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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. 11-FH-2109
	)	
Claimant.	)	Div. Case No. [redacted]
_____	)	

FAIR HEARING DECISION

STATEMENT OF THE CASE

[redacted] (Claimant) applied for Medicaid Home and Community Based Waiver services (hereinafter "Medicaid HCB Waiver services").[1] On March 9, 2011 the Division of Senior and Disabilities Services (Division) sent the Claimant notice her application was denied. (Ex. D) The Claimant requested a fair hearing contesting the denial on March 14, 2011. (Ex. C)

This Office has jurisdiction pursuant to 7 AAC 49.010.

The hearing was held on May 19, 2011. The Claimant appeared telephonically; she represented herself and testified on her own behalf. [redacted], the Claimant's Care Coordinator, appeared telephonically and assisted the Claimant with her representation; she also testified on the Claimant's behalf. The Division was represented by [redacted], Medical Assistance Administrator III, who appeared in person, who also testified on behalf of the Division. [redacted], a registered nurse employed with the Division, appeared telephonically and testified on the Division's behalf.

ISSUE

Was the Division correct to deny the Claimant's application for Medicaid HCB Waiver services on March 9, 2011 because she did not require a nursing facility level of care?

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

SUMMARY OF DECISION

The Division was correct to deny the Claimant's application for Medicaid HCB Waiver services on March 9, 2011 because she did not require either a skilled nursing facility or intermediate care facility level of care as of March 7, 2011, the date she was assessed to determine her eligibility for Medicaid Home and Community Based Waiver services.

FINDINGS OF FACT

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

1. The Claimant is a 53 year old woman (date of birth [redacted]). (Ex. E, p. 1) The Claimant experiences a number of conditions: herniated discs, degenerative disc disease, arthritis, chronic back pain, chronic pain syndrome, post traumatic stress disorder, anxiety disorder, traumatic brain injury, hypothyroidism, and seizure disorder. (Ex. E, p. 3; Ex. F, p. 3)

2. The Claimant applied for Medicaid HCB Waiver services. She was assessed for Medicaid HCB Waiver eligibility on March 7, 2011. (Ex. E, p. 1) The person who conducted the assessment was [redacted], a registered nurse. *Id.*

3. The results of March 7, 2011 Medicaid HCB Waiver assessment were recorded on the Consumer Assessment Tool (CAT). The CAT scored the claimant with a "0" and found she did not qualify for Medicaid HCB Waiver services. (Ex. E, p. 29) Specifically, the CAT recorded the Claimant's condition as follows:

   a. The Claimant did not require any professional nursing services (injections, IV feeding, feeding tubes, suctioning/tracheotomy care, treatments or dressings, catheter, coma, ventilator, catheters, uncontrolled seizure disorder). (Ex. E, pp. 13 - 14)

   b. The Claimant did not receive any therapies (physical therapy, speech therapy, occupational therapy or respiratory therapy). (Ex. E, p. 14)

   c. The Claimant did not require any special treatments or therapies performed by or under the supervision of a registered nurse. (Ex. E, p. 15)

   d. The Claimant's short-term memory is impaired; her long-term memory is not. (Ex. E, p. 16) Her daily decision making skills are moderately impaired. *Id.* She does not require "professional nursing assessment, observation and management" to manage her decision making skills. *Id.*

   e. The Claimant does not exhibit problem behaviors (wandering, verbally/physically abusive, disruptive behavior, resisting care). (Ex. E, p. 17)

f. The Claimant was able to turn and reposition herself in bed (bed mobility). (Ex. E, p. 6) She made herself a "stepstool" to assist her in getting in and out of bed. *Id.* She does not have any bed sores. *Id.* She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. E, pp. 6, 18)

g. The Claimant was able to get up and down from chairs, bed, etc. (transfers) by herself with some supervision. (Ex. E, p. 6) She uses a cane to assist herself when transferring. *Id.* She received a self-performance code of 1 (supervision) and a support code of 0 (none required) in this category. (Ex. E, pp. 6, 18) The assessor observed her transfer several times, using her cane, during the assessment. (Ex. E, p. 6)

h. The Claimant is able to walk/use a wheelchair (locomotion) by herself with some supervision. (Ex. E, p. 7) She received a self-performance code of 1 (supervision) and a support code of 0 (none required) in this category. (Ex. E, pp. 7, 18) The assessor observed her walking using her cane. (Ex. E, p. 7)

i. The Claimant was able to dress herself without assistance. (Ex. E, p. 8) She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. E, pp. 8, 18)

j. The Claimant did not require any hands on assistance with eating. (Ex. E, p. 9) She received a self-performance code of 0 (independent) and a support code of 0 (no assistance required) in this category. (Ex. E, pp. 9, 18)

k. The Claimant did not require any hands on assistance with toileting. (Ex. E, p. 9) She received a self-performance code of 0 (independent) and a support code of 0 (no assistance required) in this category. (Ex. E, pp. 9, 18)

l. The Claimant did not require assistance with her personal care needs (combing hair, brushing teeth, washing face). (Ex. E, p. 10) She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. E, pp. 10, 18)

m. The Claimant did not require physical assistance with transferring in and out of the shower, bathing and drying herself. (Ex. E, p. 11) She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. E, pp. 11, 18)

n. The Claimant does not require assistance with her medications. (Ex. E, p. 12)

o. The Claimant has "absence seizures." She takes Trileptal to control them. (Ex. E, p. 3)

4. On March 8, 2011, [redacted], a registered nurse employed by the Division, reviewed the March 7, 2011 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 Medicaid HCB Waiver services. (Ex. F, pp. 1 - 2) Ms. [redacted]'s review found that while the Claimant required supervision for transfers and locomotion, she did not satisfy the factors for either a skilled level of care or an intermediate level of care. *Id.*

5. On April 7, 2011, Dr. [redacted], MD, signed and completed a form that indicated the Claimant's abilities were as follows:

a. The Claimant did not require assistance for the activities of bed mobility, transfers, wheelchair, standing, locomotion, dressing, toilet use, or walking.

b. The Claimant requires assistance with personal hygiene, and bathing.

c. The Claimant did not require assistance with meal preparation; however she needed assistance with main meal preparation.

d. The Claimant requires assistance with light housework, routine housework, grocery shopping, and laundry.

(Ex. G, p. 5)

6. The Claimant testified as follows:

a. She has blackouts/absence seizures. They are not controlled by medication. She experiences petit mal seizures approximately five or six times per day, and grand mal seizures two or three times per month. As the time of the hearing, she had not spoken to her doctor about the seizures being uncontrolled, but planned to do so within the next week.

b. She has a rash/bed sore on the right side of her hip. It seeps and weeps and turns black and red. She is treating it herself with Lotrimin. She cannot afford to have it medically treated.

c. She requires assistance with bed mobility. She can get in and out of the bed but cannot reposition herself in the bed.

d. She needs physical assistance when getting up from a chair or couch. She described the physical assistance as being one where she grabs onto

another person and pulls herself up from the chair/couch using the other person as a stabilizer or support.

e. For locomotion, she requires someone to push her wheelchair for her. However, if she is walking in her room, she does not require assistance. If she is walking any distance, she needs physical support.

f. For toileting, she does not require assistance 75 percent of the time transferring off and on the toilet. However, she needs physical weight bearing assistance transferring off and on the toilet 25 percent of the time. She is also having problems cleaning herself after using the toilet.

g. She requires physical assistance putting on her bra and pants. She can put on her shirt, and has slip on shoes.

h. She requires assistance with personal hygiene, specifically with brushing her hair. Brushing her teeth is also difficult.

i. She needs assistance with meal preparation.

j. She has a TENS (transcutaneous electrical nerve stimulator) unit that she uses for pain relief. She needs help placing it on her back. However, the unit can be placed on her back by someone who is not a nurse.

k. She had been receiving twice weekly physical therapy but was discharged from receiving physical therapy.

7. [redacted], a registered nurse employed by the Division, testified as follows:

a. The Claimant does not require any nursing services.

b. The Claimant's assessment (Ex. E, p. 3) states that the Claimant's seizures are under control.

c. The Claimant does not require a nurse to help her with her TENS unit, a non-nurse can help her put it on.

PRINCIPLES OF LAW

A party who is seeking a change in the status quo has the burden of proof, by a preponderance of the evidence, in an administrative case. *State, Alcoholic Beverage Control Board v. Decker,* 700 P.2d 483, 485 (Alaska 1985); *Amerada Hess Pipeline v. Alaska Public Utilities Comm'n,* 711 P.2d 1170, n. 14 at 1179 (Alaska 1986). "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." *Robinson v. Municipality of Anchorage,* 69 P.3d 489, 495 (Alaska 2003).

An adult, under the age of 65 years who experiences physical disabilities, who requires "a level of care provided in a nursing facility…" is entitled to receive Medicaid HCB Waiver services. 7 AAC 130.205(d)(1)(B) and (d)(2)(ii). [2]

Regulation 7 AAC 130.205(d)(2) states, in relevant part, that an applicant is not eligible for Medicaid HCB Waiver services unless the individual requires a nursing facility level of care as determined under 7 AAC 130.230(b) and under 7 AAC 140.505 - 7 AAC 140.515.

Regulation 7 AAC 130.230(b) requires a level of care assessment to determine eligibility:

> …to determine if the applicant meets the level of care required under 7 AAC 130.205(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.

Regulation 7 AAC 130.230(b)(2), which applies to adults with physical disabilities, requires the department to:

> (A) …determine whether the applicant requires skilled care under 7 AAC 140.515 or intermediate care under 7 AAC 140.510; and
>
> (B) [the] level of care determination under (A) … must incorporate the results of the department's *Consumer Assessment Tool (CAT)*, adopted by reference in 7 AAC 160.900. (Emphasis supplied.)

Regulations 7 AAC 140.505 - 140.515 set out factors the department must consider when determining the appropriate level of care for an individual seeking Medicaid HCB Waiver services.

Regulation 7 AAC 140.505 requires the department to consider:

> (1) the type of care required;
> (2) the qualifications of the person necessary to provide direct care; and
> (3) whether the recipient's overall condition is relatively stable or unstable.

Regulation 7 AAC 140.515, titled "Skilled nursing facility services,"[3] provides that skilled level of care is:

[2] There are other eligibility criteria, however, those are not at issue in this case. *See* 7 AAC 130.205(a) and (b).

[3] The acronym SNF refers to "skilled nursing facility." *See* 7 AAC 160.990(b)(80).

> (a) (1) needed to treat an unstable condition; (2) ordered by and under the direction of a physician; and (3) provided directly by or under the supervision of qualified technical or professional personnel, who are authorized by state law to provide that service and who are on the premises at the time service is rendered; technical or professional personnel include a registered nurse, a licensed practical nurse, a licensed physical therapist, a licensed physical therapy assistant, a licensed occupational therapist, a certified occupational therapy assistant, a licensed speech-language pathologist, a registered speech-language pathologist assistant, and an audiologist.
>
> (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 recipient's condition stabilizes.

Regulation 7 AAC 140.510, titled "Intermediate care facility services," provides that intermediate care services are:

> (a) (1) needed to treat a stable condition; (2) ordered by and under the direction of a physician (except as provided in (c) of this section; and (3) provided to a recipient who does not require the level of care provided by a skilled nursing facility.
>
> (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) Intermediate care may include occupational, physical, or speech-language therapy provided by an aide or orderly under the supervision of licensed nursing personnel or a licensed occupational, physical, or speech-language therapist.

Regulation 7 AAC 130.230(b)(2)(B) requires the department to incorporate results of the Consumer Assessment Tool (CAT) into the level of care determination made for an older adult applying for Medicaid HCB Waiver services.[4]

[4] The Consumer Assessment Tool (CAT) is adopted by reference in regulation 7 AAC 160.900(d)(6) and is specifically included in the eligibility determination for Medicaid HCB Waiver services by regulation 7 AAC 130.230(b)(2)(B). The CAT also is applied to determine if an applicant is eligible for other Medicaid based services and is designed to present a comprehensive picture of an applicant's medical needs.

The CAT records an applicant's needs for professional nursing services, for physician prescribed care for care of skin ulcers, direct care for an uncontrolled seizure disorders, 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. 13 - 14)

The CAT records an applicant's conditions and needs for the 7 day time period immediately preceding the assessment date. (Ex. E, pp. 13 - 14) Each of the 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. 29)

The CAT also records 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.18) 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/cueing provided three or more times during the last seven days or supervision 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. 18)

If an individual receives a self-performance code of 2 (limited assistance), 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, p. 29) 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. 30)

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 Medicaid HCB Waiver services. (Ex. E, p. 30)

In addition to use of the CAT in its determination of an applicant's level of care, the Division also uses the factors contained in the *Manual for Prior Authorization of Long-term Care Services* to determine if an applicant qualifies for Medicaid HCB Waiver services.[5] The specific factors contained in the Division's checklist measure whether a Claimant requires either a Skilled Level of Care or an Intermediate Level of Care.[6]

[5] The Division was required by prior regulation 7 AAC 43.190 (repealed effective February 1, 2010) to "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."* The current regulation, found at 7 AAC 140.505 (effective February 1, 2010) no longer requires consideration of those criteria, which are referred to as the "*Manual* factors." However, the Division utilized those factors in this case to evaluate the Claimant's eligibility for Medicaid HCB Waiver services.

[6] 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; 4) does the patient require medications that are administered either intravenously or by naso-gastric tube; 5) does the patient have a colostomy-ileostomy; 6) does the patient have a gastrostomy; 7) is the patient on oxygen; 8) does the patient have a tracheostomy; 9) is the patient undergoing either radiation therapy or cancer chemotherapy; 10) does the patient have sterile dressings that require prescription medication; 11) does the patient have decubitus ulcers; or 12) 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. F, pp. 2 - 3)

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 nursing assistance with medications; 5) does the patient require assistance with activities of daily living, including maintaining Foley catheters, ostomies, special diet supervision, or skin care with incontinent patients; 6) does the patient have a colostomy-ileostomy; 7)

ANALYSIS

Because this is an application, the Claimant has the burden of proof by a preponderance of the evidence.

A Medicaid HCB Waiver services eligibility determination is based upon an assessment performed by the Division or its designee. 7 AAC 130.205(d)(2). The Consumer Assessment Tool (CAT) is the primary assessment tool used to determine if an applicant satisfies the regulatory requirement that an applicant require either skilled care or intermediate care. 7 AAC 130.230(b)(2)(B). In addition, the Division determines if an applicant requires skilled care or intermediate care using the factors listed in the *Manual for Prior Authorization of Long-term Care Services* (Manual factors).[7] Eligibility for Medicaid HCB Waiver services is therefore based on the CAT and Manual factors.

A. Consumer Assessment Tool (CAT)

The Claimant may qualify for Medicaid HCB Waiver services if she meets the scoring requirements set out in the CAT. The Claimant's position is that the March 7, 2011 assessment wrongly assessed the Claimant's level of care.

1. Activities of Daily Living

The Claimant disagreed with four of the five scored activities of daily living, i.e. bed mobility, transfers, locomotion, and toilet use. Each of these is addressed below.

a. Bed Mobility. The Division scored the Claimant with a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. The Claimant testified this was incorrect. She stated that she could get in and out of bed, but was not able to position herself in the bed. This appears inconsistent. She can get in and out of the bed without assistance, which also implies that she can reposition herself in the bed. In addition, the Claimant's physician stated, on April 7, 2011, that the Claimant did not require assistance in this category. The Claimant did not meet her burden of proof on this issue. Accordingly, the Division's scoring on this point is accepted.

b. Transfers. The Division scored the Claimant with a self-performance code of 1 (supervision) and a support code of 0 (none required) in this category. The CAT stated that she used her cane to help her transfer herself and that

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does the patient require oxygen therapy; 8) does the patient require either radiation or chemotherapy treatment; 9) does the patient have skin conditions such as decubitus ulcers, minor skin tears, abrasions, or chronic skin conditions; 10) is the patient a diabetic who needs daily supervision of diet or medications; or 11) does the patient have behavioral problems such as wandering, verbal disruptions, combativeness, verbal or physical abusiveness, or inappropriate behavior. (Ex. F, p. 3)

[7] *See* fn. 5 above.

her transferring was observed several times during the assessment. The Claimant testified she could transfer, but that she needed physical assistance, which appeared to be grabbing onto another person and using them for support. The Claimant's testimony, that she requires limited hands-on physical support/assistance when transferring, is contradicted by the Claimant's physician's April 7, 2011 statement that the Claimant did not require assistance in this category. The Claimant did not meet her burden of proof on this issue. Accordingly, the Division's scoring on this point is accepted.

c. Locomotion. The Division scored the Claimant with a self-performance code of 1 (supervision) and a support code of 0 (none required) in this category. The Claimant's testimony was consistent with this scoring when it involved walking within her own room. However, she testified she needed someone to push her wheelchair for her. In addition, she testified that when she tried to walk any distance, she needed physical assistance. The assessor only observed her walking using the cane. She did not observe her in the wheelchair. However, the Claimant's physician stated, on April 7, 2011, that the Claimant did not require assistance in either walking or wheelchair operation. The Claimant did not meet her burden of proof on this issue. Accordingly, the Division's scoring on this point is accepted.

d. Toileting. The Division scored the Claimant with a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. The Claimant testified she needed physical weight bearing assistance when transferring on and off the toilet 25 percent of the time, and that she was having difficulty cleaning herself properly after toilet use. The Claimant's testimony on this point is slightly inconsistent with her testimony on non-toilet transfers, i.e. that she needed more support/stabilizing rather than weight bearing support for her transfers, as discussed above. Additionally, the Claimant's physician stated, on April 7, 2011, that the Claimant did not require assistance in this category. The Claimant did not meet her burden of proof on this issue. Accordingly, the Division's scoring on this point is accepted.

In summary, the Division correctly scored the Claimant in the categories of transfers, locomotion, and toileting. If the Claimant had received scores of "3" in three of the scored activities of daily living, bed mobility, transfers, locomotion, eating, or toilet use, she would have qualified for Medicaid HCB Waiver services. (Ex. E, p. 30) However, because she did not receive any "3"s in any of the scored categories, she does not qualify for HCB Waiver services based solely on her scored activities of daily living.

2. Professional Nursing Services

This portion of the CAT deals with items such as professional nursing services required for various items, such as prescribed treatments and dressings for skin ulcers. It additionally deals with nursing services required for an uncontrolled seizure disorder. The Division found that the Claimant had no needs in this area.

The Claimant testified that she has a bed sore, which is not being medically treated. However, in order for her to receive a score for the treatment of skin ulcers, she must be receiving a prescribed treatment. She is not.

The Claimant also testified that she has an uncontrolled seizure disorder. While the record shows that she has a seizure disorder, the record also shows that she takes Trileptal to control the seizures. There is no medical evidence establishing either that her seizure disorder is uncontrolled, or that she requires nursing care for management of the seizure disorder.

It is undisputed that the Claimant has a TENS unit which requires placement on her back. However, the Claimant did not claim that she required a nurse to place it. Further, as Ms. [redacted] testified, a non-nurse could place the unit on the Claimant's back. As a result, the Claimant does not require nursing services for her TENS unit.

The Claimant was therefore unable to establish that she required professional nursing services for either her bed sore or for an uncontrolled seizure disorder. As a result, the CAT was correctly scored as showing the Claimant did not require professional nursing services.

3. Therapies

This portion of the CAT deals with items such as physical therapy and occupational therapies. The Claimant did not disagree with the Division's conclusion that she was not receiving any of these therapies. As a result, the CAT was correctly scored as showing the Claimant was not receiving any physical or occupational therapies.

4. Special Treatments or Therapies

This portion of the CAT deals with items such as chemotherapy and radiation treatment. The Claimant did not disagree with the Division's conclusion that she was not receiving any of these therapies. As a result, the CAT was correctly scored as showing the Claimant was not receiving any special treatments or therapies.

5. Cognitive Impairments/Behavioral Problems

The CAT measures whether persons experience declines in mental functioning and behaviors. The CAT was scored as showing the Claimant experienced impaired short-term memory, unimpaired long-term memory, and moderately impaired daily decision

making. However, she does not require "professional nursing assessment, observation and management" to manage her decision making skills. No evidence was presented challenging that scoring. As a result, the CAT was correctly scored showing that the Claimant did not require professional nursing services to manage her cognitive impairments.

In summary, the Claimant presented evidence challenging the Division's March 7, 2011 assessment, as recorded and scored on the CAT, primarily consisting of challenges to the scored Activities of Daily Living (bed mobility, transfers, locomotion, toileting, and eating). However, her evidence regarding her ability to perform the scored Activities of Daily Living was directly contradicted by her physician's April 7, 2011 written statement that said she did not require assistance in performing those activities. In addition, the Claimant stated she had a bed sore and an uncontrolled seizure disorder. However, there was no medical evidence in the record to substantiate her testimony. As a result, as discussed above, the evidence was not sufficient to result in the Claimant receiving an improved score on the CAT. As a result, the CAT was correctly scored as finding the Claimant did not qualify for Medicaid HCB Waiver services.

B. Manual Factors

The *Manual for Prior Authorization of Long-term Care Services* factors were scored consistent with the CAT. As discussed above, the Claimant does not have either skilled or intermediate nursing needs, as assessed and recorded on the CAT. Application of the *Manual* factors do not qualify the Claimant for Medicaid HCB Waiver services.

Summary

The Claimant had the burden of proof in this case. She did not establish either that the scoring on the March 7, 2011 CAT was not correct or that she qualified for Medicaid HCB Waiver services based upon the factors contained in the *Manual for Prior Authorization of Long-term Care Services.* Consequently, she did not meet her burden of proof showing that she qualified for Medicaid HCB Waiver services at the time of her March 7, 2011 assessment. The Division was therefore correct when it denied the Claimant's application for Medicaid HCB Waiver services on March 9, 2011, based upon the March 7, 2011 assessment.

CONCLUSIONS OF LAW

1. The Claimant failed to meet her burden of proof by a preponderance of the evidence; she did not demonstrate she required either a skilled nursing facility or intermediate care facility level of care as of March 7, 2011, 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.

DECISION

The Agency was correct to deny the Claimant's application for Medicaid Home and Community Based Waiver services on March 9, 2011.

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. 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. To appeal, send a written request directly to:

Duane Mayes, Director
Division of Senior and Disability Services
4501 Business Park Blvd., Suite 24
Anchorage, AK 99503-7167

DATED this 11th day of July, 2011.

/Signed/
Larry Pederson
Hearing Authority

Certificate of Service

I certify that on this 11th day of July, 2011, true and correct copies of the foregoing were sent to:
Claimant by U.S.P.S First Class Certified Mail, Return Receipt Requested
and to the following by secure e-mail:

[redacted], Division Representative
[redacted], Director
[redacted], Policy & Program Development
[redacted], Staff Development & Training
[redacted], Administrative Assistant II
[redacted] Eligibility Technician I
[redacted], DHCS

/signed/
J. Albert Levitre, Jr.
Law Office Assistant I