Department of Health and Human Services
Office of Inspector General
Office of Audit Services

November 2025 | A-02-22-01017

Nearly All Skilled Nursing Services Provided by Pinnacle Multicare Nursing and Rehabilitation Center Did Not Meet Medicare Payment Requirements

REPORT HIGHLIGHTS

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Why OIG Did This Audit

- In October 2019, CMS implemented a new payment system for determining Medicare Part A payments for skilled nursing facilities (SNFs) known as the Patient Driven Payment Model (PDPM).
- Prior OIG audits found that skilled nursing services are susceptible to noncompliance with Medicare requirements, resulting in improper payments to SNFs.
- This audit is the first in a series of audits of SNFs that billed for skilled nursing services under the PDPM. Our audit determined whether Pinnacle Multicare Nursing and Rehabilitation Center's (Pinnacle's) claims for skilled nursing services were made in accordance with Medicare requirements.

What OIG Found

- Pinnacle did not comply with Medicare requirements for 99 of 100 sampled claims, resulting in overpayments totaling $1.1 million, for skilled nursing services provided during calendar years 2020 and 2021. As a result, we estimated that Pinnacle received Medicare overpayments of at least $31.2 million.
- Pinnacle incorrectly billed Medicare for skilled nursing services (1) when the medical record did not support that the associated individual was assigned the correct reimbursement rate code, (2) provided to individuals who did not require skilled nursing services, and (3) that did not meet documentation requirements.
- The errors occurred because Pinnacle's clinical and billing staff did not always follow its procedures to properly assign reimbursement rate codes in accordance with Medicare requirements and provide sufficient clinical review to verify that enrollees required skilled nursing services. In addition, Pinnacle did not follow its procedures to ensure that it always complied with Medicare documentation requirements.

What OIG Recommends

We made three recommendations to Pinnacle, including that it refund to the Medicare program $31.2 million for skilled nursing services claims that did not meet Medicare requirements, consider conducting one or more internal audits or investigations for claims before and after our audit period, and provide additional training to its clinical and billing personnel on its procedures to properly claim skilled nursing services. The full recommendations are in the report. Pinnacle did not concur with any of our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Prior Office of Inspector General (OIG) audits found that skilled nursing services are susceptible to noncompliance with Medicare requirements, resulting in improper payments to skilled nursing facilities (SNFs).[1] In October 2019, the Centers for Medicare & Medicaid Services (CMS) implemented a payment system known as the Patient Driven Payment Model (PDPM) for determining Medicare Part A payments for skilled nursing services. This audit is the first in a series of audits of SNFs that billed for skilled nursing services under the PDPM. Using computer matching, data mining, and data analysis techniques, we identified SNFs at risk of noncompliance with Medicare requirements. For this audit, we selected Pinnacle Multicare Nursing and Rehabilitation Center (Pinnacle), located in the Bronx, New York.

OBJECTIVE

Our objective was to determine whether Pinnacle's claims for skilled nursing services were made in accordance with Medicare requirements.

BACKGROUND

The Medicare Program and Payments for Skilled Nursing Services

CMS administers the Medicare program and contracts with Medicare administrative contractors (MACs) to process and pay skilled nursing services claims submitted by SNFs.

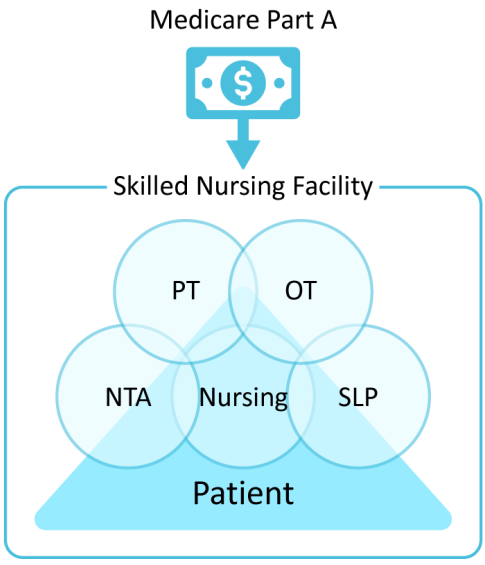
Medicare Part A covers eligible skilled nursing services under a prospective payment system (PPS). The PPS covers SNF skilled nursing care and rehabilitation services, such as physical, speech, and occupational therapy, to Medicare enrollees who need assistance after a hospitalization. Under the PPS for SNFs, CMS pays SNFs for up to 100 days of service.[2] In October 2019, CMS implemented the PDPM for determining Medicare Part A payments under the SNF PPS. As compared to the prior Resource Utilization Group IV (RUG) payment model, which was based on the number of therapy minutes provided to enrollees and created financial incentives for SNFs to focus on patients who required therapy, the PDPM was designed to improve payment accuracy and appropriateness by focusing on the enrollee, rather than volume of services provided.

[1] OIG, *Highlands of Little Rock West Markham Holdings, LLC: Audit of Documentation of Therapy Resource Utilization Groups* (A-06-18-08003), issued Nov. 12, 2019, and *CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met* (A-05-16-00043), issued Feb. 14, 2019.

[2] CMS, *Medicare Benefit Policy Manual*, chapter 3, § 20(B).

Payments to SNFs under the PDPM are determined through the combination of six payment components. Five of the components, illustrated in Figure 1, are case-mix adjusted based on specific sets of an enrollee's characteristics, needs, or goals that include: physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), nursing, and non-therapy ancillary (NTA) classification.[3]

Figure 1: New Patient Driven Payment Model



Within the first 8 days of an enrollee's stay at a SNF, the SNF must complete the Minimum Data Set (MDS) assessment—the federally mandated tool used to evaluate the health status of residents in SNFs certified to participate in Medicare or Medicaid. The MDS assessment is a comprehensive evaluation that includes information on a number of areas, such as functional and cognitive status, psychosocial functioning, geriatric syndromes, life care wishes, diagnoses, and treatments. The MDS assessment classifies enrollees receiving skilled nursing services into case-mix groups that are used as the basis for Health Insurance Prospective Payment System (HIPPS) codes and represents specific sets of patient characteristics from the case-mix groups.[4] HIPPS codes represent the basis for which payment determinations are made for an enrollee under the SNF PPS and are reported on providers' claims for Medicare reimbursement.[5]

Pinnacle Multicare Nursing and Rehabilitation Center

Pinnacle is a 480-bed SNF located in the Bronx, New York. National Government Services (NGS) serves as the MAC that processes SNF skilled nursing care and rehabilitation services claimed by Pinnacle under Medicare Part A. Data analytics indicated that Pinnacle had a significant increase in Medicare Part A reimbursement for skilled nursing services under the PDPM as compared to the prior RUG payment model. NGS paid Pinnacle $51 million for skilled nursing

[3] Additionally, there is a separate component, the Variable Per Diem adjustment, for utilization of SNF resources that do not vary according to enrollee characteristics.

[4] 85 Fed. Reg. 47594, 47601 (Aug. 5, 2020).

[5] Each HIPPS code is comprised of five alphanumeric digits that correlate to a case-mix group under the PDPM to calculate the provider's reimbursement rate. The first digit represents both the PT and OT case-mix groups, the second digit represents the SLP case-mix group, the third digit correlates to the nursing case-mix group, the fourth digit represents the NTA classification case-mix group, and the fifth digit represents the assessment code (e.g., CDXE1).

services provided to enrollees for calendar years (CYs) 2020 and 2021 (audit period) based on CMS's Integrated Data Repository.[6]

HOW WE CONDUCTED THIS AUDIT

Our audit covered $50,828,595 in Medicare payments to Pinnacle for 3,371 claims for skilled nursing services provided during the audit period.[7] We selected a simple random sample of 100 claims, with payments totaling $1,605,609, for review. We evaluated these claims to determine if they complied with billing requirements, were timely submitted to the MAC, and if associated case records contained all required clinical documentation. We then submitted these claims and the associated supporting documentation to an independent medical review contractor to determine whether the associated services met Medicare coverage, medical necessity, and coding requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D details the types of deficiencies, if any, for each sample item.

FINDINGS

Pinnacle's claims for skilled nursing services were not made in accordance with Medicare requirements for 99 of the 100 skilled nursing services claims we sampled, which resulted in overpayments totaling $1,059,443.[8] Specifically, for 95 sampled claims, the associated medical record did not support the HIPPS code that Pinnacle assigned to the enrollee. Additionally, Pinnacle incorrectly billed Medicare for services provided to enrollees who did not require skilled nursing services (54 claims) and billed for some services that did not meet Medicare documentation requirements (2 claims). The total errors amount to more than 99 because 52 claims contained multiple deficiencies.[9]

[6] CMS's Integrated Data Repository is a high-volume data warehouse integrating Medicare Parts A, B, C, D, and Durable Medical Equipment claims, enrollee and provider data sources, along with ancillary data such as contract information and risk scores.

[7] This was the most current data available at the start of our audit.

[8] We determined that for one claim, Pinnacle provided case records that contained all required clinical and billing documentation to support that the enrollee required Medicare skilled nursing services and that the associated HIPPS code was appropriately assigned to the enrollee.

[9] Appendix D details the deficiencies, if any, for each sampled claim.

These errors occurred because Pinnacle's clinical and billing staff did not always follow its procedures to properly assign HIPPS codes in accordance with Medicare requirements and provide sufficient clinical review to verify that enrollees required skilled nursing services. In addition, Pinnacle did not follow its procedures to ensure that it always complied with Medicare documentation requirements. On the basis of our sample results, we estimated that Pinnacle received overpayments of at least $31,227,884 for skilled nursing services claims that did not meet Medicare requirements.[10]

HEALTH INSURANCE PROSPECTIVE PAYMENT SYSTEM CODING ERRORS RESULTED IN OVERPAYMENTS

At the time each resident is admitted to a SNF, the facility must have a physician's order for the resident's immediate care. The SNFs must then make a comprehensive assessment of a resident's needs, strengths, goals, life history, and preferences.[11] SNFs use the MDS to make these assessments, which is the basis for how much SNFs are paid for skilled nursing services. Specifically, SNFs use clinical data from the MDS assessment to assign case-mix classifiers, which correspond to specific HIPPS codes that are then used to calculate a per-diem payment under the SNF PPS.

To be considered valid for use in determining the payment amount, the MDS assessment should be completed in compliance with the instructions in CMS's *Long Term Care Facility Resident Assessment Instrument* (RAI) user manual.[12] The RAI manual is the primary source of information for completing an MDS assessment and offers guidance about the appropriate use of HIPPS coding for skilled nursing services.[13] Further, the RAI manual provides item-by-item coding instructions for all required sections and items in the MDS assessment.[14]

Pinnacle made HIPPS coding errors that resulted in overpayments for most of our sampled claims. For 95 of our 100 sampled claims, the associated medical record did not support the

[10] To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

[11] 42 CFR § 483.20.

[12] 85 Fed. Reg. 47594, 47601 (Aug. 5, 2020).

[13] Specifically, the RAI manual provides guidance on the appropriate use of HIPPS coding for an enrollee's need for skilled nursing services in the areas of physical therapy, occupational therapy, speech-language pathology, nursing, and non-therapy ancillary classification.

[14] CMS, *Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual*, version 1.17.1, chapters 1 and 3 (issued October 2019).

HIPPS code that Pinnacle assigned to the enrollee.[15] For these 95 claims, the medical record did not support at least one case-mix group assigned to the enrollee.[16] Specifically:

- The nursing case-mix group assigned to the enrollee was unsupported (88 claims).

Example 1: HIPPS Coding Error in Nursing Case-Mix Group

The medical records indicated that an individual was assigned to a nursing case-mix group due to septic shock while also experiencing moderate depression. However, the medical records did not support that the patient's depression level was moderate. Specifically, there was no support that the SNF investigated the causes/contributing factors for the individual's mood distress level or if any interventions were put into place to maintain her safety. Further, the medical records did not confirm that the individual's mood distress was communicated to the physician. Additionally, the physician's progress notes explicitly stated that "no depressed mood" was associated with the individual. Based on the medical documentation, if the appropriate HIPPS code was applied, the total Medicare reimbursement for skilled nursing services would have decreased by $289.

- The SLP case-mix group assigned to the enrollee was unsupported (63 claims).

Example 2: HIPPS Coding Error in Speech Language Pathology Case-Mix Group

An individual was assigned to the SLP case-mix group even though the individual had not been determined to need speech therapy. Although Pinnacle's screening note listed a diagnosis of aphasia,[17] it did not confirm that this diagnosis impacted the individual's functional status, cognitive status, mood or behavioral status, medical treatments, nursing monitoring, or risk of death. Further, the note explicitly stated that "no speech therapy intervention is indicated at this time." Accordingly, based on the documentation provided, the code used (based on aphasia as a diagnosis impacting the individual's functional status) for the SLP case-mix group in the HIPPS code was incorrect. Based on the

[15] For claims that contained HIPPS coding errors, we questioned the difference between the reimbursement amount associated with the incorrect HIPPS code(s) assigned to the enrollee and the appropriate HIPPS code(s) that should have been applied based on the enrollee's medical documentation.

[16] The total number of claims exceeds 95 because some claims had multiple coding errors.

[17] Aphasia is a disorder that results from damage (usually from a stroke or traumatic brain injury) to areas of the brain that are responsible for language. Aphasia impairs the expression and understanding of language, as well as reading and writing.

medical documentation, the total Medicare reimbursement for skilled nursing services decreased by $18,010.[18]

- The PT and OT case-mix group assigned to the enrollee was unsupported (38 claims).

Example 3: HIPPS Coding Error in Physical Therapy/Occupational Therapy Case-Mix Group

The medical records indicated that an individual was assigned to an incorrect PT/OT case-mix group based on the diagnosis of osteoarthritis as the primary reason that skilled nursing services were needed. However, based on the medical documentation, the appropriate HIPPS code should have corelated with major depressive disorder as the primary reason for the need for skilled nursing services, which would have decreased the total Medicare reimbursement for skilled nursing services by $216.

- The NTA classification case-mix group assigned to the enrollee was unsupported (31 claims).

Example 4: HIPPS Coding Error in Non-Therapy Ancillary Classification Case-Mix Group

Pinnacle determined that an individual needed intravenous (IV) medication. However, medical records indicated that the individual had been diagnosed with active multidrug-resistant organisms (bacteria) for which the corresponding treatment did not require the administration of IV medication. Accordingly, the code used (based on the need for IV medication) for the NTA classification case-mix group was not supported. Based on the medical documentation, the total Medicare reimbursement for skilled nursing services decreased by $5,097.[19]

MEDICARE ENROLLEES DID NOT REQUIRE SKILLED NURSING SERVICES

Upon admission to a SNF, an individual must require the skills of technical or professional health care personnel (i.e., registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, speech-language pathologists, or audiologists) for the safe

[18] The total decrease in the Medicare reimbursement amount for the claim depicted in the example does not represent the corrected HIPPS coding errors solely related to the SLP case-mix group component. The claim also had errors related to three other case-mix grouping components that also decreased the total Medicare reimbursement amount.

[19] The total decrease in the Medicare reimbursement amount for the claim depicted in the example does not represent the corrected HIPPS coding errors solely related to the NTA case-mix group component. The claim also had errors related to three other case-mix grouping components that also decreased the total Medicare reimbursement amount.

and effective treatment of the patient's condition(s).[20] A condition that does not ordinarily require skilled services may require them because of special medical complications.[21] In addition, the individual must require skilled nursing or skilled rehabilitation services, or both, on a daily basis and the services must be ones that can only be provided on an inpatient basis in a SNF.[22]

For 54 of our sampled claims, Pinnacle incorrectly billed Medicare for services provided to enrollees who did not require skilled nursing services. The following is an example of an enrollee who did not require skilled nursing services.

Example 5: Individual Did Not Require Skilled Nursing Facility Services

Although Pinnacle indicated on an MDS assessment that an individual had a need for daily skilled nursing services for bed mobility and wheelchair training, the description of the individual's condition in the medical records did not indicate such a need. Specifically, the medical records indicated that the individual was ambulating (i.e., moving) independently, which contradicted the need for transfer/wheelchair training. Therefore, the documentation did not justify the need for skilled nursing services.

REQUIREMENTS FOR SKILLED NURSING SERVICES WERE NOT DOCUMENTED

The Social Security Act (the Act) states that Medicare payment is precluded to any provider of services without information necessary to determine the amount due the provider.[23] SNFs must make a comprehensive assessment of a resident's needs, strengths, goals, life history, and preferences.[24] The MDS is used as the clinical assessment and basis for payment for skilled nursing services.

For two of our sampled claims, Pinnacle incorrectly billed Medicare for skilled nursing services that were not documented. For one of our sampled claims, Pinnacle did not provide sufficient medical records to support that the individual required skilled nursing services. For the other sampled claim, Pinnacle did not provide the MDS assessment used to support the HIPPS code assigned to its claim for Medicare reimbursement.

[20] 42 CFR §§ 409.31, 409.32 and 409.33(c).

[21] 42 CFR § 409.32(b).

[22] 42 CFR §§ 409.31(b) and 409.34.

[23] The Act § 1815(a).

[24] 42 CFR § 483.20.

PINNACLE STAFF DID NOT FOLLOW PROCEDURES TO PROPERLY CLAIM SKILLED NURSING SERVICES

Pinnacle had written procedures to identify and prevent noncompliance with Medicare requirements related to clinical review, proper coding, and documentation retention. Additionally, Pinnacle required all personnel to attend a one-time compliance training and billing personnel to annually complete a separate 1-hour training specific to coding, billing, and reimbursement. Despite establishing these procedures and training requirements, we determined that Pinnacle's clinical and billing staff did not always follow its procedures to properly code 95 of our sampled claims in accordance with Medicare requirements and verify that enrollees required skilled nursing services for 54 of our sampled claims.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that Pinnacle received overpayments of at least $31,227,884 for skilled nursing services claims that did not meet Medicare requirements.[25]

RECOMMENDATIONS

We recommend that Pinnacle Multicare Nursing and Rehabilitation Center:

- refund to the Medicare program $31,227,884 for skilled nursing services claims that did not meet Medicare requirements;[26]

- consider conducting one or more internal audits or investigations for claims before and after our audit period based on the risks identified by this audit to identify any similar overpayments the provider might have received and return any identified overpayments to the Medicare program; and

- provide additional training to its clinical and billing personnel on its procedures related to:

    - assigning appropriate billing codes when submitting claims for Medicare reimbursement,

[25] See footnote 10.

[26] OIG audit recommendations do not represent final determinations. CMS, acting through a Medicare contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal.

- providing enrollees only reasonable and necessary skilled nursing services, and
- maintaining proper documentation to support services provided.

PINNACLE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Pinnacle did not concur with our recommendations and disagreed with our associated findings. However, Pinnacle stated that it will continue to maintain a robust compliance program committed to properly documenting, billing, and upholding the highest standards for resident care.

Pinnacle provided what it described as clinical rebuttals to two examples in the report. Also, Pinnacle stated that OIG's independent medical reviewer misapplied coding guidelines and that the audit report failed to consider CMS-approved waivers in place during the COVID-19 Public Health Emergency (PHE). Additionally, Pinnacle described our error rate as "statistically implausible" and disputed the validity of our extrapolation. Finally, Pinnacle questioned the qualifications of our independent medical review contractor's employees and asserted that the employees' lack of knowledge, experience, and limitations call into question the validity and integrity of the audit findings.

After reviewing Pinnacle's comments, we maintain that our findings and related recommendations are valid.

A summary of Pinnacle's comments and our responses follows. Pinnacle's comments appear in their entirety as Appendix E.

CLINICAL REBUTTALS TO OFFICE OF INSPECTOR GENERAL FINDINGS

Pinnacle Comments

Pinnacle stated that OIG's independent medical review contractor consistently misapplied MDS and PDPM coding guidelines.

Regarding Example 1 (page 5), Pinnacle stated that OIG's interpretation of the MDS assessment improperly conflates care planning with reimbursement criteria. Pinnacle stated that OIG misapplied MDS coding guidelines related to the interview used to assess the resident's mood distress level. Pinnacle referenced the RAI Manual and indicated that the manual states: "The responses in the Resident Mood Interview are recorded exactly as stated by the resident. Staff observations or documentation from other sources should not influence coding." As a result, Pinnacle stated that the OIG's interpretation inaccurately concluded that the nursing case-mix classification was unsupported.

According to Pinnacle, Example 2 (page 5) mischaracterizes the need for speech therapy services for residents with aphasia. Pinnacle stated that, although a screening note for the resident indicated that "no speech therapy intervention is indicated at this time," this conclusion overlooks RAI Manual guidance for identifying and coding an active diagnosis. Pinnacle stated that this guidance specifies that a diagnosis is considered active if (1) it is documented by a qualified provider within 60 days preceding the assessment reference date and (2) it was active (i.e., had a direct impact on the resident's functioning or care) during the 7-day look-back period ending on the assessment reference date. According to Pinnacle, while the receipt of skilled therapy services may serve as one indicator of an active diagnosis, it is not a requirement. Pinnacle cited the RAI Manual, which states that an active diagnosis may also be supported through documentation in the care plan, staff communication assessments, staff interviews, or other clinical notes. Further, Pinnacle stated that the presence of a documented diagnosis of aphasia within the required timeframe, combined with its ongoing relevance to the resident's condition (even in the absence of active therapy), satisfies the criteria for coding under PDPM. Therefore, according to Pinnacle, the speech-language pathology case-mix group classification was appropriate and in compliance with CMS guidelines.

Office of Inspector General Response

Regarding Example 1, we noted that Pinnacle, in its comments, misquoted the RAI Manual and omitted a portion of the guidance related to coding instructions. The RAI Manual states that SNFs should "[r]ecord the resident's responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood. Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician" [emphasis added]. Notably, Pinnacle omitted the guidance that calls for further evaluation of the relevance of symptoms. Accordingly, we maintain that our findings related to unsupported nursing case-mix classification are valid.

Pinnacle's comments suggest that Example 2 was cited as an error solely because no skilled therapy services related to aphasia were provided. However, in this example, our independent medical review contractor determined that the enrollee did in fact have a diagnosis of aphasia; however, the enrollee did not have an active diagnosis. The RAI Manual states, that "[l]isting a disease/diagnosis … on the resident's medical record … is not sufficient for determining active or inactive status. To determine if arthritis, for example, is an 'active' diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis." For the resident associated with Example 2, a physician's progress note listed a diagnosis of aphasia; however, an active aphasia diagnosis was not documented. The note did not confirm that aphasia impacted the patient's functional status, required medical treatments,

or necessitated nurse monitoring. Accordingly, we maintain that our findings related to unsupported speech-language pathology case-mix classification are valid.[27]

PUBLIC HEALTH EMERGENCY WAIVER PROVISIONS

Pinnacle Comments

Pinnacle stated that OIG did not acknowledge COVID-19 PHE waiver provisions in place during our audit period. Pinnacle stated that this resulted in determinations that are fundamentally flawed and not in accord with the law in place at the time the sampled claims were submitted for reimbursement. Additionally, Pinnacle noted that the findings in this audit report concern services rendered during the height of the PHE and overlook the extraordinary challenges faced by frontline healthcare workers.

Pinnacle also noted that it is one of the largest SNFs in New York City and was at the epicenter of the COVID outbreak in the Bronx, serving a vulnerable population. The comments stated that CMS instructed providers to prioritize care over compliance and that PDPM was implemented in fiscal year 2020 with new guidelines rolled out by CMS 3 months prior to the PHE. Pinnacle also noted that CMS did not conduct small-scale audits or provide education, as it usually does when it implements large scale changes, such as the PDPM model.

Office of Inspector General Response

We worked closely with our independent medical review contractor to ensure that it considered all relevant waiver provisions in place during our audit period. The audit report does not reference CMS's waiver provisions in place during the COVID-19 PHE because none of the deficiencies we identified were associated with these provisions. For example, we instructed our medical review contractor to consider flexibilities outlined in CMS's "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," which included waiving the 3-day prior hospitalization requirement for SNF coverage and allowing renewed SNF benefits without a new benefit period for certain beneficiaries. Further, as part of these waivers, CMS also waived timeframes for performing MDS assessments and staffing data submissions.

In addition, as part of its technical assistance to prepare SNFs and other stakeholders on the implementation of the PDPM model, CMS developed a variety of educational and training resources prior to the PHE that remain available on its website.[28]

We recognize that extraordinary conditions were in place during our audit period and that health providers, especially SNFs, faced many challenges. However, we stand by the accuracy

[27] In its comments, Pinnacle identified a technical inaccuracy in our draft report related to the maximum number of days an enrollee must reside at a SNF before the MDS must be completed. After reviewing Pinnacle's comments, we revised the report to correct the technical inaccuracy. The change did not impact any of our determinations.

[28] CMS, "Patient Driven Payment Model." Accessed on Nov. 14, 2025.

of our determinations. As noted earlier in the report (footnote 26), OIG recommendations do not represent a final determination. Our determinations are transmitted to CMS, which is the agency responsible for determining whether (1) overpayments exist and (2) to recoup those funds.

STATISTICAL PLAUSIBILITY OF ERROR RATE AND EXTRAPOLATION

Pinnacle Comments

Pinnacle described OIG's 99-percent error rate in the sample of 100 claims as "statistically implausible" and disputed the validity of our extrapolation. Pinnacle also stated that the underlying sample was not neutrally reviewed and appears to have excluded well-documented and compliant claims. Further, according to Pinnacle, several sample claims contain only "trivial omissions" and should not justify full denial of claims or extrapolated recoupment.

Office of Inspector General Response

Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare.[29] We properly executed our statistical sampling methodology in that we defined our sampling frame and sample unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software to apply the correct formulas for the extrapolation. We believe this methodology provides a reasonable basis for our monetary recommendation.

Further, as described in Appendix B of our report, our sample was selected using a simple random sample design. Each sample unit (i.e., a SNF claim) in our sampling frame is unique and had the same chance of being selected. Such a sample provides a fair and valid representation of the sampling frame because it is free from any selection bias. Additionally, we evaluated each sampled item using a specific set of characteristics to be measured to determine whether the claims for skilled nursing services met Medicare coverage and coding requirements and were reasonable and necessary. The overpayment or partial overpayment amount for each sample item was calculated based on comparing the amount Pinnacle was paid by Medicare to the amount they should have been paid given all applicable laws and regulations.

[29] *See Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius*, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), *adopted by* 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

INDEPENDENT MEDICAL REVIEW CONTRACTOR QUALIFICATIONS

Pinnacle Comments

Pinnacle described the qualifications of OIG's independent medical review contractor's employees as a matter of serious concern and stated that OIG has not informed Pinnacle of the reviewers' qualifications. Additionally, Pinnacle stated that OIG's medical reviewer made consistent and persistent errors in applying requirements that may have adversely impacted all 99 claims in error. Pinnacle also described what it perceived as a lack of knowledge, experience, and limitations of the reviewers and stated that it calls into question the validity and integrity of the audit findings.

Office of Inspector General Response

OIG provided a summary of the qualifications for the two or more independent medical review contractor employees who reviewed each sample claim.[30] Our medical reviews were performed by credentialed and board-certified professionals. These included a Registered Nurse with 20 years' experience in coding skilled MDS Assessments, validating medical necessity, and performing medical reviews. Also, another reviewer was a physician who is licensed to practice medicine, is knowledgeable in the treatment of enrollees' medical conditions, and is familiar with guidelines and protocols in the area of treatment reviewed.[31] We maintain that our audit methodology, including the medical review of the sampled claims is valid; and, accordingly, we did not make any adjustments to this report based on Pinnacle's comments regarding our audit methodology.

[30] We acknowledge that we did not provide Pinnacle with curricula vitae of the medical review contractor employees in order to protect their personally identifiable information.

[31] Additionally, the physician is board certified in internal medicine and has no history of disciplinary action or sanctions against their license.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $50,828,595 in Medicare payments to Pinnacle for 3,371 claims for skilled nursing services provided during CYs 2020 and 2021. We selected for review a simple random sample of 100 claims with payments totaling $1,605,609.

We evaluated compliance with selected Medicare coverage and billing requirements and submitted the sampled claims and the associated supporting documentation to an independent medical review contractor to determine whether the associated services met medical necessity and coding requirements.

We limited our review of Pinnacle's internal controls to those applicable to specific Medicare billing procedures because our objective did not require an understanding of all internal controls over the submission and processing of claims. To assess the reliability of the data obtained from CMS's Integrated Data Repository, we: (1) performed electronic testing for obvious errors in accuracy and completeness, (2) reviewed existing information about the data and the system that produced the data, and (3) traced our random sample of 100 skilled nursing service claims to source documents. We determined that the data were sufficiently reliable for the purposes of this report.

We conducted our audit from May 2022 through June 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed Pinnacle's procedures for billing and submitting Medicare claims;
- obtained Pinnacle's paid claims data from CMS's Integrated Data Repository for the audit period;
- created a sampling frame of 3,371 claims totaling $50,828,595;
- selected a simple random sample of 100 claims for detailed review (Appendix B);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been canceled or adjusted;

- obtained and reviewed billing and medical record documentation provided by Pinnacle to support the claims sampled;

- used an independent medical review contractor to determine whether the 100 claims contained in the sample were reasonable and necessary and met Medicare coverage and coding requirements;

- calculated the correct payments for those sampled claims requiring adjustments;

- used the results of the sample to estimate the total Medicare overpayments to Pinnacle in the sampling frame (Appendix C); and

- discussed the results of our audit with Pinnacle officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 3,371 claims for which there was a payment from the Medicare Trust Fund for skilled nursing services provided by Pinnacle during our audit period with total Medicare payments of $50,828,595.[32]

SAMPLE UNIT

The sample unit was a SNF claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG Office of Audit Services (OIG/OAS) statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the sample units in the sampling frame by the unique claim number and then consecutively numbered the items in the frame. After generating the random numbers in accordance with our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of overpayments made to Pinnacle in the sampling frame. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

[32] Our sampling frame included claims that were not (1) identified in the Recovery Audit Contractor Data Warehouse as previously excluded or under review, or (2) previously reviewed by CMS's Unified Program Integrity Contractor.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Sampling Frame Size	Total Value of Sampling Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Value of Overpayments in Sample
3,371	$50,828,595	100	$1,605,609	99	$1,059,443

Estimated Overpayments in the Sampling Frame
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$35,713,836
Lower limit	$31,227,884
Upper limit	$40,199,789

APPENDIX D: TYPES OF DEFICIENCIES BY SAMPLE ITEM

DESCRIPTION OF DEFICIENCIES	
1A	**HIPPS Coding Error—Nursing Case Mix Group**
1B	**HIPPS Coding Error—Speech Language Pathology Case Mix Group**
1C	**HIPPS Coding Error—Physical Therapy and Occupational Therapy Case Mix Group**
1D	**HIPPS Coding Error—Non-Therapy Ancillary Classification Case Mix Group**
2	**Medicare Enrollees Did Not Require Skilled Nursing Services**
3	**Requirements for Skilled Nursing Services Were Not Documented**

Sample Number	1A	1B	1C	1D	2	3	Overpayment
1	X						$1,747
2					X		3,138
3	X						3,802
4	X		X				977
5		X			X		14,286
6		X			X		12,713
7						X	19,602
8	X	X	X	X	X		18,010
9	X			X	X		21,511
10	X	X					1,577
11	X	X					1,306
12	X	X	X	X			6,931
13		X	X		X		19,964
14	X	X	X		X		10,419
15	X						915
16	X	X					1,315
17	X	X			X		17,960
18	X						5,601
19	X	X			X		5,537
20	X		X				4,512
21	X	X		X	X		21,467
22	X	X	X	X			5,097
23	X			X			5,711
24	X	X			X		20,165

Sample Number	1A	1B	1C	1D	2	3	Overpayment
25	X	X			X		$16,541
26	X	X		X	X		10,795
27	X	X					2,109
28	X	X	X		X		21,899
29	X	X		X			3,515
30	X	X	X		X		20,693
31	X			X			5,329
32	X			X	X		7,754
33	X	X	X	X	X		20,615
34	X			X			1,503
35	X			X	X		21,081
36	X	X	X	X	X		21,877
37	X	X	X	X			7,440
38		X	X	X	X		23,505
39	X	X	X		X		4,902
40	X	X					6,328
41	X			X	X		15,034
42	X						2,740
43	X	X	X				6,464
44	X	X		X	X		21,377
45	X	X	X		X		21,615
46							0
47	X	X			X		23,304
48	X			X	X		1,778
49					X		25,940
50	X	X	X				6,534
51	X	X					5,424
52	X	X	X		X		29,331
53	X	X	X				3,615
54	X	X	X				3,684
55	X				X		7,623
56	X	X		X	X		21,712
57	X				X		13,681
58	X	X	X				6,751

Sample Number	1A	1B	1C	1D	2	3	Overpayment
59	X		X	X			$6,980
60	X	X					1,978
61	X	X			X		15,441
62	X	X	X	X	X		19,210
63	X	X	X	X			6,185
64	X	X					4,351
65	X						289
66	X	X		X			7,878
67	X	X	X		X		2,982
68	X						4,480
69	X	X	X	X	X		14,665
70	X	X		X	X		7,884
71	X						4,308
72	X	X	X				4,544
73	X		X		X		17,147
74	X	X	X		X		18,850
75	X		X		X		26,130
76	X	X			X		7,420
77		X	X				1,479
78	X				X		20,389
79	X	X			X		3,678
80						X	8,123
81	X	X	X	X	X		1,673
82	X	X					3,162
83	X	X	X	X			7,479
84	X				X		20,785
85	X				X		16,330
86	X	X			X		24,306
87	X	X			X		9,453
88	X						4,081
89	X				X		4,392
90	X	X					3,944
91	X			X			1,942
92	X				X		24,444

Sample Number	1A	1B	1C	1D	2	3	Overpayment
93			X				$216
94	X	X	X	X	X		18,786
95		X					7,712
96	X	X			X		15,970
97	X	X	X	X	X		22,066
98	X	X			X		18,335
99	X		X				841
100	X	X	X		X		12,382
Totals:	**88**	**63**	**38**	**31**	**54**	**2**	**$1,059,443***

*Amounts do not add up exactly due to rounding.

APPENDIX E: PINNACLE COMMENTS

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On Behalf of
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September 15, 2025

Re: *Reply to Draft Audit Report for Pinnacle Multicare Nursing and Rehabilitation Center – A-02-22-01017*

Dear Regional Inspector General Webb,

On behalf of Pinnacle Multicare Nursing and Rehabilitation Center (Pinnacle), I respectfully submit the reply to the OIG's Draft Audit Report. Pinnacle disagrees with all of the findings. Pinancle's reply to the Draft Audit Report is set forth in the attached.

Thank you for your consideration. We respectfully request that OIG consider the above comments in reviewing and revising the Draft Audit Report.

Sincerely,

Alyssa A. Friedman, Esq.
Partner | Healthcare Fraud Chair

Pinnacle Response to OIG Draft Audit Report A-02-22-01017

Introduction

Pinnacle Multicare Nursing and Rehabilitation Center (Pinnacle) respectfully submits this response to the Office of Inspector General's (OIG) Draft Audit Report, A-02-22-01017, dated July 16, 2025. As one of the largest skilled nursing facilities in New York City with 480 certified beds, Pinnacle has been on the front lines of care throughout the COVID-19 pandemic, protecting and serving some of the most vulnerable members of our community. The findings in this report, which concern services rendered during the height of the public health emergency, overlook the extraordinary challenges faced by frontline healthcare workers and the regulatory flexibilities that CMS deliberately instituted to preserve the lives of our vulnerable residents in an unprecedented crisis. We respectfully submit this reply with deep respect for the oversight process, but also with an urgent appeal for fairness, context, and recognition of the real-world conditions and regulatory waivers under which these services were rendered.

The OIG's Draft Audit Finding Report is deficient in the following areas:

1. Clinical Rebuttals to HIPPS Coding and Documentation Findings

The facility's review of the OIG's sampled claims identified consistent errors in how OIG reviewers applied MDS and PDPM coding guidelines. Specifically:

- Example 1 regarding mood documentation misapplies Section D of the MDS. The MDS 3.0 RAI Manual requires that PHQ-9 responses be coded solely on resident self-report. Physician notes are not relevant to the coding of this section. OIG's interpretation improperly conflates care planning with reimbursement criteria.

- Example 2 mischaracterizes the need for speech therapy services in residents with aphasia. CMS guidelines allow diagnosis-based classification when the diagnosis is active and documented, even absent active therapy. The presence of aphasia as an active diagnosis during the look-back period was correctly reflected in Pinnacle's MDS submissions.

The finding that residents did not require skilled nursing care is flawed. Many residents had conditions that, when considering age, acuity, frailty, and comorbidities, did absolutely require the attention of skilled professionals even where the documentation did not reflect it in a format preferred by the reviewers. Despite that, the documentation was adequate.

Additionally, PDPM was implemented in FY 2020 with brand new and complex guidelines rolled out by CMS a mere three (3) months before the COVID-19 pandemic began. Typically, when CMS makes large scale changes, Facilities are given time to adapt and learn through smaller audits and education by CMS. This opportunity was never afforded to Pinnacle due to the pandemic and Pinnacle is now being penalized for alleged, immaterial and trivial PDPM related "errors" that occurred during Covid and which in many instances misconstrue or misstate actual regulatory and correct coding guidelines for the new payment system.

2. COVID-19 Pandemic and Applicable CMS Waivers

The draft audit report fails to address the crucial fact that calendar year 2020 was governed by an active federal Public Health Emergency (PHE) declaration and associated Section 1135 waivers issued by the Centers for Medicare & Medicaid Services (CMS). CMS guidance during the early phase of the pandemic prioritized patient safety over administrative formality—a philosophy CMS described as 'People Over Paper.' This ethos was reflected in a wide array of waivers specifically affecting skilled nursing facilities, including:

- Suspension of MDS transmission timeframes and frequency enforcement.
- Flexibilities in nurse staffing levels and documentation of care.
- Waiver of the 3-day prior hospitalization requirement for SNF coverage.
- Authorization for facilities to admit and treat COVID-positive patients even without traditional Medicare-compliant paperwork.
- Postponement or suspension of many routine compliance audits.

New York State, in particular, was designated a federal COVID-19 hotspot in early 2020, and its nursing homes bore the brunt of the first wave of the pandemic. Pinnacle was at the epicenter of the outbreak in the Bronx. Facilities, including Pinnacle, were instructed by state and federal authorities to preserve hospital capacity, take in COVID-positive discharges from hospitals, and to provide life-saving care under emergency staffing conditions and limited PPE access. Clinical decision-making was appropriately driven by the urgent goal of saving lives and maintaining patient and staff safety in the midst of evolving knowledge about COVID and rapidly changing guidance from public health authorities. In the interest of patient care, CMS authorized waivers and regulatory flexibility regarding such things as timely MDS updates or perfect documentation.

The OIG's audit retroactively applies normal regulatory expectations to a time when providers were instructed explicitly to prioritize care over compliance. To disregard these federal and state-level waivers is to ignore the law in place at the time and unfairly

penalize providers for saving lives and maintaining daily operations under extraordinary conditions.

3. Statistically Implausible Error Rate and Extrapolation Dispute

The draft audit asserts a 99% error rate across a statistically sampled set of 100 claims—an outcome that is implausible. Such a rate suggests near-total systemic failure, which is not borne out by the operational reality at Pinnacle. The claims audited span the peak of the COVID-19 Public Health Emergency, during which CMS authorized significant waivers and instructed providers to focus on care delivery over administrative form. To suggest that nearly all skilled nursing claims were in error—without considering the PHE conditions—is not only irrational but could evidence confirmation bias.

Moreover, we dispute the validity of the extrapolation, which was conducted using RAT-STATS. The underlying sample was not neutrally reviewed and appears to have excluded well-documented and compliant claims.

The sampling fails to incorporate claims with clear documentation of skilled needs. Several sample items contain only trivial omissions and should not justify full denial of claims or extrapolated recoupment.

We intend to formally contest both the extrapolated overpayment estimate and the sampling methodology itself, as extrapolation is only valid when the sample is fair and unbiased.

4. Reviewer Qualifications

The qualifications of the OIG nurse / clinical reviewer are a matter of serious concern. Despite numerous requests to the OIG, Pinnacle has not been informed of the qualifications of the reviewers. To our knowledge, the reviewer appears to have never worked in a skilled nursing facility and lacks firsthand experience with the regulatory and clinical realities of long-term care. This lack of domain-specific expertise contributed to misapplication of Medicare regulations, a failure to interpret MDS coding and care planning requirements correctly, and also a fundamental misunderstanding of care delivery during the audit period. These conclusions have been validated through the clinical record reviews completed by Pinnacle's expert reviewers including a Master's prepared long term care Registered Nurse who is a certified teacher-trainer of the MDS and a certified physician who, as a nursing home medical director, was actively engaged in that capacity and led nursing home care teams during the pandemic.

The lack of knowledge, experience and limitations of the OIG reviewers call into question the validity and the integrity of the audit findings. Reviews of skilled nursing

facility claims must be conducted by individuals who understand the nuances of SNF operations, including CMS's own guidance around resident-centered care and documentation expectations under PDPM. We respectfully request that any final findings be re-evaluated by a qualified peer reviewer with relevant SNF experience.

5. Immediate Risk of Bankruptcy and Collapse of Care

The OIG's recommendation for a $31+ million repayment is not simply unjustified —it would bankrupt Pinnacle Multicare Nursing and Rehabilitation Center. This is not a theoretical concern. A forced repayment of this magnitude would result in mass layoffs, forced discharge of residents, and likely closure of the facility.

Pinnacle is one of the largest nursing homes in New York City and serves a critical safety-net function in the Bronx and surrounding boroughs. Its loss would displace a fragile population, overwhelm nearby hospitals and long-term care providers, and have cascading effects on health system capacity. We strongly urge the OIG to consider the real-world consequences of enforcing this unprecedented and fundamentally flawed repayment demand on the residents of Pinnacle and New York City more broadly.

Specific Non-Concurrence with Recommendations

The OIG makes three recommendations on page 8 of the Draft Report. Pinnacle specifically does not concur with each of those recommendations for all the reasons stated above. Regardless, Pinnacle does have and will continue to have a robust compliance program and commitment to proper documentation, billing and highest standards for resident care.

Conclusion

For all the above reasons—clinical, legal, procedural, and humanitarian—Pinnacle respectfully requests that the OIG withdraw or substantially revise the draft report and eliminate the recommended repayment amount. We remain committed to compliance with all Medicare requirements and request that the final report fully incorporate the facts and standards in place during the audit period.

Please see Appendices A & B attached hereto which are incorporated by reference for detailed clinical rebuttals and supporting citations.

Pinnacle expressly reserves all rights, claims, defenses, and remedies available under applicable law and regulations, including but not limited to its rights to contest any findings, determinations, or recoupment efforts in all appropriate administrative and judicial forums

Appendix A: Detailed Clinical Rebuttals and Citations

COVID-19 1135 Waiver (All 99 Beneficiaries/All Claims)

The audit findings report issued by the OIG did not reference or acknowledge the COVID-19 Public Health Emergency (PHE) 1135 waiver provisions in relation to the identified issues. All coverage determinations and clinical documentation were profoundly altered by the waiver authority and the ongoing and evolving series of guidelines issued by CMS and New York State including, but not limited to, putting People over Paper in this emergency situation. The wholesale failure to take these facts and circumstances into account as part of this review resulted in denial determinations that are fundamentally flawed and that are arbitrary, capricious and not in accord with the law in place at the time the care was rendered and these claims submitted for reimbursement by the Provider.

Page 2 of the OIG report (99 Beneficiaries)

The OIG report on page 2 inaccurately stated that the Skilled Nursing Facility (SNF) must complete the Minimum Data Set (MDS) within the first five days of a Medicare enrollee's stay.

Per 42 CFR § 413.343(c), the federal requirement is that the Assessment Reference Date (ARD) for the 5-Day PPS MDS assessment may be set on any day between Day 1 and Day 8 of the Part A stay, at the discretion of the facility. The assessment must then be completed and submitted within the regulatory timeframes outlined in 42 CFR § 483.20.

The OIG Reviewer made consistent and persistent errors in MDS requirements that may have adversely impacted all 99 claims.

Rebuttal to Example 1: HIPPS Coding Error in Nursing Case-Mix Group (88 Beneficiaries)

The OIG reviewer erroneously interpreted and applied the MDS coding process. Any denials based on this rationale are wrong.

The OIG report in Example 1: HIPPS Coding Error in Nursing Case-Mix Group asserts that there was no documentation indicating that the facility investigated the causes or contributing factors related to the resident's mood distress, nor was there evidence of any interventions to maintain her safety. It further states that the medical record did not confirm physician notification and that the physician's progress notes documented "no

depressed mood."

This finding reflects a misunderstanding of the Minimum Data Set (MDS) coding process. According to the MDS 3.0 RAI User's Manual, Version 1.17, in effect at the time of the assessment, the coding of Section D (Resident Mood Interview/PHQ-9) is based exclusively on the resident's self-reported responses during the standardized interview process. The Manual clearly instructs that:

"The responses in the Resident Mood Interview are recorded exactly as stated by the resident. Staff observations or documentation from other sources should not influence coding." (Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual v1.17, Chapter 3, Section D, page D-5).

Accordingly, the MDS interview results must stand on the resident's expressed perceptions, regardless of physician notes or staff observations. The Care Area Assessment (CAA) and subsequent care planning process are the appropriate venues for addressing any follow-up action based on the resident's mood interview responses. These requirements are established under the Omnibus Budget Reconciliation Act (OBRA) of 1987 and pertain to resident-centered care—not Medicare Part A reimbursement.

Therefore, the OIG's interpretation conflates the MDS coding process with care planning requirements and inaccurately concludes that the nursing case-mix classification was unsupported.

Rebuttal to Example 2: HIPPS Coding Error in Speech-Language Pathology Case-Mix Group (63 Beneficiaries)

The OIG based a denial of claims for 63 beneficiaries on an alleged coding error in the SLP Case-Mix Group that is incorrect.

In Example 2: HIPPS Coding Error in Speech-Language Pathology Case-Mix Group, the OIG report states that although the speech therapy screen listed a diagnosis of aphasia, the accompanying note indicated that "no speech therapy intervention is indicated at this time."

This conclusion overlooks the regulatory guidance for identifying and coding an active diagnosis. As outlined in the MDS 3.0 RAI User's Manual, Version 1.17, a diagnosis is considered active if it meets the following criteria:

- It was documented by a physician (or qualified provider) within 60 days preceding the

Assessment Reference Date (ARD), and
- It was active, i.e., had a direct impact on the resident's functioning or care, during the 7-day look-back period ending on the ARD.

While the receipt of skilled therapy services may serve as one indicator of an active diagnosis, it is not a requirement. The Manual states that an active diagnosis may also be supported through documentation in the care plan, staff communication assessments, staff interviews, or other clinical notes.

The presence of a documented diagnosis of aphasia within the required timeframe, combined with its ongoing relevance to the resident's condition (even in the absence of active therapy), satisfies the criteria for coding under PDPM. The speech therapy case-mix group classification was therefore appropriate and in compliance with CMS guidelines.

The complete disregard of coding guidance for both the PDPM reimbursement and MDS completion results in denials and allegations of error that are arbitrary, capricious and not in accord with the law in place at the time the care was rendered and these claims submitted for reimbursement by the Provider.

Appendix B: Legal and Regulatory Citations

1. Centers for Medicare & Medicaid Services (CMS), COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. Available at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf
2. Section 1135 of the Social Security Act, 42 U.S.C. § 1320b–5 – Authority to Waive Requirements During National Emergencies.
3. CMS Memorandum QSO-20-28-NH (April 24, 2020) – Interim Final Rule and waivers related to COVID-19 for Skilled Nursing Facilities. Available at: https://www.cms.gov/files/document/qso-20-28-nh.pdf
4. CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1 – Guidance on PHQ-9 and MDS Coding. Available at: https://downloads.cms.gov/files/MDS-3.0-RAI-Manual-v1.17.1_October_2019.pdf
5. 42 C.F.R. § 483.20 – Resident Assessment Requirements.
6. 42 C.F.R. § 409.31-34 – Medicare Coverage of Skilled Nursing Facility Services including level of care requirements for skilled nursing.
7. 42 C.F.R. § 413.343(c) –MDS Assessment Schedule Compliance.
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9. CMS COVID-19 FAQs on Medicare Fee-for-Service Billing. Available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
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11. New York State Department of Health, Medicaid 1135 Waiver Request (March 23, 2020). Available at: https://coronavirus.health.ny.gov/system/files/documents/2020/03/1135_waiver_request.pdf
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17. New York State Department of Health, COVID-19 Guidance for Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) 1915(c) Medicaid Waiver Providers (March 20, 2020). Available at: https://coronavirus.health.ny.gov/system/files/documents/2020/03/covid19nhtdtbi3.20.20.pdf
18. New York State Department of Health, *Nursing Home Advisory: Recommendations to Protect Nursing Home Residents During COVID-19* (March 20, 2020). Available at: https://coronavirus.health.ny.gov/system/files/documents/2020/03/doh_covid19_protectnursinghomeresidents_032120.pdf
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21. New York State Department of Health, *Guidance for Nursing Homes on Managing Resident Deaths During the COVID-19 Outbreak* (April 19, 2020). Available at: https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh_nhresidentdeaths_041920.pdf

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