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

In the Matter of	)	
	)	
J H	)	OAH No. 14-1092-MDS
	)	Agency No.

DECISION

I. Introduction

J H applied for Medicaid Home and Community-Based Waiver program services. The Division of Senior and Disabilities Services denied her application on June 2, 2014.[1] Ms. H requested a hearing.[2]

Ms. H's hearing took place on September 22, 2014. Ms. N W, a registered nurse[3] and the administrator and owner of the assisted living home where Ms. H has lived since the beginning of 2014, presented Ms. H's case. Tammy Smith, hearing representative, and Scott Chow, nurse assessor, appeared on behalf of the Division. A follow-up hearing was held on October 3, 2014, in order to take testimony from N X, Ms. H's care coordinator. The record was held open until October 13, 2014, in the event Mr. Chow wanted to submit a response to Ms. X' testimony.[4]

Ms. H experiences substantial physical impairments as well as some cognitive and behavioral issues. At the time of its denial, the Division reasonably concluded that Ms. H's impairments fell short of qualifying for Waiver services. However, through the hearing process Ms. H established that her activities of daily living (ADL) needs rise to the level necessary to qualify her for Waiver services. As a result, the denial of her application for Waiver services is reversed.

II. Facts

Ms. H is 82 years old. Her documented medical diagnoses consist of a right foot amputation, left above the knee amputation, diabetes, phantom limb syndrome, hypertension, mild depression, and hyperlipidemia.[5] Ms. H also suffers from chronic obstructive pulmonary

---

1 Exhibit D.
2 Ex. C.
3 http://commerce.state.ak.us/occ/OccSearch/Detail.cfm?board=NUR&LicType=R&LicNum=37163 Verified at the Alaska Board of Nursing licensed professional database.
4 The Division did not submit a response.
5 Ex. E, p. 3; Ex. 2; Ex. 3.

disease (COPD) and congestive heart failure (CHF).[6] She has difficulty communicating and struggles to find the right words.[7] The medical records noted Ms. H had a stroke, which occurred prior to her arrival at the assisted living home.[8] Ms. H's daughter, Z D, holds a power of attorney for her.[9]

On April 4, 2014, Mr. Chow assessed Ms. H's Waiver eligibility using the Consumer Assessment Tool (CAT).[10] The assessment found the following:

- Ms. H requires limited physical assistance with bed mobility, 2/2 score.
- Ms. H requires extensive assistance with transfers and toilet use, 3/3 score.
- Ms. H is independent with eating, 0/0 score.
- Ms. H requires supervision assistance only with locomotion because she can propel her own wheelchair, 1/0.
- Ms. H did not require professional nursing services, therapy from a qualified therapist, specialized treatment, or therapies.
- Ms. H had minor difficulty with speech and word-finding, but otherwise did not have cognitive or behavior problems.

Mr. Chow did not observe eating, transfers, toileting, or body mobility,[11] but relied on Ms. H's self-report and his physical assessment of her range or motion and grip strength.[12] Mr. Chow observed Ms. H propel her wheelchair using her lower right leg.[13] On the CAT, the boxes for "bruises," "rashes, itchiness, body lice, scabies," and "open sore or lesions" were all checked.[14] The "open sore or lesions" related to a boil.[15]

Ms. W and Ms. X testified convincingly, and the Division did not dispute, that Ms. H's physical and mental health has declined since the assessment visit. Ms. H can no longer propel her own wheelchair, has been hospitalized, and is now on oxygen. Her arms have weakened and

---

6 Ex. 2, p. 13. At the time of her assessment, Ms. H was not diagnosed with COPD or shortness of breath. These diagnoses were given during an admittance to No Name Medical Center on July 25, 2014.
7 W testimony; X testimony.
8 Ex. 2, p. 18; W testimony.
9 Ex. E, p. 4; Ex. 1.
10 Ex. E.
11 W testimony.
12 Chow testimony.
13 Chow testimony.
14 Ex. 26.
15 Chow testimony.

exhibit slight trembling.[16] Ms. H has expressive aphasia, or the inability to "find the right words," which continues to worsen. She gets angry and frustrated, both with services and her failing health. When frustrated, Ms. H shouts at caregivers.[17] Ms. H refuses physical therapy and does not like to travel because of waiting on transportation.[18]

After the Division's denial, Ms. H submitted medical records from a July 25 – 31, 2014, stay at No Name Medical Center (NNMC), and follow up records. The basis for the admittance was acute shortness of breath.[19] Upon her discharge, Ms. H was diagnosed with acute hypoxemic and hypercapnic respiratory failure, acute exacerbation of COPD, acute bronchitis, atrial fibrillation with rapid ventricular response, acute systolic CHF (congestive heart failure) exacerbation, insulin-dependent diabetes with labile glucose, chronic kidney disease, borderline hyperkalemia, asymptomatic bacteruria/pyuria, and probable coronary artery disease.[20] Ms. H's breathing difficulties are relatively new and developed after the Division's denial.[21]

The NNMC medical records contain a "current patient status" section which addresses some of the ADLs.[22] For "bed mobility, supine to sit," Ms. H was scored in that assessment as needing "moderate assist, (50% patient effort), 1 person assist; verbal cues; nonverbal cues (demo/gestures); set-up required, bed rails, bed features." Ms. H is noted as needing maximum assistance for transfers.[23]

Ms. H was admitted to the hospital for 3 days in September 2014 because of complications with a wound located on her lower right leg, at the site of her foot amputation.[24] Ms. H used this leg to propel herself in her wheelchair at the time of the assessment visit and since her arrival at the assisted living home.[25] Because of this significant and continuous wound, which now has a needle in the wound site and is prone to infection, Ms. H is no longer able to propel her own wheelchair.[26]

---

16 W testimony.
17 W testimony.
18 W testimony.
19 Ex. 2, p. 12.
20 Ex. 2, p. 13.
21 Ex. 2, p. 18.
22 Ex. 2, p. 25.
23 Ex. 2, p. 25.
24 W testimony. The record does not contain medical documentation from this admittance.
25 Ex. E, p. 9; W testimony.
26 W testimony; X testimony.

Although contradictory to Mr. Chow's assessment, both Ms. W and Ms. X testified credibly that Ms. H is unable to use her arms to propel herself due to weakness.

There is no evidence that Ms. H required professional nursing services, therapy from a qualified therapist, specialized treatment, or therapies at the time of the assessment visit or up until the time of the Division's denial.

III. Discussion

A. Method for Assessing Eligibility

Because this is an initial application for services, Ms. H has the burden of showing, by a preponderance of the evidence, that the Division's denial was inaccurate.[27]

The Alaska Medicaid program provides Waiver services to adults with physical disabilities who require "a level of care provided in a nursing facility."[28] A person can qualify if he or she requires intermediate[29] or skilled[30] level of nursing care. The purpose of these services is "to offer a choice between home and community-based Waiver services and institutional care."[31]

The nursing facility level of care[32] requirement is determined in part by an assessment, which is documented by the CAT.[33] The CAT records an applicant's needs for professional nursing services, therapies, and special treatments,[34] and whether an applicant has impaired cognition or displays problem behaviors.[35] 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.[36] If an applicant's score is a 3 or higher, the applicant is medically eligible for Waiver services.[37]

A person can receive points for combinations of required nursing services, therapies, impaired cognition (memory/reasoning difficulties), or difficult behaviors (wandering, abusive

---

27 7 AAC 49.135.
28 7 AAC 130.205(d)(1)(B) and (d)(2).
29 7 AAC 140.510.
30 7 AAC 140.515.
31 7 AAC 130.200.
32 *See* 7 AAC 130.205(d)(4); 7 AAC 130.230(b)(2)(A).
33 7 AAC 130.215(4).
34 Ex. E, pp. 13 – 15.
35 Ex. E, pp. 16 - 17.
36 Ex. E, p. 30.
37 Ex. E, p. 30.

behaviors, etc.), and required assistance with five specified ADLs, commonly called the "shaded" ADLs.[38]

The shaded ADLs are: bed mobility (moving within a bed), transfers (i.e., moving from the bed to a chair or a couch, etc.), locomotion (walking or movement when using a device such as a cane, walker, or wheelchair) within the home, eating, and toileting.[39]

The CAT includes ADL self-performance and support scores. Self-performance codes range from 0 (the person is independent and requires no help or oversight) to 4 (the person is totally dependent).[40] Support scores range from 0 (no setup or physical assist from staff) to 3 (two+ persons physical assist).[41]

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 activities of daily living.[42] A person who is scored as needing extensive assistance or total dependence in three of the five shaded ADLs receives a score of 3, thus qualifying for Waiver services.

B. Eligibility

It is undisputed that at the time of the assessment visit Ms. H did not require professional nursing services, therapy from a qualified therapist, or specialized treatment. Therefore, the only way Ms. H could qualify for Waiver services is through ADL scoring or a combination of ADL and cognitive or behavior scoring.

1. Activities of Daily Living

At the time of the assessment visit, Ms. H was scored as needing extensive assistance with 2 of the 5 shaded ADLs, transfers and toileting. In order to qualify for Waiver through ADL scoring only, Ms. H would need to score extensive assistance with 3 of the 5 shaded ADLs. It is undisputed that Ms. H is independent with eating.[43] The two ADLs at issue are therefore bed mobility and locomotion.

---

38 Ex. E, p. 30.

39 Ex. E, p. 18.

40 *See* Ex. E, p. 6, *See also* 7 AAC 125.020. There are also codes 5 (cueing) and 8 (the activity did not occur during the past 7 days). These are not used to determine Waiver eligibility.

41 *See* Ex. E, p. 6. There are also codes 5 (cueing support required 7 days a week) and 8 (activity did not occur during the past 7 days).

42 Ex. E, NF 1(e), p. 30.

43 W testimony.

a. Bed mobility

For purposes of Waiver services eligibility, bed mobility is defined as how a person moves to and from a lying position, turns side to side, and positions his or her body while in bed.[44] In order to receive a self-performance score of three (extensive assistance) with regard to bed/body mobility, a person must require either weight-bearing support three or more times per week, or full caregiver performance of the activity part of the time.[45]

The evidence is contradictory with regards to bed mobility. Ms. H's CAT score was 2/2, or limited assistance. The CAT states, "HG said she can turn slightly in bed but needs help to sit up because she isn't strong enough."[46] Ms. W reported that Ms. H needs complete assistance with all of her ADLs.[47] She described that Ms. H could assist using her elbows. Ms. W is understandably concerned with Ms. H developing decubitus ulcers, especially in light of her diabetes and amputations. However, much of Ms. W's testimony on bed mobility relates more closely to transfers. She discussed using two caregivers to move Ms. H from her bed to her wheelchair because they wanted to ensure safe transfers. Any movement to or from the bed involves a transfer.

Ms. H's medical records indicate that she needs a "moderate assist" with bed mobility. The record states that Ms. H requires minimum assistance to roll and moderate assistance for supine to sit and movement to the edge of bed.[48] It also states that, once sitting, she has fairly good sitting balance and is able to laterally scoot along edge of bed with only minimum assistance.[49] This information generally supports the CAT score and Ms. H's self-report. Ms. W explained that the hospital bed has rails, but Ms. H's bed in the assisted living home does not. Ms. W appears to argue that this distinction causes Ms. H to need extensive assistance at her home, but not in the hospital. Ms. X testified that Ms. H has not been able to turn independently in bed for years.

Whether someone is coded a 2 or 3 in self-performance depends heavily on whether the assistance provided is weight-bearing at least 3 times a week. The record is not clear that Ms. H needs weight-bearing assistance in bed mobility three times a week. It is a close call, but the

---

44 Ex. E p. 8.
45 Ex. E p. 6.
46 Ex. E, p. 8.
47 W testimony.
48 Ex. 2, p. 25-26.
49 Ex. 2, p. 26.

preponderance of the evidence does not support an "extensive assistance" score. The Division's score of 2/2 is reasonable based on the record and is upheld.

b. Locomotion

Based on Ms. W's and Ms. X' credible testimony, Ms. H, if reassessed today, would score as needing extensive assistance, 3/3, in locomotion. However, the relevant date in terms of scoring is the Division's denial letter date.[50] At the time of the assessment visit, which was two months before the denial, Ms. H was able to propel herself in her wheelchair using her lower leg and using her hands and fingers to make turns. Ms. Chow testified that while he witnessed Ms. H propel herself using her leg, he believed she should be able to propel herself using her upper arms based on her grip strength and range of motion. But, Ms. H has never propelled her wheelchair using her upper extremities.[51] When asked, Ms. H reported she cannot do so because of pain.[52] Ms. H must rely on others to push her wheelchair in order for her to locomote.[53]

Ms. X, who has known Ms. H for approximately eight years, testified credibly that the wound on her lower leg has been a problem for years, and that part of the wound problem is Ms. H's use of that leg to propel her wheelchair. A wound would develop, be treated, and heal. Ms. H would then use that leg to propel herself and the wound would redevelop. Ms. X testified that medical providers are considering further amputation of her right leg due to the wound. The record does not contain a letter from Ms. H's physician, referenced by Ms. X, regarding the wound and when this current wound developed. The Division argues that the wound developed after the denial date. Ms. X stated that the onset date of the most recent wound is not clear, but is likely before the Division's denial date.

In this particular instance, the exact onset of the current wound is not determinative. The assessment is not a singular moment in time. The Division considers the assessment visit, the prior year, and any evidence submitted prior to the decision date. Here, the evidence supports a finding that Ms. H cannot use her arms to propel herself. She has never done so. The record also supports a finding that it was precisely Ms. H's use of her lower amputated leg to propel her wheelchair that caused the wound that required her hospitalization. While Ms. H used that leg for locomotion, it was an unsafe practice. Essentially, because of its deleterious effects, Ms. H

---

50 *See In re T.C.*, OAH No. 13-0204-MDS (Commissioner of Health and Soc. Serv. 2013).
51 W testimony; X testimony.
52 W testimony.
53 W testimony; X testimony.

cannot propel herself with her leg even if it were to heal in the future. Ms. H now requires extensive assistance and, given the wound's location and genesis, it is more likely than not that she required extensive assistance prior to the Division's June 2, 2014 denial letter.

While Mr. Chow's observations supported the score of 1/0 because Ms. H was propelling herself at the time of the assessment visit, the fully developed record shows Ms. H required extensive assistance, whether she got it or not, in locomotion. Based on the entire record, Ms. H has established that, at least by the time of the denial, her locomotion score should have been extensive assistance, 3/3.

2. Cognition and Problem Behavior

Contradictory evidence also exists regarding cognition and problem behavior. Ms. W and Ms. X testified that Ms. H has problems finding the right words, is difficult to communicate with and does not make good decisions. Mr. Chow was able to understand and evaluate Ms. H with little difficulty. Ms. D, Ms. H's daughter and attorney-in-fact, stated that while Ms. H has trouble finding her words, she can make her own decisions and knows what is going on.[54] Ms. W testified that Ms. H yells at caregivers and gets very frustrated waiting for rides. Overall, the level of cognition and behavior problems discussed would not lead to a notable change in Ms. H's CAT scores.[55]

IV. Conclusion

Ms. H had the burden of proof to demonstrate that she qualifies for Waiver services. She has met that burden by showing a need for physical assistance at the 3/3 level or higher for three shaded ADLs. The Division's decision to deny Ms. H's Waiver application, though reasonable based on the information at the time of the assessment visit, is not supported by the fuller record developed through the hearing process. It is reversed.

Dated this 31st day of October, 2014.

Signed
Bride A. Seifert
Administrative Law Judge

[54] D statement. Ms. D chose not to participate in the hearing, stating that Ms. H was able to make her own decisions. Ms. D believed that Ms. X had a good understanding of Ms. H's situation and should participate in the hearing.

[55] Because Ms. H qualifies for Waiver services under ADLs alone, a detailed analysis of her cognition and behavior scores is not necessary for the outcome of the case.

Adoption

The undersigned by delegation from the Commissioner of Health and Social Services, adopts this decision as final under the authority of AS 44.64.060(e)(1).

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 17th day of November, 2014.

By: *Signed*
Signature
Bride A. Seifert
Name
Administrative Law Judge
Title

[This document has been modified to conform to the technical standards for publication.]