BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of:	)	
	)	OAH Nos. 13-1418/1755-MDS
L O-Q	)	
	)	

DECISION AFTER REMAND

I. Introduction

L O-Q was receiving Medicaid Home and Community-based Waiver (Waiver) benefits and Personal Care Assistance (PCA) services. She was reassessed by the Division of Senior and Disabilities Services (Division) to determine her ongoing eligibility and benefit level for both programs. The Division notified her on September 30, 2013 that her PCA services were reduced, and on November 6, 2013 that her Waiver services were terminated. Ms. O-Q requested a hearing to challenge both the PCA reduction and the Waiver termination actions. The PCA reduction case[1] and the Waiver termination case[2] were consolidated.

During the ongoing course of this case, the Division agreed to reassess Ms. O-Q's eligibility for Waiver and PCA benefits, conducting that assessment on May 1, 2014. Following the 2014 assessment visit, the Division notified Ms. O-Q on May 15, 2014 that her PCA services would be reduced, and, on June 5, 2014, that she no longer qualified for Waiver services. These new determinations, based on the May 1, 2014 assessment visit, became the issues for these consolidated cases. Ms. O-Q received a hearing on July 2, 2014, at which she was represented by Daniel Coons of Alaska Legal Services Corporation. The Division was represented by Assistant Attorney General Elizabeth Smith.

A proposed decision was issued finding that Ms. O-Q's Waiver services should not be terminated and her PCA services should not be reduced. The basis for that decision was that the Division's 2014 assessment visit was conducted without proper notice. The Division filed a proposal for action which argued that the hearing held on July 2, 2014 rectified any possible notice defect. The Commissioner's designee declined to adopt the ALJ's proposed decision and, in accordance with AS 44.64.060(3), returned this case to the ALJ:

> to issue a new proposed decision on the merits, which addresses both Ms. O-Q's Medicaid Waiver eligibility and the amount of her Medicaid PCA benefits. That decision shall be based upon the entire record in this case, including the record of

[1] OAH Case No. 13-1418-MDS.
[2] OAH Case No. 13-1755-MDS.

the evidentiary hearing which was held on July 2, 2014. A second evidentiary hearing is not ordered.

After a review of the evidence, the Division's termination of Ms. O-Q's Waiver services is upheld. However, its determination regarding her PCA services is affirmed in part and reversed in part, as discussed in detail below.

II. Background Facts

Ms. O-Q is 56 years old. She lives with her husband, who has a full-time job outside the home. She is diabetic, which is poorly controlled, has Bipolar Disorder Type 1, and is incontinent. She is 4'9" tall and weighs 300 lbs.[3] She has lumbosacral disc degeneration and has a dropped foot on her right leg.[4] She uses a walker for locomotion.[5]

Ms. O-Q was receiving Waiver benefits and 21 hours of PCA services. Denise Kichura, a Division nurse, made a visit to reassess Ms. O-Q's PCA service needs on May 1, 2014. She recorded the assessment visit in the CAT. Her findings resulted in a termination of Ms. O-Q's Waiver benefits and a reduction of her PCA services to 7.25 hours per week.[6] In general, Ms. Kichura found that Ms. O-Q's physical functionality had increased, which resulted in her no longer qualifying for Waiver benefits, and in a decrease in her need for PCA services. The Division's determination that Ms. O-Q no longer qualified for Waiver services was reviewed by Qualis Health, which concurred in the determination.[7]

Ms. O-Q disputed the termination of her Waiver services and the reduction in her PCA services.

III. Discussion

In this case, in which the Division is seeking to terminate or reduce a benefit a citizen is already receiving, the Division has the overall burden to prove, by a preponderance of the evidence,[8] facts that show the citizen's level of eligibility has changed.[9] Similarly, if the citizen is seeking to increase the level of benefits, the citizen has the burden of proof by a preponderance of the evidence.[10]

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3 Ex. K, pp. 3, 9; Ex. 6.
4 Ex. 4, pp. 1- 2.
5 Ex. K, pp. 4, 6 - 7.
6 Exs. L, M.
7 H J's testimony; Ex. L, p. 2.
8 Proof by a preponderance of the evidence means that the fact in question is more likely true than not true.
9 7 AAC 49.135.
10 *Id.*

A. Waiver Eligibility

1. Overview

The Alaska Medicaid program provides Waiver services to adults with physical disabilities who require "a level of care provided in a nursing facility."[11] The purpose of these services is "to offer a choice between home and community-based waiver services and institutional care."[12]

The nursing facility level of care[13] requirement is determined in part by an assessment which is documented by the CAT.[14] The CAT records an applicant's needs for professional nursing services, therapies, and special treatments,[15] and whether an applicant has impaired cognition or displays problem behaviors.[16] Each of the assessed items is coded and contributes to a final numerical score. For instance, if an individual required 5 days or more of therapies (physical, speech/language, occupation, or respiratory therapy) per week, he or she would receive a score of 3.[17]

The CAT also bases Waiver eligibility upon the coding provided for five specified activities of daily living (ADLs): body mobility, transfers, locomotion, toileting, and eating. The CAT numerical coding system has two components. The first component is the *self-performance code.* These codes rate how capable a person is of performing a particular ADL. The possible codes are **0** (the person is independent and requires no help or oversight); **1** (the person requires supervision); **2** (the person requires limited assistance[18]); **3** (the person requires extensive assistance[19]); and **4** (the person is totally dependent[20]). There are also codes which are not used in calculating a service level: **5** (the person requires cueing); and **8** (the activity did not occur during the past seven days).[21]

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11 7 AAC 130.205(d)(1)(B) and (d)(2).
12 7 AAC 130.200.
13 *See* 7 AAC 130.205(d)(2); 7 AAC 130.230(b)(2)(A).
14 7 AAC 130.230(b)(2)(B).
15 Ex. E, pp. 13 – 15.
16 Ex. E, pp. 16 - 17.
17 Ex. E, p. 31.
18 Pursuant to 7 AAC 125.020(a)(1), limited assistance with an ADL "means a recipient, who is highly involved in the activity, receives direct physical help from another individual in the form of guided maneuvering of limbs, including help with weight-bearing when needed."
19 Pursuant to 7 AAC 125.020(a)(2), extensive assistance with an ADL "means that the recipient is able to perform part of the activity, but periodically requires direct physical help from another individual for weight-bearing support or full performance of the activity."
20 Pursuant to 7 AAC 125.020(a)(3), dependent as to an ADL, or dependent as to an IADL, "means the recipient cannot perform any part of the activity, but must rely entirely upon another individual to perform the activity."
21 Ex. E, p. 18.

The second component of the CAT scoring system is the *support code*. These codes rate the degree of assistance that a person requires for a particular ADL. The possible codes are **0** (no setup or physical help required); **1** (only setup help required); **2** (one person physical assist required); and **3** (two or more person physical assist required). Again, there are additional codes which are not used to arrive at a service level: **5** (cueing required); and **8** (the activity did not occur during the past seven days).[22]

If a person has a self-performance code of 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) or 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), plus a support code of 2 (physical assistance from one person) or 3 (physical assistance from two or more persons) with any of the five specified ADLs, that person receives points toward his or her total eligibility score on the CAT. A person can also receive points for combinations of required nursing services, therapies, impaired cognition (memory/reasoning difficulties), or difficult behaviors (wandering, abusive behaviors, etc.), and required assistance with any of the five specified ADLs.[23]

In order for a person who only has physical assistance needs to score as eligible for Waiver services on the CAT, he or she would need a self-performance code of 3 (extensive assistance) or 4 (total dependence) and a support code of 2 or 3 for three or more of the five specified ADLs (bed mobility, transfers, locomotion within the home, eating, and toileting).[24]

The results of the assessment portion of the CAT are then scored. If an applicant's score is 3 or higher, the applicant is medically eligible for Waiver services.[25]

2. Eligibility Decision

Ms. O-Q has been receiving Waiver benefits since 2005.[26] That assessment found that she was eligible for Waiver benefits because she required extensive assistance (self-performance code of 3) with three of the five specified ADLs: transfers, locomotion, and toilet use.[27] There was an assessment performed in 2012 that found she no longer technically qualified for Waiver

22 Ex. E, p. 18.
23 Ex. E, p. 31.
24 Ex. E, p. 31.
25 Ex. E, p. 31.
26 Ex. D, p. 1.
27 Ex. F, p. 5.

benefits. However, a Division nurse reviewer made the decision to continue Ms. O-Q's Waiver benefits based upon her overall condition.[28] A 2013 assessment was performed that similarly found Ms. O-Q was also not Waiver eligible.[29] Neither of those assessments are at issue in this case, because the termination is based upon the 2014 assessment, and not the preceding ones; this decision will only address the 2014 assessment.

The 2014 assessment found that Ms. O-Q was not receiving any therapies (physical, speech, occupation, respiratory, or specialized treatments/therapies), had no impaired cognition or behavioral issues, and was not receiving professional nursing services.[30] Ms. O-Q was prescribed physical therapy on July 23, 2013 for three times per week for an anticipated eight week period.[31] However, the time period for this therapy expired well before June 5, 2014, which was the date the Division determined Ms. O-Q no longer qualified for Waiver benefits.[32] In addition, there is a June 30, 2014 doctor's note (written on a prescription pad) that she "is in need of Physical Therapy."[33] However, there is no evidence Ms. O-Q was receiving prescribed therapies as of June 5, 2014, which means that she is not entitled to receive a point towards her eligibility scoring for therapies.[34] Consequently, her only path to continued eligibility for Waiver benefits is if she requires extensive physical assistance (self-performance code of 3) or is completely dependent (self-performance code of 4) in three or more of the qualifying ADLs of bed mobility, transfers, locomotion within the home, eating, and toileting.

Ms. O-Q argues that she requires extensive assistance in three ADLs: transfers, locomotion, and toileting. Each is addressed below.

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[28] Ex. 9; Jan Bragwell's testimony.

[29] Ex. E.

[30] Ex. K, pp. 5, 13 – 17.

[31] Ex. 5.

[32] The Division argued based upon a recent Superior Court decision that the determinative date for eligibility/termination purposes was the date of the assessment, rather than the date of the Division's termination letter. *See Casey v. State, Dept. of Health and Social Services*, Superior Court Case No. 3AN-13-05178 (Suddock, J. April 21, 2014). The issue, among others, in *Casey* was whether eligibility should be determined as of the date of the administrative hearing instead of using the date of the assessment. However, the Superior Court's holding was that utilizing the date of the assessment was within the Division's discretion. After the underlying administrative decision was issued in the *Casey* matter (January 7, 2013), the Commissioner's designee issued a decision which expressly held that the date of the Division's decisional document, being the termination or reduction notice, rather than the assessment date, was the appropriate date for determining eligibility. *In re T. C.* OAH Case No. 13-0204-MDS (Commissioner of Health and Social Services, October 2, 2013). That decision is available online at http://aws.state.ak.us/officeofadminhearings/Documents/MDS/HCW/MDS130204.pdf. The Commissioner's level decision is that the Division is to use the applicant/recipient's condition as of the date of the decisional document, and not the date of the assessment, for determining eligibility for benefits.

[33] Ex. 19.

[34] If Ms. O-Q was receiving prescribed therapies 5 or more days per week, she would be eligible for Waiver benefits. *See* Ex. K, p. 29, Section NF1(d). If she was receiving prescribed therapies 3 or 4 days per week, she would receive one point towards her eligibility scoring. *See* Ex. K, p. 29, Section NF2(b).

a. Transfers

Ms. O-Q had previously been assessed as requiring extensive assistance (self-performance code of 3) with transfers.[35] In 2014, the nurse-assessor concluded that Ms. O-Q only required supervision assistance (self-performance code of 1) for transfers. This conclusion was based upon her observation of Ms. O-Q sliding from a lying position on the couch to a sitting position on the floor, without assistance, and then seeing Ms. O-Q move from a sitting position on the floor to a standing position, without assistance, by reaching up and grabbing the handles on her walker and pulling herself up. The nurse-assessor stated that Ms. O-Q told her she could get up from the floor on her own without requiring assistance.[36]

T C is Ms. O-Q's PCA. She is very familiar with Ms. Q's care needs, having worked as her PCA both in the past and since 2013. She testified that Ms. O-Q had asked the Medicaid program to provide her with a gait belt, which was denied. She said the purpose for the gait belt was to provide the PCA with some leverage for assisting Ms. O-Q with transfers on bad days, which occur approximately four days per week. On those bad days, she has to be pulled up to a sitting position from a reclining or lying down position to initiate a transfer from between three to six times per day. Once she is in a sitting position, she can usually complete the transfer herself. Upon further questioning, Ms. C clarified her testimony to provide that Ms. O-Q needs to be pulled up from a sitting position to complete a transfer three to four times per week. She also occasionally needs assistance to transfer down. Ms. C further stated that the assessment occurred on one of Ms. O-Q's good days.[37]

The Division has the burden of proof on this point, because Ms. O-Q was previously assessed as requiring extensive assistance with transfers. When the evidence is examined, the Division did not meet its burden of proof. Ms. C is quite familiar with Ms. O-Q's care needs. In contrast, the nurse-assessor had a limited time to observe Ms. O-Q and conduct her assessment. While Ms. C described Ms. O-Q as requiring weight-bearing assistance to be pulled up from a lying or reclining position to a sitting position, that would be more consistent with body mobility needs rather than transfers.[38] Her testimony about the need to be pulled up from a sitting position to a standing position three to four times a week was consistent with transfer needs. It is also consistent with the reported need for a gait belt, inasmuch as a gait belt would be of use in

[35] Ex. F, p. 5.
[36] Ex. K, p. 6; Denise Kichura's testimony.
[37] T C's testimony.
[38] *See* Ex. K, p. 6 for a definition of body mobility. Ms. O-Q, however, is not arguing that she requires extensive assistance with body mobility.

moving from a sitting to a standing position, rather than in moving from a lying or reclining position to a sitting position. A person who requires weight-bearing assistance with transfers three or more times per week would qualify for extensive assistance with transfers. Accordingly, the Division did not meet its burden of proof and Ms. O-Q still requires extensive assistance with transfers.

b. Locomotion

Ms. O-Q had previously been assessed as requiring extensive assistance (self-performance code of 3) with locomotion.[39] In 2014, the nurse-assessor concluded that Ms. O-Q only required supervision assistance (self-performance code of 1) for transfers. She arrived at this conclusion by observing Ms. O-Q move around in her home using her walker.[40] The testimony provided by Ms. C is consistent with the nurse-assessor's conclusion: Ms. C reported that, although Ms. O-Q had an extensive history of falls, including one that caused broken ribs in the fall of 2013, Ms. O-Q was able to walk with standby assistance, such as grabbing onto clothes, in the event she started to fall.[41]

Given the consistency of Ms. C's testimony with that of the nurse-assessor, the Division has met its burden of proof on this point and established that Ms. O-Q no longer requires extensive assistance with transfers, and instead requires supervision/standby assistance.

c. Toileting

Ms. O-Q had previously been assessed as requiring extensive assistance (self-performance code of 3) with toileting.[42] In 2014, the nurse-assessor concluded that Ms. O-Q only required limited assistance (self-performance code of 2) for toileting. She arrived at this conclusion by observing Ms. O-Q move to the bathroom using her walker, and seeing her sit down and then get up from the toilet without requiring assistance.[43]

Ms. C's testimony was that Ms. O-Q only needed assistance being pulled up from the toilet about once per week. She, however, testified that she continually required hands-on assistance with cleansing herself after either using the toilet, or after incontinence episodes. Ms. C's description of the physical process was that Ms. O-Q stood and held onto the counter while Ms. C cleaned her. This is not weight-bearing assistance. At most, Ms. C's testimony described a need for weight-bearing assistance once per week. In order to qualify for extensive assistance,

39 Ex. F, p. 5.
40 Ex. K, p. 7; Ms. Kichura's testimony.
41 Ms. C's testimony.
42 Ex. F, p. 5.
43 Ex. K, p. 9; Ms. Kichura's testimony.

Ms. O-Q would have to require weight-bearing assistance three or more times per week.[44] Accordingly, the Division has met its burden of proof on this point and established that Ms. O-Q requires limited assistance with toileting, rather than extensive assistance.

d. Material Improvement

Before the Division may terminate Waiver services for a person who was previously approved for those services, Alaska Statue 47.07.045, enacted in 2006, requires that the Division must satisfy two conditions. First, it must conduct an assessment that shows the recipient's condition has materially improved to the point that the recipient "no longer has a functional limitation or cognitive impairment that would result in the need for nursing home placement, and is able to demonstrate the ability to function in a home setting without the need for waiver services."[45] It is undisputed that Ms. O-Q's overall medical condition has not improved. However, her functionality, as determined through the assessment process, has improved to the point where she only requires extensive assistance with transfers, but not with locomotion or toileting. This means that the Division has met its burden of proof on the larger question of whether Ms. O-Q continues to qualify for Waiver benefits, since she no longer requires extensive assistance in three or more of the scored ADLs.

Second, the Division's assessment showing material improvement must be "reviewed by an independent qualified health care professional under contract with the department."[46] The Division satisfied this condition when Qualis Health performed its third-party review. The reviewer agreed with the Division's conclusion that Ms. O-Q's condition had materially improved. The Division's determination that Ms. O-Q no longer qualifies for Waiver services is therefore affirmed.

B. PCA Assistance

The Medicaid program authorizes PCA services for the purpose of providing "*physical assistance* with activities of daily living (ADL), *physical assistance* with instrumental activities of daily living (IADL), and other services based on the *physical condition* of the recipient . . . ."[47] Accordingly, "[t]he department will not authorize personal care services for a recipient if the

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44 Ex. K, p. 9.
45 AS 47.07.045(b)(1) and (b)(3)(C).
46 AS 47.07.045(b)(2).
47 7 AAC 125.010(a) [emphasis added].

assessment shows that the recipient only needs assistance with supervision, cueing, and setup in order to independently perform an ADL or IADL."[48]

As with the Waiver program, the Division uses the Consumer Assessment Tool (CAT) to determine the level of physical assistance that an applicant or recipient requires in order to perform their ADLs and their IADLs.[49] The ADLs measured by the CAT for PCA services include bed mobility, transfers (non-mechanical), transfers (mechanical), locomotion (in room), locomotion (between levels), locomotion (to access apartment or living quarters), dressing, eating, toilet use, personal hygiene, personal hygiene-shampooing, and bathing.[50]

The CAT also codes certain activities known as "instrumental activities of daily living" (IADLs). These are light meal preparation, main meal preparation, light housekeeping, laundry (in-home), laundry (out-of-home), and shopping. [51]

The CAT codes IADLs slightly differently than it does ADLs. The *self-performance codes for IADLs* are **0** (independent either with or without assistive devices - no help provided); **1** (independent with difficulty; the person performed the task, but did so with difficulty or took a great amount of time to do it); **2** (assistance / done with help - the person was somewhat involved in the activity, but help in the form of supervision, reminders, or physical assistance was provided); and **3** (dependent / done by others - the person is not involved at all with the activity and the activity is fully performed by another person). There is also a code that is not used to arrive at a service level: **8** (the activity did not occur). [52]

The *support codes* for IADLs are also slightly different than the support codes for ADLs. The support codes for IADLs are **0** (no support provided); **1** (supervision / cueing provided); **2** (set-up help); **3** (physical assistance provided); and **4** (total dependence - the person was not involved at all when the activity was performed). Again, there is an additional code that is not used to arrive at a service level: **8** (the activity did not occur). [53]

If a person is coded as requiring limited or a greater degree of physical assistance (self-performance code of 2, 3, or 4, and a support code of 2, 3, or 4) in any one of the ADLs of

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48 7 AAC 125.020(e). This regulation defines "cueing" as "daily verbal or physical guidance provided to a recipient that serves as a signal to the recipient that the recipient needs to perform an activity;" "setup" as "arranging items for use or getting items ready for use so that the recipient can independently perform an ADL or IADL;" and "supervision" as "observing and giving direction, as needed, so that the recipient can independently perform an ADL or IADL." *Id.*

49 *See* 7 AAC 125.020(a) and (b).

50 Ex. E, pp. 6 – 11.

51 Ex. E, p. 26.

52 Ex. E, p. 26.

53 Ex. E, p. 26.

transfers, locomotion, eating, toilet use, dressing or bathing, then he or she is eligible for PCA services. Similarly, if a person is coded as requiring some degree of hands-on assistance[54] (self-performance code of 1, 2, or 3, and a support code of 3 or 4) with any one of the IADLs of light or main meal preparation, light housework, routine housework, grocery shopping or laundry, then he or she is eligible for PCA services.[55]

The codes assigned to a particular ADL or IADL determine how much PCA service time a person receives for each occurrence of a particular activity. For instance, if a person is coded as requiring extensive assistance (code of 3) with bathing, he or she would receive 22.5 minutes of PCA service time every day he or she was bathed.[56]

The specific areas in dispute are:

1. Transfers

As discussed above, it is more likely true than not true that Ms. O-Q requires weight-bearing assistance (extensive assistance) for transfers. She had previously been provided with this assistance 28 times per week. The Division eliminated this assistance altogether.[57] At hearing, the evidence was that Ms. O-Q could transfer by herself, for the most part, when she was in a sitting position. However, she does have bad days, and her PCA estimated that she required extensive assistance, being pulled up from a sitting to standing position, to transfer three to four times weekly. Although the Division has not demonstrated that Ms. O-Q's transfer assistance should be eliminated in its entirety, it has met its burden of proof to show that it should be reduced. That reduction, as supported by the PCA's testimony, is that Ms. O-Q should receive extensive assistance with transfers four times weekly.

2. Locomotion Within Home

As discussed above, it is more likely than not true that Ms. O-Q no longer requires extensive assistance (self-performance code of 3) with locomotion within her home, but rather only requires supervision/standby assistance once per day, seven days per week. Because the PCA program does not provide a person with PCA services for supervision/standby assistance, Ms. O-Q is no longer eligible to receive PCA assistance with locomotion.

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[54] For the purposes of this discussion, "hands-on" assistance does not include supervision/cueing or set-up assistance (support codes of 1 or 2). *See* Ex. E, pg. 26.

[55] Ex. E, p. 31.

[56] *See* 7 AAC 125.024(a)(1) and the Division's *Personal Care Assistance Service Level Computation* chart contained at Ex. B, pp. 34 - 36.

[57] Ex. K, p. 6; Ex. M, p. 9.

3. Toileting

The Division reduced Ms. O-Q's toileting assistance to limited assistance 28 times per week.[58] As discussed above, it is more likely true than not true that Ms. O-Q no longer requires extensive assistance (self-performance code of 3) with toileting. Instead, because she requires weight-bearing assistance approximately once per week, and because she requires physical hands-on assistance with cleansing after toileting and incontinence episodes, she instead requires limited assistance. Ms. O-Q does not dispute the frequency for toileting assistance: 28 times weekly. Accordingly, the Division has met its burden of proof and demonstrated that Ms. O-Q's toileting assistance should be reduced to limited assistance 28 times per week.

4. Dressing

Ms. O-Q was previously provided limited assistance with dressing twice daily. The Division did not change her level of assistance.[59] At hearing, Ms. O-Q did not disagree that she required limited assistance; however, she wished to increase the frequency of her assistance.[60] A review of Ms. C's testimony demonstrates that the increased need for dressing is occasioned by Ms. O-Q's incontinence issues. However, that would properly fall under toileting.[61] Accordingly, Ms. O-Q has not met her burden of proof on this increase. Her dressing assistance should remain at limited assistance, twice daily, for a total of 14 times per week.

5. Personal Hygiene

Ms. O-Q previously received limited assistance with personal hygiene. The Division determined that she was capable of performing this task herself with setup assistance (self-performance code of 0, support code of 1) and eliminated PCA assistance with this task.[62] The nurse-assessor arrived at this determination by her observation of Ms. O-Q's range of motion, and by seeing her stand over the sink, obtain a glass of water, and bring her hand to her face.[63]

Ms. C testified that she has to squeeze Ms. O-Q's toothpaste onto her brush and pours her mouthwash into a cup. Ms. O-Q is able to brush her own teeth and gargle. Ms. O-Q has her PCA comb her hair due to pain, and is unable to shave herself, which she does approximately

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58 Ex. K, p. 9; Ex. M, p. 9.

59 Ex. M, p. 9.

60 Ms. O-Q's post-hearing briefing does not address dressing. In the interest of completeness, it is addressed instead of assuming that she has abandoned this request.

61 "Toilet use (How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes)." Ex. K, p. 9.

62 Ex. K, p. 10; Ex. M, p. 9.

63 Ms. Kichura's testimony; Ex. K, p. 10.

once per week. Ms. O-Q is unable to apply lotion, due to her girth, and the PCA has to do it for her.[64]

The evidence on this point is somewhat equivocal. The nurse-assessor described a person who needed setup help only. Ms. O-Q can probably comb her own hair. However, Ms. C's testimony described someone who receives setup help, but needs some degree of hands-on assistance with items like lotions and shaving. The Division has the burden of proof on this case. Given Ms. C's testimony, which is supported by the fact that Ms. O-Q undoubtedly has functional limitations due to her weight, the Division has not met its burden of proof. It is more likely true than not true that Ms. O-Q continues to require limited assistance with personal hygiene. She is therefore entitled to continue to receive daily personal hygiene assistance.

6. Medication

In order to receive assistance with medication, a person must have a personal hygiene coding of limited assistance (self-performance code of 2) or higher. Ms. O-Q has satisfied that threshold. Ms. Q has an extensive list of medications, which are taken at various times daily.[65] It is therefore more likely true than not true that Ms. O-Q requires medication assistance twice daily.

7. Medical Escort

The Division reduced Ms. O-Q's authorization from 52 minutes weekly to 3.85 minutes weekly. It arrived at this amount by calculating that she should receive 10 minutes per doctor visit for 20 doctor visits per year.[66] The applicable regulation authorizes PCA services for medical escort for "traveling with the recipient to and from a routine medical or dental appointment outside the recipient's home **and** conferring with medical or dental staff during that appointment."[67] Given that Ms. O-Q requires transportation and conferring,[68] 10 minutes per visit is highly unrealistic. Although Ms. C's testimony was rather vague on escort timing and needs, the estimate that Ms. O-Q has an average of two doctor's appointment monthly with an average time for escort (transportation and conferring) of 30 minutes each appointment, is realistic and is supported by the available evidence. This results in an average of 14 minutes per week. It is therefore more likely true than not true that medical escort should be reduced;

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64 Ms. C's testimony.
65 Ms. C's testimony; Ex. K, p. 20.
66 Ex. M, pp. 4, 9.
67 7 AAC 125.030(d)(9) (emphasis supplied).
68 *See* Ex. K, p. 26.

however that reduction should be to 14 minutes per week rather than the 3.85 minutes posited by the Division.

8. Laundry

Ms. O-Q requested that she be provided PCA assistance with laundry due to the high volume occasioned by her incontinence. The PCA regulations do not allow assistance with IADLs such as laundry if "provided by a spouse of the recipient."[69] Ms. O-Q resides with her husband. He has a full-time job outside the home. However, there is nothing in the record that demonstrates that he is physically or mentally incapable of doing laundry. As a result, it is more likely true than not true that Ms. O-Q is ineligible for PCA assistance with laundry.

9. Prescribed Tasks

Ms. O-Q has a prescribed task form completed by Dr. D on April 29, 2014. That form prescribes 45 minutes daily for range of motion exercises, 45 minutes daily for walking exercise, and 30 minutes weekly for foot care.[70] PCA services are allowed for prescribed foot care, range of motion exercises, and walking exercise, if those prescriptions are consistent with the assessment and meet the recipient's needs.[71] The Division declined to allow PCA assistance for these tasks. The Division's written reasons for denying the range of motion exercises was that Ms. O-Q had a good range of motion and was able to perform the functional assessment; the written reason for denying walking exercise was that she was capable of walking with only supervision assistance; and the written reasons for denying foot care was that she was able perform her foot care herself with setup help, and she was provided bathing assistance.[72] At hearing, the nurse-assessor provided additional reasons for denial, to wit: Ms. O-Q told her that she could not perform the exercises, and that foot care was only available for non-diabetics.

It must first be noted that the Division's written reasons refer to a task form completed by a Dr. N on April 9, 2014 and refers to range of motion exercises three days per week, when the prescribed task form was signed by Dr. D on April 29, 2014 and prescribes daily range of motion exercises.[73] Given that the Division's written reasons refer to an entirely different document than the one at issue, it is questionable whether those written reasons apply. Regardless, the

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[69] 7 AAC 125.040(a)(13).

[70] Ex. 14. Ms. O-Q also submitted a different prescribed task form, which was dated July 1, 2014 (Ex. 18). Because the prescribed task form, that Ms. O-Q's PCA services should be reduced, was signed well after the Division made its determination, on May 15, 2014, it will not be considered.

[71] 7 AAC 125.030(b)(1)(B), (b)(3)(B), (d)(5), and (e)(2); *Personal Care Assistance Service Level Computation*, p. 3 (adopted by reference in 7 AAC 160.900(d)(29).

[72] Ex. M, p. 9.

[73] Ex. 14.

evidence shows that Ms. O-Q has functional limitations due to her weight and lumbosacral disc degeneration, and despite the fact that she can use her walker with supervision, she is a fall risk. The evidence therefore corroborates the prescriptions for PCA assistance with range of motion exercises and walking exercises, rather than negating the prescriptions. The nurse-assessor's other reason for denying the prescribed tasks being her testimony that Ms. O-Q told her she could not perform the exercises,[74] does not negate the need for PCA services. Those services should be in place in the event Ms. O-Q chooses to avail herself of them.

With regard to foot care, Ms. O-Q needs help taking care of her feet, as demonstrated by Ms. C's testimony. She has a prescription for foot care.[75] She has a letter from her doctor authorizing the PCA to provide foot care.[76] She has a statement from her podiatrist stating she "requires PCA to apply lotion to feet daily and sand nails when sharp [with] socks."[77] The nurse-assessor's testimony raised a reason at hearing[78] for not allowing foot care, being that foot care is not allowed for a diabetic. That is a reading of the regulations that neglects to take the entire regulation into account. A person is not provided assistance under personal hygiene for nail care for a diabetic.[79] However, a person can be provided foot care if prescribed.[80] Reading the regulation in its entirety, while a diabetic is not normally allowed nail care, foot care, even if it includes nail care, is allowable when prescribed.

Ms. O-Q had the burden of proof on the issues of whether she should be provided PCA assistance with range of motion exercises, walking exercises, and foot care. She has a current prescription for those activities which predated both the 2014 assessment and the Division's denial notice. She also has demonstrated functional impairments that corroborate the need for these prescriptions. She has met her burden.

IV. Conclusion

Ms. O-Q's condition, as measured by the CAT, has materially improved. She is no longer eligible for Medicaid Waiver services. The Division's decision to terminate those services is affirmed.

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74 The Division is advised that reasons for denial of services are to be contained in the denial notice itself, not raised for the first time at hearing. "[T]he department will state in the written notice the reasons for the proposed action, including the statute, regulation, or policy upon which that action is based." 7 AAC 49.070.

75 Ex. 14.

76 Ex. 15.

77 Ex. 17.

78 *See* n. 74 above.

79 7 AAC 125.040(b)(7).

80 7 AAC 125.040(d)(5).

As discussed in detail above, Ms. O-Q's PCA service plan does not accurately reflect her needs for assistance in the areas of transfers, personal hygiene, medication, medical escort, and the prescribed tasks of range of motion exercises, walking exercises, and foot care. Her PCA service plan should be revised to be consistent with this decision.

DATED this 5th day of November, 2014.

Signed
Lawrence A. Pederson
Administrative Law Judge

Adoption

The undersigned, under the authority of AS 44.64.060(e)(1), adopts the foregoing as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 7th day of November, 2014.

By: *Signed*
William Streur
Commissioner
Department of Health and Social Services