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STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF HEARINGS AND APPEALS

In the Matter of	)	
	)	
[redacted],	)	OHA Case No. 09-FH-124
	)	
Claimant.	)	Div. Case No. [redacted]
_____	)	

FAIR HEARING DECISION

STATEMENT OF THE CASE

[redacted] (Claimant) applied for Medicaid benefits[1] under the Home and Community Based Waiver (hereinafter "HCB Waiver") program. On February 24, 2009 the Division of Senior and Disabilities Services (Division) sent her notice her application was denied. (Ex. D) The Claimant requested a fair hearing contesting the denial on March 5, 2009. (Ex. C) This office has jurisdiction pursuant to 7 AAC 49.010.

The hearing was held on April 14, 2009 and May 13, 2009 before Hearing Officer Jay Durych. The Claimant attended the hearing in person, represented herself and testified on her own behalf. [redacted], the Claimant's Personal Care Assistant, and Tiffany [redacted], the Claimant's Care Coordinator, both appeared in person on May 13, 2009 and testified on the Claimant's behalf.

[redacted], a Health Program Manager III employed with the Division of Health Care Services, appeared in person and represented the Division. Mollie Erickson, a registered nurse employed with the Division, appeared in person at the April 14, 2009 hearing. [redacted], a registered nurse employed with the Division, appeared in person at the May 13, 2009 hearing and testified on the Division's behalf.

Following the May 13, 2009 hearing, this case was reassigned to Hearing Officer Larry Pederson, who reviewed the entire hearing record and listened to the recording of the entire hearing before issuing this Decision.

[1] The record does not indicate the date of Claimant's application.

ISSUE

Was the Division correct to deny the Claimant's application for Medicaid HCB Waiver benefits because she did not require a nursing facility level of care?

FINDINGS OF FACT

The following facts were established by a preponderance of the evidence:

1. Claimant is a [redacted] year old woman (date of birth [redacted]) who lives with her husband. (Ex. E, p. 1) The April 4, 2009 physician's medical certification contains diagnoses of knee pain and type II diabetes. (Ex. E, p. 19) The Claimant reported additional conditions of arthritis, hypertension, obesity, shortness of breath, back pain resulting from an injury, right leg sciatica, neuropathy and numbness in both hands, edema in both ankles and feet, and a prior small stroke. (Ex. E, p. 1)

2. Claimant applied for Medicaid assistance under the HCB Waiver program. Claimant was assessed for HCB Waiver eligibility on February 5, 2009. (Ex. E, p. 1) The person who conducted the assessment was [redacted], a registered nurse. *Id.* The Claimant and her husband were present for the assessment. *Id.*

3. The February 5, 2009 HCB Waiver assessment (Consumer Assessment Tool) scored the claimant with a "0" and found she did not qualify for HCB Waiver services. (Ex. E, p. 15) Specifically, the assessment found that as of February 5, 2009:

   a. The Claimant did not require any professional nursing services. (Ex. E, p. 6)

   b. The Claimant did not receive any therapies (physical therapy, speech therapy, occupational therapy or respiratory therapy). (Ex. E, p. 6)

   c. The Claimant did not require any special treatments or therapies. (Ex. E, p. 6)

   d. The Claimant did not experience memory problems. (Ex. E, p. 6)

   e. The Claimant did not exhibit any problem behaviors. (Ex. E, p. 7)

   f. The Claimant was able to turn and reposition herself in bed (bed mobility) albeit with difficulty. (Ex. E, p. 3) She received a self performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. E, pp. 3, 7)

   g. The Claimant had difficulty moving (transferring) herself to and from a bed, couch, chair, etc; she required physical assistance to transfer. (Ex. E, pp. 3) She received a self performance code of 3 (extensive assistance

required) and a support code of 2 (one person physical assistance) in this category. (Ex. E, pp. 3, 7)

h. The Claimant used a cane to walk (locomotion) in the home and a walker outside the home. (Ex. E, p. 3) Standing and walking were difficult and painful for her. *Id.* She received a self performance code of 2 (limited assistance required) and a support code of 2 (one person physical assistance) in this category. (Ex. E, pp. 3, 7)

i. The Claimant was not able to dress herself without hands on physical assistance. (Ex. E, p. 4) She received a self performance code of 3 (extensive assistance required) and a support code of 2 (one person physical assistance) in this category. (Ex. E, pp. 4, 7)

j. The Claimant did not require any hands on assistance with eating. (Ex. E, p. 4) She did need help with cutting up her food. *Id.* She received a self performance code of 0 (independent) and a support code of 1 (setup assistance) in this category. (Ex. E, pp. 4, 7)

k. The Claimant required physical assistance with transferring and personal hygiene when using the toilet. (Ex. E, p. 4) She received a self performance code of 3 (extensive assistance required) and a support code of 2 (one person physical assistance) in this category. (Ex. E, pp. 4, 7)

l. The Claimant required some assistance with personal care needs. (Ex. E, p. 4) She received a self performance code of 2 (limited assistance required) and a support code of 2 (one person physical assistance) in this category. (Ex. E, pp. 4, 7)

m. The Claimant required physical assistance with transferring in and out of the shower, bathing and drying herself. (Ex. E, p. 4) She received a self performance code of 3 (extensive assistance required) and a support code of 2 (one person physical assistance) in this category. (Ex. E, pp. 4, 7)

4. On February 19, 2009, [redacted], a registered nurse employed by the Division, reviewed the February 5, 2009 assessment and compared it to the factors listed in the State of Alaska *Manual for Prior Authorization of Long Term Care Services* in order to determine whether the Claimant qualified for HCB Waiver services. She checked a form box that stated the Claimant required "[a]ssistance with [activities of daily living]." (Ex. D, p. 5) She provided comments that the Claimant required extensive assistance with transfers, toileting, bathing, and dressing, and limited assistance with locomotion. *Id.* [redacted] did not find any of the other factors to be present, including a need for direct nursing services, or a need to control behavioral problems. (Ex. D, pp. 4 – 5)

5. The Claimant has had her ability to participate in day to day activities severely limited since she had a fall in 2006. (Claimant testimony) It is difficult and painful for her to stand or walk even for short periods of time. (Claimant testimony) She is currently receiving Personal Care Assistant (PCA) services. (Claimant testimony)

6. The Claimant's pastor and other persons witnessed the Claimant having difficulty walking up and down stairs, having difficulty transferring in and out of a vehicle, and experiencing severe pain while sitting. (Ex. F, pp. 9 – 10)

7. The Claimant's husband witnessed the Claimant having severe pain with walking and standing, and difficulties with transferring, dressing, showering, and performing household tasks. (Ex. F, pp. 11 - 12)

8. The Social Security Administration found the Claimant was disabled, under Social Security rules, effective July 26, 2007. (Ex. F, p. 23)

9. The Claimant's physician prescribed physical therapy exercises for her, 7 days per week, on March 6, 2009. (Ex. F, p. 25) On April 29, 2009, the Claimant's physician wrote that the Claimant needed to "attend Physical Therapy and Rehab. 5 days per week and she also needs to go to Water Aerobics on Mondays and Wednesday." (Ex. G, p. 1)

PRINCIPLES OF LAW

This case involves the denial of an application for benefits. When an application is denied, the applicant has the burden of proof[2] by a preponderance of the evidence.[3]

An adult between the ages of 21 and 65, with physical disabilities, who requires "a level of care provided in a nursing facility" is entitled to receive Medicaid Home and Community Based Waiver services. 7 AAC 43.1010(d)(1)(B) and (d)(2).[4] Pursuant to 7 AAC 43.1010(d)(2), the Division is required to perform a level of care assessment under 7 AAC 43.1030(b):

> If the assessment is to determine if the applicant falls within the recipient category for

[2] "Ordinarily the party seeking a change in the status quo has the burden of proof." *State, Alcohol Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985)

[3] Preponderance of the evidence is defined as follows:

> Evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not.

Black's Law Dictionary 1064 (5th Ed. 1979)

[4] There are other eligibility criteria, however, those are not at issue in this case. *See* 7 AAC 43.1010(a) and (b).

* * *

(2) adults with physical disabilities or older adults, the

(A) Department will make a determination to determine whether the applicant requires skilled care under 7 AAC 43.180 or intermediate care under 7 AAC 43.185; and

(B) level of care determination under (A) of this paragraph must incorporate the results of the department's *Consumer Assessment Tool (CAT),* revised as of 2003 and adopted by reference.

7 AAC 43.1030(b).

State Medicaid regulation 7 AAC 43.180 defines skilled level of care as follows:

> (a) Skilled care is characterized by the need for skilled nursing or structured rehabilitation ordered by and under the direction of a physician; these services must be provided either directly by or under supervision of qualified technical or professional personnel, who must be on the premises at the time service is rendered; e.g., registered nurse, licensed practical nurse, physical therapist, licensed physical therapy assistant, occupational therapist, certified occupational therapy assistant, speech pathologist, and audiologist.

7 AAC 43.185 defines intermediate level of care as follows:

> (a) Intermediate care is characterized by the need for licensed nursing services ordered by and under the direction of a physician, provided in a certified ICF and not requiring care in a hospital or SNF.
> (d) Intermediate care may include therapy provided by an aide or orderly under the supervision of licensed nursing personnel or a therapist.

The acronyms "ICF" and "SNF" contained in 7 AAC 43.185 respectively refer to intermediate care facility and skilled nursing facility.

The Consumer Assessment Tool (CAT), referenced in 7 AAC 43.1030(b)(2)(B), is used to determine whether an applicant requires either skilled care or intermediate care. The CAT performs this determination by assessing an applicant's needs for professional nursing services, for therapy provided by a qualified therapist, for special treatments (chemotherapy, radiation therapy, hemodialysis, peritoneal dialysis), and whether or not an applicant experiences impaired cognition, or problem behaviors. (Ex. E, pp. 6 - 8)

The CAT only assesses an applicant based on their conditions and needs for the 7 day time period immediately preceding the assessment date. (Ex. E, pp. 6 - 8) Each of assessed items is given a numerical score. For instance, if an individual required 5 days or more of therapies (physical, speech/language, occupation, or respiratory therapy) per week, she would receive a score of 3. (Ex. E, p. 15)

The CAT also assesses the degree of assistance an applicant requires for activities of daily living (ADL), which specifically include bed mobility (moving within a bed), transfers (i.e. moving from the bed to a chair, or a couch, etc.), locomotion (walking), eating, and toilet use, which includes transferring on and off the toilet. (Ex. E, p. 7) These are broken down into self-performance codes and support codes as explained below:

The self-performance codes rate how capable a person is of performing a particular ADL:

0 Independent, no help/oversight, or help/oversight provided two times or less during the last seven days.
1 Supervision, which consists of encouragement/oversight/encouragement provided three or more times during the last seven days plus non-weight bearing physical assistance provided one or two times during the last seven days.
2 Limited Assistance, which consists of non-weight bearing physical assistance three or more times during the last seven days, or limited assistance plus weight bearing assistance one or two times during the last seven days.
3 Extensive Assistance, which consists of weight bearing support three or more times during the past seven days, or the caregiver provides complete performance of the activity during a portion of the past seven days.
4 Total Dependence, which consists of the caregiver performing the activity for the applicant during the entire previous seven day period.
5 Cueing, which is spoken instruction or physical guidance for a particular activity required seven days per week.
8 Activity did not occur during the previous seven days.

The support codes rate the amount of assistance a person receives for each ADL:

0 None.
1 Setup assistance only.
2 One person physical assistance.
3 Physical assistance from two or more people.
5 Cueing required seven days per week.
8 Activity did not occur during the previous seven days.

(Ex. E, p. 7)

If an individual receives a self-performance code of 3 (extensive assistance required) or 4 (total dependence) in 3 or more of 5 specified activities of daily living (bed mobility, transfer, locomotion, eating, and toileting), the Claimant receives a score of 3 on the CAT. (Ex. E, pp. 7, 15) Alternatively, a person can receive points for combinations of required nursing services, therapies, impaired cognition (memory/reasoning difficulties), or difficult behaviors (wandering, abusive, etc), and required assistance with the 5 specified activities of daily living. (Ex. E, p. 15)

The results of the assessment portion of the CAT are then scored. If an applicant's score is a 3 or higher, the applicant is medically eligible for Waiver services. (Ex. E, p. 15)

In addition to use of the CAT in its determination of an applicant's level of care, the Agency is also required to consider the factors contained in the *Manual for Prior Authorization of Long Term Care Services*: [5]

> The division or the division's designee will make a level-of-care evaluation in accordance with the guidelines established in the Criteria for Placement section of the *Manual for Prior Authorization of Long Term Care Services*, prepared by the division of medical assistance, as revised October 1993, and adopted by reference. The division will make the final level-of-care decision based upon that evaluation.

7 AAC 43.190. *See Bogie v. State, Division of Senior and Disabilities Services*, Superior Court Case No. 3AN-05-10936 (Decision dated August 22, 2006); *Casey v. State, Dept. of Health & Social Services, Division of Senior and Disabilities Services*, Superior Court Case No. 3AN-06-6613 (Decision dated July 11, 2007).

ANALYSIS

The Claimant's position is that the February 5, 2009 Consumer Assessment Tool (CAT) wrongly assessed the Claimant's level of care. Because this is an application, the Claimant has the burden of proof by a preponderance of the evidence.

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[5] The *Manual* contains two sets of factors. The Skilled Level of Care factors are: 1) whether a patient requires 24 hour observation and assessment by a registered nurse or licensed practical nurse; 2) whether a patient requires intensive rehabilitative services, which is defined as 5 days or more per week of physician ordered physical, occupational, respiratory or speech therapy; 3) whether a patient requires 24 hour performance of direct services that must be furnished by a registered nurse, licensed practical nurse or someone acting under their supervision; 3) does the patient require medications that are administered either intravenously or by naso-gastric tube; 4) does the patient have a colostomy-ileostomy; 5) does the patient have a gastrostomy; 6) is the patient on oxygen; 7) does the patient have a tracheostomy; 8) is the patient undergoing either radiation therapy or cancer chemotherapy; 8) does the patient have sterile dressings that require prescription medication; 9) does the patient have decubitus ulcers; or 10) does the patient have unstabilized medical conditions requiring skilled nursing, such as a new stroke, new fractured hip, new amputation, being in a coma, terminal cancer, new heart attack, uncompensated congestive heart failure, new paraplegia or quadriplegia. (Ex. D, pp. 4 – 5)

The Intermediate Level of Care factors are: 1) whether a patient requires 24 hour observation and assessment by a registered nurse or licensed practical nurse; 2) whether a patient requires restorative services, which include encouraging, assisting or supervising the patient in self-care, transfers, ambulation, positioning and alignment, range or motion, handrail use; 3) does the patient require a registered nurse to perform services; 4) does the patient require assistance with activities of daily living, including maintaining Foley catheters, ostomies, special diet supervision, or skin care with incontinent patients; 5) does the patient have a colostomy-ileostomy; 6) does the patient require either radiation or chemotherapy treatment; 6) does the patient have skin conditions such as decubitus ulcers, minor skin tears, abrasions, or chronic skin conditions; 7) is the patient a diabetic who needs daily supervision of diet or medications; or 8) does the patient have behavioral problems such as wandering, verbal disruptions, combativeness, verbal or physical abusiveness, or inappropriate behavior. (Ex. D, p. 5)

A HCB Waiver services eligibility determination is based upon an assessment performed by the Division or its designee. 7 AAC 43.1010(d)(2). The CAT is the assessment tool used in determining whether an applicant satisfies the regulatory requirement that an applicant requires either skilled care or intermediate care. 7 AAC 43.1030(b)(2)(B). Eligibility for HCB Waiver services is therefore based on the CAT. Because the CAT itself only measures an applicant's physical condition and need for services for a specified period of time, the 7 day time period immediately preceding and including the date of the assessment, eligibility for HCB Waiver services is based solely on their physical condition and need for services at that limited time period, the 7 day time period immediately preceding and including the date of the assessment.

This Decision requires a review of the February 5, 2009 CAT, and the hearing evidence to determine whether there is sufficient evidence showing the Claimant met the necessary medical level of care as of the date of the February 5, 2009 assessment. Neither the discussion portion of the CAT nor the scored areas of the CAT show any requirement for professional nursing care or special treatments or therapies as of the date of the assessment. Nor does the CAT show that the Claimant experienced any impaired cognition or behavioral problems as of the date of the assessment. The Claimant presented no testimony or evidence contradicting the CAT's rating of her level of care.

After the February 5, 2009 CAT was performed, the Claimant obtained two prescriptions for therapy. On March 9, 2009, the Claimant was prescribed physical therapy exercises 7 days per week. *See* Finding of Fact 9 above. The Claimant also presented an April 29, 2009 physician's statement that she required physical therapy and rehabilitation therapy 5 days per week. *See* Finding of Fact 9 above. If the Claimant had been prescribed 5 days or more of physical therapy as of the date of her February 5, 2009 assessment, she may have qualified for HCB Waiver services. Because these therapies were prescribed after the February 5, 2009 assessment, they do not invalidate the February 5, 2009 CAT's finding the Claimant did not require therapies as of the date of the February 5, 2009 CAT.

An applicant may also qualify for HCB Waiver services solely based on her need for assistance with her activities of daily living. In order to do so, the Claimant would have to require extensive assistance (self performance code of 3) or be totally dependent (self performance code of 4) for three or more of five specified activities of daily living (bed mobility, transfers, locomotion, eating, and toilet use) (Ex. E, pp. 7, 15) The February 5, 2009 assessor found the Claimant required either extensive assistance or was totally dependent in 2 of these specified activities of daily living, transferring and toilet use. *See* Finding of Fact No. 2(g) and (i) above.

The evidence presented by the Claimant did not establish that the Claimant needed extensive assistance (physical hands on weight bearing assistance) or was totally dependent in any of the other 3 specified activities of daily living (bed mobility, locomotion, and eating), merely that the Claimant had difficulty and experienced pain with regard to bed mobility and locomotion, and was independent in eating with some setup help. *See* Finding of Fact No. 2(f), (h), and (j).

While the Claimant was assessed as requiring extensive assistance in both dressing and bathing (Finding of Fact No. 2(i) and (m)), neither of these items are among the 5 activities of daily living used to determine HCB Waiver eligibility. The Claimant did not meet her burden of proof by a preponderance of the evidence to establish she required either extensive assistance, or was totally dependent, for 3 or more of the specified activities of daily living (bed mobility, locomotion, transfers, eating, and toileting).

A review of the *Manual for Prior Authorization of Long Term Care Services* demonstrates the only factor[6] that could have potentially qualified the Claimant for HCB Waiver services, as of her February 5, 2009 assessment, was her need for physical assistance with activities of daily living. However, as is discussed above, her needs for physical assistance with her activities of daily living are not sufficient to qualify her for HCB Waiver services.

The Claimant also presented evidence that the Social Security Administration had determined she was disabled under Social Security rules. The Alaska rules for HCB Waiver eligibility do not take Social Security disability rulings into account, only the scoring contained in the CAT and the factors contained in the *Manual for Prior Authorization of Long Term Care Services.* Her Social Security disability status is not relevant to this Decision.

The Claimant had the burden of proof in this case. She did not establish either that the February 5, 2009 CAT was not correct or that she qualified for HCB Waiver services based upon the factors contained in the *Manual for Prior Authorization of Long Term Care Services.* Consequently, she did not satisfy her burden of proof as to her qualification for HCB Waiver services at the time of the February 5, 2009 assessment.

In summary, the Claimant did not qualify for HCB Waiver services when she was assessed. The Division was correct when it denied the Claimant's application for HCB Waiver services, based upon the February 5, 2009 assessment.

CONCLUSIONS OF LAW

1. The Claimant failed to meet her burden of proof by a preponderance of the evidence and failed to demonstrate she required either a skilled nursing facility or intermediate care facility level of care as of February 5, 2009, the date she was assessed to determine her eligibility for Medicaid Home and Community Based Waiver services.

2. The Claimant therefore did not qualify for Medicaid Home and Community Based Waiver services.

[6] *See* fn. 5 above for a list of the factors.

DECISION

Based upon a preponderance of the evidence, the Agency was correct to deny the claimant's application for Medicaid Home and Community Based Waiver services on February 24, 2009.

APPEAL RIGHTS

If for any reason the Claimant is not satisfied with this decision, the Claimant has the right to appeal by requesting a review by the Director. To do this, send a written request directly to:

Director of the Division of Senior and Disabilities Services
Department of Health and Social Services
PO Box 110680
Juneau, AK 99811-0680

If the Claimant appeals, the request must be sent within 15 days from the date of receipt of this Decision. Filing an appeal with the Director could result in the reversal of this Decision.

DATED this __ day of July 2009.

Larry Pederson
Hearing Authority

CERTIFICATE OF SERVICE
I certify that on this __ day of July 2009, true and correct copies of the foregoing were sent to:
Claimant via USPS First Class Certified Mail, Return Receipt Requested.
And to the following by email:
[redacted], Hearing Representative
[redacted], Director
[redacted], Policy & Program Development
[redacted], Policy & Program Development
[redacted], Staff Development & Training

_____
Al Levitre, Law Office Assistant I