **H**igh level (greater than or equal to 720 minutes/week and a **C** level of assistance is required for activities of daily living (ADLs) (a moderate to high dependence on assistance); and Samples 9 and 10 at an **RHB** level which also means that rehabilitation is required at a high level but that the resident is only partially dependent on assistance with ADLs. The audit corrected the Sample 3 and Sample 9 to the RUG category of Physician Directed – Level 1 (**PD1**), used when a resident's care is managed by a physician but therapy is not required, and the Sample 10 category to **IB1**, which is indicative of mild behavioral problems that require some level of intervention or monitoring but not therapy. The OMIG found that the Appellant nursing home did not properly document the medical basis and specific

need for the resident Samples 3, 9 and 10, to receive rehabilitation in the form of occupational therapy (OT) during the week before the assessment reference date (ARD). (Exhibit 6, p 166, 171.)

6. By letter dated August 11, 2025, the Appellant requested an administrative hearing to challenge the audit findings and overpayment determination, specifically concerning resident Samples 3, 9, and 10. (Exhibit 8.)

ISSUE

Has the Appellant established that the OMIG's audit determination to recover Medicaid overpayments attributable to the disallowance of occupational therapy reported for the Samples 3, 9 and 10 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.

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.

Each resident's RAI evaluates the resident as of a specific assessment review date (ARD) set by the facility. Occupational therapy is reported by the number of minutes of therapy provided in a seven day "look back" before the ARD. 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.

DISCUSSION

At issue in this hearing are the OMIG audit findings that the Appellant did not properly document the medical basis and specific need for the resident Samples 3; 9 and 10 to receive occupational therapy (OT) during the week before the assessment reference date (ARD). (Exhibit 6, p 166, 171.) This issue turns on 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:

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.

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 OT to satisfy MDS standards. The auditor looked for some documentation of why the 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).

The Appellant argues that ADL decline may be established by any discipline, including rehabilitation itself. Therefore, the OT evaluations alone are the requisite documentary proof that the sample residents' conditions required OT and then improved because of OT -- and that this is evidence that the therapy was medically necessary. However, 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 (4th Dept 2020), *lv denied* 36 NY3d 910 (2021); *Elderwood at Cheektowaga v Zucker*, 188 AD3d 1578, 1579 (4th Dept 2020); *Elderwood at Amherst v Zucker*, 188 AD3d 1568, 1569 (4th Dept 2020).

OMIG determined that for all three residents, there was insufficient documentation in their medical records to support the reason OT referrals were made. The audit did not produce adequate documentation of decline prior to the 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 OT during the seven day "look back" before the ARD.

Sample 3

The ARD for the Sample 3 resident was [REDACTED], 2017. The Appellant reported the resident's RUG category as RHC. The audit corrected it to PD1 on the

grounds that the medical basis and specific need for OT during the week before the ARD were not fully and properly documented in the resident record. (Exhibit 6 pp 157, 162.)

On [REDACTED] 2017, the resident, age [REDACTED] and diagnosed with hypertension, [REDACTED], [REDACTED], was referred for an OT evaluation. (Exhibit 7 pp 174, 176; T 23.) The reason for the referral was indicated as “new onset of decrease in functional mobility, decrease in strength, increased need for assistance from others, reduced dynamic balance and reduced ADL participation.” (Exhibit 7 p 177.)

Appellant records did not document who referred this resident for OT. As referrals are normally made by nursing, Auditor Forward reviewed the nursing notes and found that “prior to the start of [OT], there was not a single nurse’s note that documented any type of decline in function, loss of balance, inability to complete ADLs or anything.” (T 25.) Next, Auditor Forward examined the physician records to see if the OT referral was made by a physician. However, the physician’s note in the week prior to OT’s commencement “does not state any issues with functional mobility, balance, decline in status or ADLs, or [give] any indication that [the] resident might need [OT].” (T 27.) Finally, Auditor Forward reviewed the resident’s ADL chart and found that there was no record of decline from the beginning of [REDACTED] 2017 in ambulation, bathing, bed mobility, bladder and bowel incontinence, toilet use, eating or transfer. No reason could be ascertained why OT was needed beginning on [REDACTED], 2017. (T 27-30.) The only indication that this resident’s condition improved because of OT was the OT discharge

summary itself. The Appellant failed to provide any ADL records to verify any alleged improvement despite that Auditor Forward requested same. (T 31.)

In sum, the Appellant's documentary evidence from the OT therapist, signed off on by a physician, indicating that therapy was needed, given and achieved its desired results, does not correlate with the documents from the nursing, physician or the resident's ADL charts which instead show no sign that OT was required. The Appellant did not meet its burden of proving medical necessity for the Sample 3 resident to receive OT during the one-week look back period.

Sample 9

The ARD for the Sample 9 resident was [REDACTED], 2017. The audit corrected the resident's RUG category from RHB to PD1 on the grounds that the medical basis and specific need for OT during the week before the ARD were not fully and properly documented in the resident record. (Exhibit 6 pp 157, 162.)

On [REDACTED] 2017, this resident, age [REDACTED] and diagnosed with [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED], was referred for an OT evaluation. (Exhibit 7 p 250; T 31.) The reason for the referral was indicated as "new onset of decrease in functional mobility, decrease in strength, increased need for assistance from others, reduced dynamic balance, reduced static balance and reduced ADL participation." (Exhibit 7 p 254.)

Auditor Forward testified that, like the Sample 3 resident, it was not noted who referred this resident for OT. As referrals are normally made by nursing, she reviewed the

seven nursing notes from [REDACTED] 2017 for the resident and found that “there is not a single note about therapy or possible reasons why the resident needed [OT].” (T 32.) Next, Auditor Forward examined the physician records to see if the OT referral was made by a physician. There were no physician notes for the resident in the entire month of [REDACTED] 2017. (T 32.) Finally, Auditor Forward reviewed the resident’s ADL charts and found that there was no record of decline from the beginning of [REDACTED] 2017 in ambulation, bathing, bed mobility, bladder and bowel incontinence, toilet use, eating or transfer. No reason was documented to explain why OT was needed beginning on [REDACTED], 2017. (T 33-35.) Furthermore, there was no indication that the resident’s condition improved because of the OT. (T 35.)

In sum, the Appellant’s documentary proof from the OT therapist, and signed off on by a physician, indicating that therapy was needed and given does not correlate with the documents from nursing, physicians or the resident’s ADL charts, which instead show no sign that OT was required. The Appellant did not meet its burden of proving medical necessity for the Sample 9 resident to receive OT during the one-week look back period.

Sample 10

The ARD for the Sample 10 resident was [REDACTED] 2018. The audit corrected the resident’s RUG category from RHB to IB1 on the grounds that the medical basis and specific need for OT during the week before the ARD were not fully and properly documented in the resident record. (Exhibit 6 pp 157, 162.)

On [REDACTED] 2018, this resident, age [REDACTED] and diagnosed with Par[REDACTED] [REDACTED], was referred for an OT evaluation. (Exhibit 7 p 321; T 31.) The reason for the referral was indicated as “new onset of decrease in

strength, decrease in functional mobility, increased need for assistance from others, reduced dynamic balance and reduced ADL participation.” (Exhibit 7 p 340.)

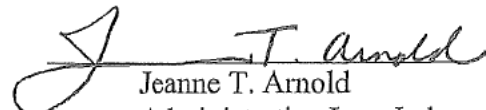
As in Samples 3 and 9, Appellant records did not document who referred this resident for OT. As referrals are normally made by nursing, Auditor Forward reviewed the nursing notes from the beginning of [REDACTED] 2018 and found that there was no documentation in them suggesting that the resident needed OT. (T 36-37.) Next, Auditor Forward examined the physician records to see if the OT referral was made by a physician. There are physician notes from [REDACTED], and [REDACTED] 2018 but none indicate new and/or acute symptoms or anything about recent falls and/or declines and there is no indication of any need for OT. (T 37-39.) Finally, Auditor Forward reviewed the resident’s ADL charts and found that there was no record of decline from the beginning of [REDACTED] 2018 in ambulation, bathing, bed mobility, bladder and bowel incontinence, toilet use, eating or transfer. No reason could be ascertained why OT was needed beginning on [REDACTED], 2018. (T 39-41.) There was also no indication that the resident’s condition improved because of OT. (T 41-42.)

In sum, the Appellant’s documentary proof from the OT therapist, and signed off on by a physician, indicating both that therapy was needed and given does not correlate with the documents from the nursing, physician or the resident’s ADL charts which instead show no sign that OT was required. The Appellant did not meet its burden of proving medical necessity for the Sample 10 resident to receive OT during the one-week look back period.

DECISION

The OMIG's determination to recover overpayments based upon the MDS audit findings that OT rehabilitation therapy for the Samples 3, 9 and 10 residents was not documented to be reasonable and necessary for the residents' medical conditions is affirmed.

DATED: Rochester, New York
August 17, 2026


Jeanne T. Arnold
Administrative Law Judge

TO:

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