Office of Hearings and Appeals
3601 C Street, Suite 1322
P. O. Box 240249
Anchorage, AK 99524-0249
Phone: (907) 334-2239
Fax: (907) 334-2285

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

In the Matter of:	)	
	)	
[redacted],	)	OHA Case No. 10-FH-2006
	)	
Claimant.	)	DPA Case No. [redacted]
	)	
	)	

FAIR HEARING DECISION

STATEMENT OF THE CASE

[redacted] (Claimant) applied for Medicaid benefits under the Home and Community-Based Waiver Services Program (hereafter "HCBW"). [1] On January 27, 2010 the State of Alaska Division of Senior and Disabilities Services (DSDS or Division) mailed a notice to the Claimant stating that her application had been denied (Ex. D). The Claimant requested a fair hearing contesting the denial on January 28, 2010 (Ex. C).

This Office has jurisdiction to decide this case pursuant to 7 AAC 49.010.

Hearings were held in this case on March 24, April 7, and June 2, 2010 before Hearing Examiner Jay Durych. The Claimant was represented by [redacted], Esq. of the Disability Law Center of Alaska, who attended each hearing in-person. The Division was represented by Assistant Attorney General [redacted], Esq. of the State of Alaska Department of Law, Attorney General's Office. She attended the March 24 hearing in person and participated by telephone in the hearings of April 7 and June 2, 2010.

The Claimant attended the March 24 and June 2, 2010 hearings in person and testified on her own behalf. [redacted], R.N. testified by telephone on behalf of the Claimant at the hearing of March 24, 2010. [redacted], R.N. of DSDS attended the April 7, 2010 hearing in person and testified on behalf of the Division. Dr. [redacted], M.D. testified by telephone on behalf of the Claimant at the hearing of April 7, 2010. [redacted], R.N. of DSDS testified by telephone on behalf of the Division at the hearing of June 2, 2010. The witnesses' testimonies were received and all

[1] Although the record does not appear to reflect the exact date of the Claimant's application, the specific application date is not required for the resolution of this matter.

exhibits submitted were admitted into evidence. At the end of the hearing the record was closed except for submission of post-hearing briefs. [2]

The parties' opening post-hearing briefs were filed on June 25, 2010. The parties' post-hearing reply briefs were filed on July 9, 2010. Following completion of this post-hearing briefing, the record was closed and the case became ripe for decision.

ISSUE

Was the Division correct when on January 27, 2010 it denied the Claimant's application for Medicaid Home and Community-Based Waiver Services based on the assertion that, as of the date of her assessment, the Claimant did not require a nursing facility level of care?

SUMMARY OF DECISION

As of the date of her assessment on December 7, 2009, the Claimant did not require either a skilled nursing facility level of care or an intermediate nursing facility level of care. Accordingly, the Division was correct when on January 27, 2010 it denied the Claimant's application for participation in the Medicaid Home and Community-Based Waiver Services Program.

FINDINGS OF FACT

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

1. The Claimant is a 57 year old woman (date of birth [redacted], 1953) (Ex. E-1). At the time of her assessment she lived alone in [redacted], Alaska. *Id.*

2. On September 23, 2009 the Claimant's physician completed DSDS' Medical Certification Form (Ex. F-3). The Claimant's primary diagnoses were listed as lung cancer, brain tumor, factor X 1 bleeding disorder, and severe fibromyalgia. *Id.* The form also listed secondary diagnoses of elevated liver enzymes and diabetes. *Id.*

3. Based on the record as a whole, the Claimant's primary diagnoses include (a) lung cancer, (b) a brain tumor or lesion which is suspected to be a glioma, (c) Factor X1 bleeding disorder, (d) severe fibromyalgia, (e) posttraumatic brain injury from a motor vehicle accident in 1990, (f) anemia, (g) peripheral neuropathy, (g) chronic pain, (h) hypertension, (i) hypercholesterolemia, (j) diabetes in remission; (k) monoclonal gammopathy, (l) cervical foraminal stenosis, (m) chemical sensitivities, and (n) food allergies. The Claimant's secondary diagnoses include abnormal/elevated liver enzymes, GERD, adrenal insufficiency, bleeding, chronic fatigue, migraines, and depression (Ex. E-3; testimony of [redacted] and [redacted]).

4. The Claimant applied for Medicaid assistance under the HCBW Program (undisputed fact). The Claimant was assessed for HCBW Program eligibility on December 7, 2009 (Ex. E-1). The person who conducted the assessment was [redacted], a registered nurse employed by DSDS. *Id.* Only the Claimant and Mr. [redacted] were present for the assessment; a friend of the Claimant left immediately before the start of the assessment (Ex. E-2; [redacted] testimony).

[2] The Claimant's post-hearing briefing was submitted by [redacted], Esq. of the Disability Law Center of Alaska. This Office appreciates the time and effort invested by both sides in the hearing and briefing of this matter.

5. Mr. [redacted] completed a Consumer Assessment Tool or "CAT" based on the HCBW assessment her performed on December 7, 2009 (Exs. E-1 – E-31; [redacted] testimony). He scored the claimant with a "1" and found that she did not qualify for HCBW Program services (Ex. E-29, E-30). Specifically, his assessment found that, as of December 7, 2009:

a. The Claimant had no cognitive problems (Ex. E-4).

b. The Claimant did not require any therapies provided by a qualified therapist (physical therapy, speech therapy, occupational therapy or respiratory therapy) (Ex. E-5).

c. The Claimant had no prescriptions requiring hands-on assistance from a Personal Care Assistant (PCA) (Ex. E-5).

d. The Claimant was able to turn and reposition herself in bed (bed mobility) albeit with pain (Ex. E-6). She received a self performance code of 0 (independent) and a support code of 0 (none required) in this category (Ex. E-6).

e. The Claimant rarely had difficulty moving (transferring) herself to and from a bed, couch, chair, etc; she rarely needed physical assistance to transfer (and needed no such assistance within the 7 days prior to the assessment) (Ex. E-6). She received a self performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Ex. E-6).

f. The Claimant did not need to use a cane, walker, or wheelchair to get around, and she had not fallen within the past 6 months (Ex. E-7). However, the Claimant had difficulty standing long enough to prepare full meals. *Id.* She received a self performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Ex. E-7).

g. The Claimant was able to dress herself with no assistance (Ex. E-8). She received a self performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Ex. E-8).

h. The Claimant did not require any hands on assistance with eating (Ex. E-9). She received a self performance code of 0 (independent – no assistance required) and a support code of 0 (no assistance required) in this category (Ex-9).

i. The Claimant required no physical assistance with transferring or personal hygiene when using the toilet (Ex. E-9). She received a self performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Ex. E-9).

j. The Claimant performed her own personal care / hygiene, with the caveat that sometimes a friend would help with toenail care (Ex. E-10). She received a self performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Ex. E-10).

k. The Claimant generally required no physical assistance with bathing, although sometimes she would wait to shower until a friend was available to wait outside in case she fell (Ex. E-11). She had required no hands-on assistance in the 7 days prior to the assessment. *Id.*

She received a self performance code of 1 (supervision – oversight help only) and a support code of 0 (no assistance required) in this category (Ex. E-11).

l. The Claimant required help with her medications once a day each day (Ex. E-12).

m. The Claimant did not require any professional nursing services (Ex. E-13, E-14).

n. The Claimant required no special treatments or therapies, (although the assessor gave the Claimant a score of 2 in this category for assistance with medications three (3) or more times per week - see Exs. E-12, E-15).

o. The Claimant did not experience memory problems. (Ex-16).

p. The Claimant did not exhibit any problem behaviors (Ex. E-17).

q. The Claimant had no problems with hearing, speaking, or seeing, other than the need to wear glasses or contact lenses to correct her vision (Ex. E-22).

r. The Claimant had no nutritional problems other than food allergies (Ex. E-23). The Claimant had no incontinence problems. *Id.* The Claimant had no balance problems. *Id.*

s. The Claimant had no skin problems or pressure ulcers (Ex. E-24). However, she had lost some of her natural teeth, and she had someone else inspect her feet on a regular basis. *Id.*

t. There were no problems with regard to the habitability of the Claimant's apartment (Ex. E-24). However, the Claimant did have some problems with her mood and sleep (Ex. E-25).

u. The Claimant needed help with many of her Instrumental Activities of Daily Living (IADLs) (Ex. E-26). Specifically, she needed help with meal preparation, light housework, routine housework, laundry, grocery shopping. *Id.* She also needed transportation. *Id.*

6. On January 26, 2010 [redacted], a registered nurse employed by the Division, reviewed the December 7, 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 HCBW Program services Ex. F-1, F-2; [redacted] testimony. Ms. [redacted] did not find any factors indicating that the Claimant required a skilled level of nursing care (Ex. F-1). Ms. [redacted] found only one (1) factor (assistance with medications), out of the total of 11 factors indicating that the Claimant required an intermediate level of nursing care (Ex. F-2).

7. At the hearing of March 24, 2010 the Claimant credibly testified in relevant part as follows:

a. Her lung cancer was diagnosed in June 2009. The treatment options given to her were (a) chemotherapy; (b) radiation therapy; (c) a combination of surgery, chemotherapy, and radiation therapy; or (d) to do nothing.

b. She decided not to undergo surgery because of her bleeding problem. She decided not to undergo chemotherapy because she has multiple chemical sensitivities and she was afraid the chemotherapy itself might kill her.

c. She had made the decision to undergo radiation treatment before her assessment. However, she does not remember if she told the assessor that she was planning to undergo radiation treatment. She has not been able to actually begin radiation treatment yet because she is not able to regularly access treatment.

d. She does not believe she was undergoing Vitamin C infusion treatment at the time of her assessment.

e. She told the assessor that she loses her balance and that she has trouble holding things because of her peripheral neuropathy in her feet and hands.

f. Aside from the peripheral neuropathy, her diabetes is fairly well controlled because she carefully regulates her diet and regularly takes her medications. She does not currently take insulin.

g. Her friend picks up her medications at the pharmacy and makes-up her medi-sets for her. Then, she is able to take her medications by herself.

h. Her pain is "way past 10;" it is "off the scale." She has nausea constantly ("24/7"). She sometimes has to cancel her doctor appointments due to her pain and nausea. She takes Zofran for her nausea when it becomes really bad. However, she uses it sparingly. She was not taking Zofran at the time of her assessment.

i. She has a card that she keeps with her that lists her medical problems. She uses it because otherwise she cannot remember all of her medical problems.

j. She does not use a cane or a walker. She dresses herself. Some days she can perform morning hygiene herself, but some days she needs assistance with all hygiene tasks. She needs help with cooking, cleaning, laundry, shopping, and transportation to and from her medical treatments. She has a friend whom is sometimes able to assist her, but the friend is disabled himself, so the amount of assistance he is able to provide is limited.

k. She qualifies for Personal Care Assistance (PCA) services. However, she has not had a PCA since the spring or summer of 2009 because she has not been able to find a PCA to provide services who she feels would be trustworthy.

l. She would like to have an IV port implanted so that she does not need to have her skin pierced with needles so often. However, she does not know for certain whether this would be workable because of her bleeding disorder.

8. At the hearing of March 24, 2010 [redacted], R.N. credibly testified in relevant part that:

a. She has been a nurse since 1967. She is nationally certified in geriatric nursing. She was involved in discharge planning for Providence Extended Care circa 1986 – 2001. She has previously performed assessments for PCA services herself while working for one of the Division's private contractors circa 2002 – 2003.

b. She is employed at the medical offices of Dr. [redacted], M.D. ([redacted]). The Claimant has been a patient there since 2006.

c. The Claimant was first diagnosed with cancer in May 2009. Dr. [redacted]'s office has treated the Claimant's lung cancer with high-dose vitamin C infusions / IVs.

d. As of the date of the March 24, 2010 hearing, the Claimant had agreed / decided to undergo radiation treatment. However, she had not actually begun radiation treatment at that time.

e. The extent of the pain caused by fibromyalgia varies widely from individual to individual and (for the same individual) from day to day. The treatment for fibromyalgia generally involves treating the pain.

f. The Claimant virtually always has a headache and is virtually always in pain. The Claimant also often has nausea, which makes it hard for her to eat enough to maintain weight.

g. The Claimant is currently trying to control her diabetes through diet; she is not currently taking medication for it.

h. The Claimant's doctors wish to operate on her spine to try to eliminate her neck pain. However, they need to wait until her cancer stabilizes to operate.

i. The Claimant is not currently receiving all of the cancer treatments that she should be receiving. She also needs transportation to her doctor appointments.

j. When a person has multiple diagnoses (like the Claimant), it is much harder for a nurse to manage the person's symptoms.

k. The Claimant is not currently receiving intermediate level nursing care as defined by the Manual factors. However, were it available to her, she could use the following intermediate level care: (i) an IV line for pain meds, monitored by a nurse; (ii) monitoring by a nurse for evidence of adequate hydration, constipation, bleeding, and adverse drug interactions; and (iii) monitoring for swollen lymph nodes at such time as she begins receiving radiation therapy.

l. She believes that, on the Claimant's worst days, the Claimant should be in a nursing facility.

9. At the hearing of April 7, 2010 Dr. [redacted], M.D. credibly testified in relevant part that:

a. She graduated from medical school at the University of Tennessee in Memphis in 1971. She has practiced, and is Board Certified in, emergency medicine. Her current practice is a general and family practice focusing on alternative medicine. She typically sees 8-15 patients per day.

b. The Claimant is one of her patients. She has treated the Claimant since August 2006.

c. Because of the Claimant's bleeding disorder, she is not a good candidate for surgery for her lung cancer and/or cervical spinal problems.

d. The cancerous portion of the Claimant's lung is growing and has been growing since before the date of the Claimant's level of care ("LOC") assessment. It is therefore vital for the Claimant to have radiation therapy.

e. The Claimant was scheduled to begin receiving radiation treatments in December 2009, prior to the date of the LOC assessment. However, the Claimant was not able to actually start the radiation treatments at that time because of a lack of transportation. The Claimant was not able to get to Dr. [redacted]'s office from December 17, 2009 until March 22, 2010 due to a lack of transportation.

f. She has treated the Claimant's cancer with Vitamin C infusion therapy and alpha lipoic acid (Vitamin B) infusion therapy. The infusion is given over a two hour period. One must be a registered nurse (RN) or a licensed practical nurse (LPN) with the necessary certifications, in order to start an IV.

g. The Claimant could probably receive her Vitamin B and C infusion therapies at home if she had a nurse monitoring the procedure. Dr. [redacted] could write a prescription for these home infusions. The Claimant would need the infusions twice a week.

h. Because of the Claimant's bleeding disorder, it would be beneficial to have an IV port implanted on the Claimant for the administration of IV infusions. This would need to be monitored by a nurse.

i. In her opinion it would be appropriate to have a nurse monitoring the Claimant for hydration, for the effectiveness of her pain medications, when administering any IVs / infusions, and (if under radiation therapy), monitoring the skin for burns. She would also like a nurse to be putting together the Claimant's medi-sets.

j. The Claimant is not currently taking pain medications. Dr. [redacted] has tried to get the Claimant into 2-3 different pain clinics, but they have refused her as a patient.

k. Dr. [redacted] has made prior nursing home referrals. She believes that the Claimant is "getting close to the point where she would need to be institutionalized," but that she did not require a nursing level of care as of the date of the hearing . She believes that the Claimant would enjoy a better quality of life if she could receive nursing services in her home.

l. The Claimant's diagnoses are very serious and her prognosis is guarded. She has lost 60 pounds over the last year.

10. At the hearing of June 2, 2010 [redacted], R.N. credibly testified in relevant part as follows:

a. He is a registered nurse with a bachelor's degree ("BSN"). He obtained his degree in 1975 and has worked as a nurse since that time (for 35 years).

b. He has received training through the Division on how to conduct LOC assessments. He has been performing assessments for Waiver Services since November 2007. He performed the Claimant's LOC assessment.

c. When he conducts an assessment he asks the claimant regarding his or her condition over the past 7 days and over the past 1 year. He makes his assessments based primarily based on a claimant's answers to his questions, and based on his observation of the claimant during the assessment.

d. He considers the physician's statement regarding a claimant's ability to perform daily activities. However, he also makes his own determination based on the information he gathers during the assessment.

e. When a claimant says that he or she has good days and bad days, he asks the Claimant to tell him how many bad days he or she typically has per week. This would impact his scoring of the claimant on the CAT.

f. When he conducted the Claimant's in-person assessment, he and the Claimant were the only persons present – a friend of the Claimant was just leaving as he arrived. He may have also spoken to the Claimant's Care Coordinator. He did not speak to the Claimant's doctors.

g. Although he noted on his assessment that the Claimant reported that she would be *starting* Vitamin C infusion therapy, he did not give that factor much weight in his assessment because the Claimant had not actually *begun* the treatment as of the assessment date. He does not think that the regulations allow him to consider future events that have not happened yet.

h. The Claimant told Mr. [redacted] that she might have radiation treatment in the future, but that she was not currently undergoing it. He did not give this factor much weight in his assessment because the Claimant had not actually *begun* radiation treatment as of the assessment date, and he does not think that the regulations allow him to consider future events.

i. Mr. [redacted] gave the Claimant one (1) point in her assessment for preparation of her medi-sets. *See* Ex. E-15 at Section B(1)(j). He awarded this point even though he felt the preparation of the Claimant's medi-set was not necessary (i.e. that she could do it herself), and even though he felt that preparation of a medi-set is not a nursing care function.

11. At the hearing of April 7, 2010 [redacted], R.N. credibly testified in relevant part that:

a. She has been an RN for 35 years. She has been employed by DSDS for the last 5 years. She makes LOC and PCA determinations. She also teaches other nurses how to perform LOC assessments.

b. She performed and signed the Claimant's assessment review (Exs. F-1 and F-2). She reviewed the Claimant's CAT and spoke to the assessor, to the Claimant, and to the Claimant's physician (Dr. [redacted]), prior to making her LOC determination.

c. She was concerned about the Claimant's medication management. Dr. [redacted] was concerned about the Claimant's ability to get to her doctor appointments, and about the Claimant being home alone on her bad days. However, the Claimant told her at the time of the determination that she was independent except with regard to driving.

d. The Claimant's glioma is a cancer. However, based on the length of time that the Claimant has been diagnosed with it, and the Claimant's current condition, the glioma is not currently terminal. That is why she marked the "no" box at the bottom of page F-1.

e. The Claimant's CAT score would only be impacted by her receipt of Vitamin C IV infusions if she received them from a nurse three (3) or more times per week. The five (5) areas on the CAT that are considered in making the LOC analysis are listed on Ex. E-29.

f. Based on recent changes in the regulations, the Claimant qualifies to receive PCA services, and in particular escort services to facilitate transportation / travel to appointments. Such services would allow the Claimant to receive radiation and/or chemotherapy even on her bad days. However, the Claimant's choice of PCA providers would be limited because, at the time of her assessment and the hearings in this case, she lived "way out" of town.

g. She believes (and informed the Claimant) that the Claimant will make LOC in the long term. However, she does not feel that the Claimant met LOC as of the date of her assessment.

PRINCIPLES OF LAW

I. Burden of Proof and Standard of Proof.

This case involves the Division's denial of the Claimant's initial application for Choice Waiver services; the case does not involve the suspension, reduction, or termination of any previously existing Medicaid benefits. The party seeking a change in the status quo or existing state of affairs normally bears the burden of proof. [3] Because the Claimant seeks to change the status quo by obtaining benefits, the Claimant bears the burden of proof in this case.

The regulations applicable to this case do not specify any particular standard of proof. Therefore, the "preponderance of the evidence" standard is the standard of proof applicable to this case. [4] This standard is met when the evidence, taken as a whole, shows that the facts sought to be proved are more probable than not or more likely than not. [5]

II. The Medicaid Program – In General.

Medicaid was established by Title XIX of the Social Security Act in 1965 to provide medical assistance to certain low-income needy individuals and families. 42 USC § 1396 et. seq. Medicaid is a cooperative federal-state program that is jointly financed with federal and state funds. *Wilder v. Virginia Hospital Association,* 496 U.S. 498, 501, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990).

---

[3] *State of Alaska Alcoholic Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985).

[4] A party in an administrative proceeding can assume that preponderance of the evidence is the applicable standard of proof unless otherwise stated. *Amerada Hess Pipeline Corp. v. Alaska Public Utilities Commission*, 711 P.2d 1170 (Alaska 1986).

[5] *Black's Law Dictionary* at 1064 (West Publishing, 5th Edition, 1979); *see also Robinson v. Municipality of Anchorage*, 69 P.3d 489, 495-496 (Alaska 2003) ("Where one has the burden of proving asserted facts by a preponderance of the evidence, he must induce a belief in the minds of the triers of fact that the asserted facts are probably true").

Because Medicaid is a federal program, many of its requirements are contained in the Code of Federal Regulations (CFRs) at Title 42, Part 435 and Title 45, Part 233. The Medicaid program's general eligibility requirements are set forth at 42 CFR Sections 435.2 – 435.1102.

The State of Alaska's statutes implementing the federal Medicaid program are set forth at A.S. 47.07.010 – A.S.47.07.900. The State of Alaska's regulations implementing the Medicaid program are set forth in the Alaska Administrative Code at Title 7, Chapters 43 and Chapters 100 – 160.

III. The Medicaid Home and Community-Based Waiver Services Program – in General. [6]

As stated in 7 AAC 43.1000, "[t]he purpose of 7 AAC 43.1000 - 7 AAC 43.1110 [i.e. the Waiver Services regulations] is to offer a choice between home and community-based waiver services and institutional care in a nursing facility or ICF/MR to aged, blind, physically or developmentally disabled, or mentally retarded individuals who meet the eligibility criteria in 7 AAC 43.1010."

An adult between the ages of 21 and 65 who has physical disabilities is entitled to receive Medicaid Home and Community-Based Waiver Services if the person requires "a level of care provided in a nursing facility." 7 AAC 43.1010(d)(1)(B) and (d)(2). However, pursuant to 7 AAC 43.1010(b), "[h]ome and community-based waiver services are not available to an individual . . . (2) if the individual's need for home and community-based services, supports, devices, or supplies may be provided for entirely under 7 AAC 43.100 - 7 AAC 43.942" (which regulations include Personal Care Services and Home Care Services).

IV. Regulations Relevant to Level-of-Care Determinations Under The Medicaid Home and Community-Based Waiver Services Program.

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). That regulation, titled "Screening, Assessment, Plan Of Care, And Level Of Care Determination," provides in relevant part as follows:

> (b) If warranted by the screening under (a) of this section and supportive diagnostic documentation, and to determine if the applicant meets the level of care required under 7 AAC 43.1010(d)(2), the department will authorize the care coordinator to prepare a complete assessment of the applicant's physical, emotional, and cognitive functioning and need for care and services. If the assessment is to determine if the applicant falls within the recipient category for . . . (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;

---

[6] At the time of the Claimant's assessment on December 7, 2009, and at the time of the Division's notification of adverse action on January 27, 2010, the State of Alaska's Home and Community-Based Waiver Services Program was governed by regulations then set forth at 7 AAC 43.990 through 7 AAC 43.1110. However, on February 1, 2010 these regulations were repealed and reenacted (with changes) at 7 AAC 130.100 – 7 AAC 130.319.

The Division asserted at hearing and in its post-hearing briefing that the "old" regulations apply to this case. The Claimant did not take a position or dispute the Division's contention. Because the Claimant's application was filed on an unknown date *prior to* the effective date of the "new" regulations, and because the "old" regulations were still in effect at the time of the Claimant's assessment and at the time of the Division's denial notice, the "old" version of Alaska's Home and Community-Based Waiver Services Program regulations will be applied in this case.

> and (B) [the] 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.

The other Waiver Services regulations pertaining to level-of-care determinations are 7 AAC 43.1110 (10), 7 AAC 43.180, 7 AAC 43.185, and 7 AAC 43.190.

7 AAC 43.1110 (10) states in relevant part that "nursing facility" means a facility certified under 7 AAC 43.170 - 7 AAC 43.280 to provide services as a skilled nursing facility (SNF) or as an intermediate care facility (ICF) . . . ".

7 AAC 43.180, titled "Skilled Level of Care," provides 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 . . . .
>
> (b) Skilled nursing services are the observation, assessment, and treatment of a recipient's unstable condition requiring the care of licensed nursing personnel to identify and evaluate the recipient's need for possible modification of treatment, the initiation of ordered medical procedures, or both, until the condition improves to the point of stabilization.

7 AAC 43.185, titled "Intermediate Level of Care," provides 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. [7]
>
> (b) Intermediate nursing services are the observation, assessment, and treatment of a recipient with long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance rather than rehabilitation, or care for a recipient nearing recovery and discharge whose condition is relatively stable but who continues to require professional medical or nursing supervision.
>
> (c) Services provided in an ICF encompass a range from the skilled level to those above residential care as defined in 7 AAC 43.280.
>
> (d) Intermediate care may include therapy provided by an aide or orderly under the supervision of licensed nursing personnel or a therapist.

[7] The acronyms "ICF" and "SNF" contained in 7 AAC 43.185 refer to "intermediate care facility" and "skilled nursing facility," respectively. *See* 7 AAC 43.1110(10), set forth above.

7 AAC 43.190, titled "Determination of Level of Care," provides as follows:

> Whether a recipient's level-of-care needs are best met by skilled care or intermediate care is determined by considering the type of care required, the qualifications of the person necessary to provide direct care, and whether the recipient's overall condition is relatively stable or unstable. 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. Oral information may not be accepted to support a level-of-care decision.

V. The Consumer Assessment Tool (CAT).

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 assessment "covers the last 7 days and considers other health, medical, or functional needs since the last assessment and/or the previous 12 months" CAT at p. 2 (Ex. E-2).

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). Each of assessed items is given a numerical score (Ex. E).

The CAT also assesses the degree of assistance an applicant requires for activities of daily living (ADLs), 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.18). The degree of assistance required is quantified using self-performance codes and support codes as explained below:

The *self-performance codes* rate how capable a person is of performing a particular ADL (Ex. E, p.18):

> 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 (Ex. E, p.18):

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.

The results of the nursing facility assessment portion of the CAT are then scored (Ex. E p. 29). If an applicant's score is 3 or higher, then the CAT instructs that the applicant "appears to be medically eligible for [a nursing facility] level of care" (Ex. E, p. 29).

VI. The Manual for Prior Authorization of Long Term Care Services.

In determining an applicant's required level of care, the Division is required to consider, *in addition to the applicant's CAT score*, the factors contained in the Criteria for Placement section of the *Manual for Prior Authorization of Long Term Care Services*. *See* 7 AAC 43.190, above. The division is to "make the final level-of-care decision based upon that evaluation." *Id.*

The "Criteria for Nursing Home Placement" section of the *Manual* contains two sets of factors (*see* Ex. B at pp. 39-43). 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; (4) whether the patient requires medications that are administered either intravenously or by naso-gastric tube; (5) whether the patient has a colostomy-ileostomy; (6) whether the patient has a gastrostomy; (7) whether the patient is on oxygen; (8) whether the patient has a tracheostomy; (9) whether the patient is undergoing either radiation therapy or cancer chemotherapy; (10) whether the patient has sterile dressings that require prescription medication; (11) whether the patient has decubitus ulcers; (12) whether the patient has uncontrolled diabetes; and (13) whether the patient has 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, or new paraplegia or quadriplegia. (Ex. B, pp. 39-40).

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, and/or handrail use; (3) whether the patient requires a registered nurse to perform services; (4) whether the patient's use of drugs requires daily observation; (5) whether the patient require assistance with activities of daily living, including maintaining Foley catheters, ostomies, special diet supervision, or skin care with incontinent patients; (6) whether the patient has a colostomy-ileostomy; (7) whether the patient requires oxygen therapy; (8) whether the patient requires either radiation or chemotherapy; (9) whether the patient has skin conditions such as decubitus ulcers, minor skin tears, abrasions, or chronic skin conditions; (10) whether the patient is diabetic and needs daily supervision of diet or medications; and (11) whether the patient has behavioral problems such as wandering, verbal disruptions, combativeness, verbal or physical abusiveness, or inappropriate behavior. (Ex. B, p. 43).

VII. Case Law Relevant to Determination of Level of Care.

In *Bogie v. State, Division of Senior and Disabilities Services*, Superior Court Case No. 3AN-05-10936 (Decision dated August 22, 2006), the court emphasized that a level of care determination may not be made solely on an applicant's CAT score, but must also consider the Manual factors and the testimony of the applicant's treating physician.

Similarly, in *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), the court stated that although the level of care determination must incorporate the results of the CAT, "[t]he Division must make its final level-of-care decision" based on the guidelines established in the *Manual*.

ANALYSIS

Introduction: Definition of Issues; Burden of Proof.

The arguments asserted by the Claimant can fairly be summarized as follows:

1. Based on language contained at page 4, section 5(C) of the Division's HCBW application (Attachment A-4 to DSDS's closing brief), it is appropriate to consider whether "there is a reasonable indication that an individual might need [skilled or intermediate level nursing] services in the near future (one month or less) but for the receipt of [HCBW] services under this waiver." *See* Claimant's Closing Brief dated June 25, 2010 at 3.

2. Even if a claimant's need for a nursing level of care in the near future cannot properly be considered, the Claimant nevertheless required an intermediate or skilled level of nursing care *as of the date of her assessment* on December 7, 2009 (*see* Claimant's brief dated June 25, 2010 at 6) because:

> a. The Claimant's most important cancer treatment is vitamin infusion therapy, which must be administered or supervised by a licensed nurse, intravenously, twice a week (Claimant's Reply Brief at 1). The Claimant could also benefit from insertion of a "central line" or medication port ("peripherally inserted central catheter" or PICC) to facilitate her vitamin infusion therapy and her taking of pain medications. *Id.* at 2. Such a central line would require a nurse to access the line. *Id.*
>
> b. The Claimant is often unable to travel due to her illness. She therefore needs transportation services and/or nursing services at home so she can have access to treatment on a regular basis (Claimant's Reply Brief at 3).

c. The Claimant needs significant levels of assistance with her Instrumental Activities of Daily Living (IADLs) (Claimant hearing testimony).

This decision will initially address the Claimant's assertion that the language of the DSDS HCBW application form requires the Division to consider what the Claimant's nursing needs *are likely to be in the near future*. This decision will then address whether the Division's level of care determination was correct when it was *based on events which had already occurred by the date of the assessment*.

In discussing the level of care as demonstrated *at and prior to the assessment*, the Claimant's specific arguments 2(a-c), as stated above, will be addressed first. The decision will next examine, pursuant to 7 AAC 43.1010(d)(2) and 7 AAC 43.1030(b), whether the Claimant's CAT was scored appropriately. Finally, the decision will examine whether the *Manual* factors were correctly applied based on events which had already occurred by the date of the assessment. [8]

Because this case involves an initial application, the Claimant bears the burden of proof on all factual issues by a preponderance of the evidence (*see* Principles of Law at p. 9, above).

I. Does The Language of The HCBW Application Form Require Consideration of What The Claimant's Nursing Needs Are Likely to be in The Near Future?

The Division's position at hearing and in its post-hearing briefs was that a LOC determination must be made based on the facts as they exist *as of and prior to the date of the assessment* (in this case December 7, 2009). *See* testimony of [redacted] and [redacted] and the Division's briefs dated June 25 and July 9, 2010. In contrast, the Claimant asserts that, based on language contained at page 4, section 5(C) of the Division's HCBW application (Attachment A-4 to DSDS's closing brief), it is also appropriate to consider whether "there is a *reasonable indication* that an individual *might need* [skilled or intermediate level nursing] services *in the near future (one month or less) but for the receipt of [HCBW] services under this waiver*" [emphasis added]. *See* Claimant's brief dated June 25, 2010 at 3.

The Claimant's proposed interpretation might be sustained were the quoted section of the HCBW application form (see above) the only authority on this issue. However, the Claimant's proposed interpretation is not consistent with regulation 7 AAC 43.1030(b) (DSDS must "determine if the applicant *meets* [*not* "will meet"] the level of care required" [emphasis added]. Likewise, the Claimant's proposed interpretation is not consistent with the CAT form's statement that the CAT assessment "covers the last 7 days and considers other health, medical, or functional needs since the last assessment and/or the previous 12 months"). *See* CAT at p. 2 (Ex. E-2).

Pursuant to the "reasonable basis" standard, the Division's interpretation of its own regulations must be upheld unless the Division's interpretation is "plainly erroneous and inconsistent with the

[8] It is clear that, in making a LOC decision, the Division may not rely solely on an applicant's CAT score, but must also consider the *Manual* factors and the testimony of the applicant's treating physician. *See Bogie v. State, Division of Senior and Disabilities Services*, Superior Court Case No. 3AN-05-10936 (Decision dated August 22, 2006). The testimony of the Claimant's treating physician will be considered, along with other relevant evidence, at both the first level (CAT scoring) and second level (*Manual* factors) of the two-tiered LOC analysis (see Principles of Law at pp. 10-15, above).

regulation." *Lauth v. State*, 12 P.3d 181, 184 (Alaska 2000). [9] The Division's interpretation of its LOC regulations, (that a LOC determination must be made based on the facts as they exist *as of and prior to the date of the assessment),* is reasonable based on the language of regulation 7 AAC 43.1030(b), quoted above. The Division's interpretation is also reasonable based on the explicit language in the CAT (quoted above), especially given that the CAT is adopted by reference in 7 AAC 43.1030(b). Accordingly, the Division's interpretation of its LOC regulations, (that a LOC determination must be made based on the facts as they exist *as of and prior to the date of the assessment*), must be upheld pursuant to the "reasonable basis" standard.

II. Did The Claimant Require a Nursing Level of Care as of The Date of Her Assessment?

The next issue is whether the Claimant required a nursing level of care *as of the date of her assessment* on December 7, 2009 (*see* Claimant's brief dated June 25, 2010 at 6). As noted in the Introduction to this Analysis (at p. 15, above), the Claimant asserted that she required an intermediate or skilled level of nursing care, as of the date of her assessment, based on three (3) specific needs (i.e. infusion therapy, travel, and assistance with IADLs). Those three needs are addressed below in the order stated.

A. Does the Claimant Meet Level of Care Based on Her Infusion Therapy?

The Claimant's diagnoses (including cancer) are very serious and her prognosis is guarded ([redacted] hearing testimony). This testimony was credible, was well-supported by the medical records, and was not disputed by the Division.

Vitamin infusion therapy is the most significant cancer treatment yet received by the Claimant (testimony of [redacted] and [redacted]; Claimant's Reply Brief at 1-2). This treatment must be administered or supervised by a licensed nurse, intravenously, twice a week. *Id.* The Claimant could also benefit from insertion of a "central line" or medication port ("peripherally inserted central catheter" or PICC) to facilitate her vitamin infusion therapy and her taking of pain medications. *Id.* Such a central line would require a nurse to access the line. *Id.*

None of the evidence (summarized above) regarding the Claimant's vitamin infusion treatment was contested by the Division. However, even though the Claimant's need for vitamin infusion treatment and a PICC is undisputed, the Claimant cannot meet the required level of care on this basis.

First, the Claimant testified that she did not believe she was undergoing Vitamin C infusion treatment *at the time of her assessment* (Claimant testimony). Similarly, the assessor testified that, although he noted on his assessment that the Claimant reported that she would be *starting* Vitamin C infusion therapy, it was his understanding that the Claimant had not actually *begun* the treatment as of the assessment date ([redacted] testimony). As discussed in Analysis Section I, above, an applicant cannot meet level of care based on services which had not been provided as of the assessment.

Second, even had the Claimant been receiving Vitamin C infusion treatment at the time of her assessment, this would have satisfied only one (1) of the 13 skilled level of care factors ("medications

[9] "[T]he deferential 'reasonable basis' test [is applied] to legal issues involving agency expertise or fundamental policy formation, including questions of whether the agency correctly interpreted its own regulations." *Hidden Heights Assisted Living, Inc. v. State, Department of Health and Social Services, Division of Health Care Services,* 222 P.3d 258, 267-268 (Alaska 2009) (internal quotations and footnotes omitted). "Under this standard, we defer to the agency unless [its] interpretation is plainly erroneous and inconsistent with the regulation." *Id.* (internal quotations and footnotes omitted).

– drugs requiring intravenous . . . administration . . . . " – see Exs. B-39 and F-1), and only two (2) of the 11 intermediate level of care factors ("medications" and "performance of services that require a licensed nurse" – see Ex. F-2).

Neither the *Manual* nor 7 AAC 43.190 ("Determination of Level of Care") state a specific number of factors that an applicant needs to satisfy in order to meet level of care. However the assessor (an R.N.), Ms. [redacted] (an R.N.), Ms. [redacted] (an R.N.), and Dr. [redacted], *all agreed that the Claimant did not currently require a nursing home level of care*. *See* Findings of Fact at Paragraphs 5, 8(k), 9(k), and 11(g), above. Accordingly, given the low percentage of specific *Manual* factors met, and the unanimous agreement of all four witnesses with medical knowledge that the Claimant did not meet level of care, the Division's finding, (that the Claimant's infusion treatments did not qualify her for at least intermediate level care), is clearly supported by a preponderance of the evidence.

B. Does the Claimant Meet Level of Care Based on Her Inability to Travel?

The Claimant testified that she was often unable to travel to medical appointments due to her illnesses. This testimony was not disputed. Dr. [redacted] testified that she would like the Claimant to receive nursing services at home so the Claimant could be certain to have access to treatment on a regular basis. This testimony was also undisputed. Accordingly, the question to be determined is whether the Claimant's need for transportation or, alternatively, in-home services, equates to requiring a skilled or intermediate level of nursing care.

Transportation is not a factor considered by the CAT in making a LOC determination (see Ex. E-29). Likewise, transportation is not a factor considered by the Manual in making a LOC determination (see Exs. B-39 to B-43 and Exs. F-1 to F-2). In addition, pursuant to 7 AAC 1010(b)(2), "[h]ome and community-based waiver services are not available to an individual . . . if the individual's need for home and community-based services, supports, devices, or supplies may be provided for entirely under 7 AAC 43.100 - 7 AAC 43.942." These regulations (7 AAC 43.100 - 7 AAC 43.942) pertain to numerous Medicaid services which are provided *outside* the HCBW Program. Among these non-waiver Medicaid programs are two programs which could provide the services needed by the Claimant. These are a travel program [10] and an in-home nursing services program.[11]

In summary, the Claimant (who bears the burden of proof) has not shown that she needs skilled or intermediate level nursing services. Although the Claimant established that she has a need for transportation and home health care services, pursuant to 7 AAC 1010(b)(2), these services can be received even *without* establishing eligibility under the HCBW Program.

[10] At the time of the Claimant's application, the travel program was codified at 7 AAC 43.501 – 7 AAC 43.530. The travel program was repealed on February 1, 2010 but was re-enacted and re-codified at 7 AAC 120.400 – 7 AAC 120.490.

[11] At the time of the Claimant's application, the home health services program was codified at 7 AAC 43.800 – 7 AAC 43.801. The home health care services program was repealed on February 1, 2010 but was re-enacted and re-codified at 7 AAC 125.300 – 7 AAC 125.399.

C. Does the Claimant Meet Level of Care Based on Her Need for Assistance With IADLs?

It was undisputed that the Claimant needs significant levels of assistance with many of her Instrumental Activities of Daily Living (IADLs) [12] (Claimant hearing testimony; see Findings of Fact at Paragraph 7(j)). Specifically, she testified that she needs help with cooking, cleaning, laundry, and shopping. *Id.*

The Claimant undoubtedly has a need for these services. However, none of these required services involve a need for skilled or intermediate level nursing services. *See* Exs. B-39 through B-43, F-1, and F-2; *see also* 7 AAC 43.180, 7 AAC 43.185, and 7 AAC 43.190 (set forth in the Principles of Law, above). Accordingly, the Claimant cannot meet her burden of proving a need for skilled or intermediate level nursing services by demonstrating that she requires assistance with her IADLs.

Further, a non-waiver program providing cooking, cleaning, laundry, shopping, and other services exists (see specifically 7 AAC 43.752(a)(2), now 7 AAC 125.030(a)(2)). [13]

In summary, although the Claimant established that she has a need for assistance with her IADLs, pursuant to 7 AAC 1010(b)(2), these services may be received even *without* establishing eligibility under the HCBW Program. The Medicaid PCA program exists as a non-waiver program and provides cooking, cleaning, laundry, and shopping services (among others). Accordingly, pursuant to 7 AAC 1010(b)(2), these services may not properly be provided to the Claimant under the HCBW Program.

III. The Claimant Identified No CAT Scoring Errors Which Would Change the Claimant's LOC Assessment.

The *Consumer Assessment Tool* or CAT is the first part of the two-part test used to determine whether an applicant requires either skilled care or intermediate care. 7 AAC 43.1030(b)(2)(B). Eligibility for HCBW services is therefore based, in the first instance, on the CAT; the Manual factors are analyzed last (see 7 AAC 43.190, set forth in the Principles of Law, above).

The only CAT scoring areas which were seriously challenged by the Claimant were with regard to (a) locomotion and standing; [14] (b) personal hygiene; (c) assistance with IADLs; [15] and (d) whether the Claimant generally required professional nursing services. These areas are discussed below in the order stated.

---

12 Instrumental Activities of Daily Living (IADLs) include meal preparation, telephone use, light and routine housework, financial management, grocery shopping, and laundry (*see* Ex. E-26).

13 At the time of the Claimant's application, this program (Personal Care Assistance or PCA services) was codified at 7 AAC 43.750 – 7 AAC 43.795. The PCA program was repealed on February 1, 2010 but was re-enacted and re-codified at 7 AAC 125.010 – 7 AAC 125.199. The Claimant acknowledged that she qualified for, and was authorized to receive, Personal Care Assistance (PCA) services (Claimant testimony; *see also* [redacted] testimony). However, the Claimant has not had a PCA since the spring or summer of 2009 because she has not been able to find a PCA who she feels would be trustworthy. *Id.*

14 The Claimant testified that she does not use a walker or a cane, but that she sometimes loses her balance because of her peripheral neuropathy in her feet.

15 The impact of the need for assistance with IADLs on the level of care analysis was previously discussed in Analysis Section II(C), above and therefore need not be repeated here.

A. Did the Division Correctly Score the Claimant's Ability to Walk and Stand?

The Claimant received a self performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in the "locomotion" category (Ex. E-7). However, at the hearing, the Claimant testified that she had told the assessor that she loses her balance and that she has trouble holding things because of her peripheral neuropathy in her feet and hands (Claimant testimony). The Claimant's testimony regarding her limitations in this category was credible. However, at best, this would raise the Claimant's self performance code to a 2 (limited assistance required), and her support code to 2 (1 person physical assistance required), *in this category*.

The Claimant's *overall* CAT score would not be effected unless the Claimant scored a 3 (extensive assistance) or a 4 (totally dependent) in the self performance category (see Ex. E-29 at section NF1(e)). Accordingly, even construing the facts in the light most favorable to the Claimant, any mis-scoring of the Claimant's CAT in the locomotion category could not have affected the Claimant's *overall* CAT score.

B. Did the Division Correctly Score the Claimant's Ability to Perform Personal Hygiene?

The Claimant received a self performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in the personal hygiene category (Ex. E-10). However, at the time of the assessment the Claimant stated that sometimes a friend was needed to help with toenail care (Ex. E-10). Also, at the hearing, the Claimant testified that, on bad days, she could not perform her daily personal care at all (Claimant testimony).

The Claimant's testimony regarding her limitations in the personal care / hygiene category was credible. However, the personal hygiene category is not one of the 5 "shaded" ADL ("Activities of Daily Living") categories used to determine LOC (*see* Ex. E-18); it is only used in determining eligibility for PCA services. Even if personal hygiene were one of the five ADLs used to determine LOC, the Claimant's testimony would, at best, raise the Claimant's self performance code in this category to a 3 (extensive assistance required), and her support code to 2 (1 person physical assistance required). The Claimant's *overall* CAT score would not be effected unless the Claimant scored a 3 (extensive assistance) or a 4 (totally dependent) with regard to *at least three (3) of the relevant ADLs* (*see* Ex. E-29 at section NF1(e)). Accordingly, even construing the facts in the light most favorable to the Claimant, any mis-scoring of the Claimant's CAT in the personal care / hygiene category could not have affected the Claimant's ultimate / total CAT score.

C. Did the Division Correctly Score the Claimant's Need for Professional Nursing Services?

The most hotly contested issue in this case was whether the Claimant required professional nursing services *at the time of her assessment*. The Claimant received scores of zero (0) on each sub-category of the Professional Nursing Services section of the CAT (Exs. E-13, E-14).

The Claimant's physician testified that in her opinion it would be appropriate to have a professional nurse monitoring the Claimant (1) for adequate hydration, (2) for the effectiveness of her pain medications, (3) when administering any IVs / infusions, [16] and (4) monitoring the Claimant's skin for burns (if/when the Claimant undergoes radiation therapy). *See* Findings of Fact at Paragraph 9(i). She would also like a nurse to be putting together the Claimant's medi-sets. *Id.*

[16] The Claimant's infusion treatments were specifically discussed in Analysis Section II(A), above.

Dr. [redacted]'s testimony (referenced above) was completely credible and was not rebutted by the Division. However, under the CAT, the test is not what professional nursing services might be appropriate or recommended for *future implementation*. Rather, the test is what professional nursing services *have actually been rendered* within the week and the 12 month period immediately prior to the assessment (*see* Exs. E-2, E-13, and E-14).

The Claimant testified that she had made the decision to undergo radiation treatment before her assessment, but that she had still (at the time of the hearings in this case) not been able to actually *begin* radiation treatment yet because she is not able to regularly access treatment (*see* Findings of Fact at Paragraph 7(c-d)). Likewise, she did not believe that she was actually undergoing Vitamin B and/or C infusion treatment at the time of her assessment. *Id.*

Similarly, [redacted], R.N. testified that the Claimant should have the following professional nursing services: (1) an IV line for pain meds, monitored by a nurse; (2) monitoring by a nurse for evidence of adequate hydration, constipation, bleeding, and adverse drug interactions; and (3) monitoring for swollen lymph nodes at such time as she begins receiving radiation therapy (*see* Findings of Fact at Paragraph 8(k)). However, she also testified that, as of the date of the March 24, 2010 hearing, the Claimant had agreed / decided to undergo radiation treatment, but had not actually *begun* radiation treatment at that time (*see* Findings of Fact at Paragraph 8(d)). She also opined that, as of the date of the March 24, 2010 hearing, the Claimant was not yet actually receiving intermediate level nursing care (*see* Findings of Fact at Paragraph 8(k)).

Finally, Dr. [redacted] testified that the Claimant was scheduled to begin receiving radiation treatments in December 2009, prior to the date of the LOC assessment, but that, as of the hearing of April 7, 2010, she had not actually started radiation treatment because of a lack of transportation (*see* Findings of Fact at Paragraph 9(e)).

In summary, the evidence presented on behalf of the Claimant failed to show that the Claimant was actually utilizing any professional nursing services at the time of the assessment. Accordingly, the Claimant failed to prove, by a preponderance of the evidence, that there was any cognizable error with regard to the Division's scoring of the Professional Nursing Services section of the CAT.

IV. The Claimant Failed to Prove That The Division Misapplied The *Manual* Factors.

Pursuant to 7 AAC 43.1030(b)(2)(B), the Division's "level of care determination . . . must *incorporate* the results of the department's *Consumer Assessment Tool (CAT)"* [emphasis added]. The Claimant failed to qualify for HCBW Services based on her CAT scores, as discussed above. However, this does not end the inquiry. Next, pursuant to 7 AAC 43.190, the "division [must] make the *final* level-of-care decision based upon" the "guidelines established in the Criteria for Placement section of the *Manual for Prior Authorization of Long Term Care Services* . . . . [emphasis added].

[redacted], a registered nurse employed by the Division, reviewed the December 7, 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 HCBW Program services (Exs. F-1, F-2; [redacted] testimony). Ms. [redacted] did not find any factors indicating that the Claimant required a skilled level of nursing care (Ex. F-1). Ms. [redacted] found only one (1) factor (medication assistance) out of the total of 11 factors indicating that the Claimant required an

intermediate level of nursing care (Ex. F-2). Accordingly, she determined that the Claimant did not meet LOC as of the date of her assessment (*see* Findings of Fact at Paragraph 11(h)).

A review of the *Manual for Prior Authorization of Long Term Care Services* demonstrates that the only *Manual* factors that could have potentially qualified the Claimant for HCBW Services, as of her December 7, 2009 assessment, were (1) whether the Claimant required a registered nurse to perform services; (2) whether the Claimant's use of medications required daily observation; (3) whether the Claimant required assistance with her activities of daily living (ADLs), and (4) whether the Claimant required either radiation or chemotherapy (*see* Ex. B, p. 43; *see also* Principles of Law at p. 15, above).

The evidence was uncontradicted that, as of the date of her assessment, the Claimant was not receiving radiation or chemotherapy; did not require daily observation with regard to her use of medications; [17] and did not otherwise require services that could only be performed by a registered nurse (*see* discussion in Analysis Section II, above and sources cited therein). There *was* evidence that the Claimant required assistance with some of her activities of daily living (ADLs). However, pursuant to the *Manual*, "[a]dmission to intermediate care *will not be authorized* solely to provide supervision . . . routine medication management, or *assistance with personal services*" (Ex. B-42 (emphasis added)). Accordingly, Ms. [redacted] was correct not to award LOC assessment "points" under the *Manual* factors based on the Claimant's need for PCA assistance with her ADLs.

In summary, the Claimant had the burden of proof in this case. However, she did not establish either that the December 7, 2009 CAT assessment was materially incorrect, or that she qualified for HCBW Services based on the factors contained in the *Manual for Prior Authorization of Long Term Care Services.* Accordingly, the Claimant failed to prove, by a preponderance of the evidence, that she required a skilled or intermediate level of nursing care at the time of her assessment. The Division was therefore correct when on January 27, 2010 it denied the Claimant's application for HCBW Services.

CONCLUSIONS OF LAW

1. The Division's interpretation of its level of care regulations (specifically 7 AAC 43.180, 7 AAC 43.185, 7 AAC 43.190, 7 AAC 43.1010, and 7 AAC 43.1030), as requiring that a level of care determination be made based on the facts *as they exist as of and prior to the date of the assessment*, is not plainly erroneous or inconsistent with the Division's level of care regulations.

2. The Claimant failed to carry her burden, and did not prove by a preponderance of the evidence, that she required either a skilled nursing facility or intermediate nursing facility level of care as of December 7, 2009, the date she was assessed to determine her eligibility for the Medicaid Home and Community-Based Waiver Services Program.

3. Because the Claimant did not qualify for Medicaid Home and Community-Based Waiver Services at the time of her assessment, the Division was correct when on January 27, 2010 it denied the Claimant's application for Medicaid Home and Community-Based Waiver Services.

DECISION

The Division was correct when on January 27, 2010 it denied the Claimant's application for Medicaid Home and Community-Based Waiver Services.

---

[17] Nevertheless, Ms. [redacted] still credited the Claimant with requiring assistance with medications (*see* Ex. F-2).

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:

Acting Director, Division of Senior and Disabilities Services
State of Alaska Department of Health and Social Services
550 West 8th Avenue
Anchorage, Alaska 99501

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 26th day of August, 2010.

(signed)
_____
Jay Durych
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on the 26th day of August 2010 true and correct copies of the foregoing document were sent to the Claimant via U.S.P.S. Mail, as follows:

[redacted], Esq.,
Legal Director, Disability Law Center of Alaska
Counsel for Claimant
Via Certified Mail, Return Receipt Requested

I certify that on the 27th day of August 2010 true and correct copies of the foregoing document will be sent to the remainder of the service list by e-mail, as follows:

[redacted], Esq.
Attorney General's Office, Department of Law
Counsel for the Division of Senior and Disabilities Services
Via e-mail

[redacted], DHCS / DSDS Hearing Representative

[redacted], Acting Director, DSDS
[redacted], Policy & Program Development
[redacted], Staff Development & Training
[redacted], Eligibility Technician I
(signed)
_____
J. Albert Levitre, Jr.
Law Office Assistant I