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

In the Matter of:	)	
	)	
U Q	)	OAH Nos. 14-1754-MDS, 14-2177-MDS
	)	Agency Nos. (Consolidated)

DECISION

I. Introduction

This matter involves two cases concerning the Medicaid benefits of Ms. U Q. The issue in Case No. 14-1754-MDS is whether Ms. Q remains eligible for Medicaid Home and Community-Based Waiver services (waiver services). The issue in Case No. 14-2177-MDS is whether Ms. Q remains eligible for Medicaid Personal Care Assistance (PCA) services. The Division of Senior and Disabilities Services (Division) conducted an assessment on June 6, 2014 and subsequently determined that Ms. Q no longer requires a nursing facility level of care (NFLOC), and is therefore no longer eligible to receive waiver services.[1] Based on the same assessment, the Division also concluded that Ms. Q is no longer eligible to receive PCA services.[2]

This decision concludes, based largely on critical incident reports filed on Ms. Q's behalf by her caregivers, that Ms. Q has a history of cataplexic / narcoleptic seizures, which require direct assistance from others for safe management, occurring once per week during the week prior to the assessment, and during the period between the assessment and the termination notice. When an applicant or recipient has uncontrolled seizures with this frequency, the Division's Consumer Assessment Tool (CAT) conclusively presumes that the individual requires skilled or intermediate level nursing care. Accordingly, Ms. Q remains eligible to receive waiver services, and the Division's termination of Ms. Q's waiver services is therefore reversed.

This decision further concludes that Ms. Q has significant physical impairments which limit her ability to function independently, and that she requires more assistance with her activities of daily living than was originally determined by the Division.[3] Accordingly, Ms. Q

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1 Exs. D, E.

2 Ex. G.

3 This is partly due to the fact that additional information was brought out through the hearing process which was not available to the Division at the time of the original assessment.

remains eligible to receive PCA services, and the Division's decision terminating her PCA services is therefore reversed.[4]

II. Facts

A. Ms. Q's Medical Diagnoses and Reports from Medical Providers

Ms. Q is a 66-year-old woman who lives alone in a single level private residence.[5] She is five feet, two inches tall and weighs about 222 pounds.[6] Her medical diagnoses include allergies, asthma, atherosclerosis / coronary artery disease, right brain trauma due to right temporal brain resection, cervical intervertebral disk problems (bulging, narrowing, and surgical fusion), chest pain, diabetes mellitus type II, epilepsy (generalized, non-convulsive), eczema, gastroesophageal reflux disease (GERD), hearing loss, hyperlipidemia, hypertension, acquired hypothyroidism, irritable bowel syndrome (IBS), kidney calculus, Meniere's cochleovestibular disease,[7] narcolepsy[8] with cataplexy,[9] obesity, obstructive sleep apnea, osteoarthritis is in multiple joints (including the neck, back, shoulders, and hands), peripheral neuropathy, Raynaud's syndrome,[10] stress incontinence, unspecified joint contracture, and loss of vision due to macular degeneration.[11]

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[4] This decision makes specific findings as to the appropriate self performance scores, support scores, and frequencies for Ms. Q's PCA services. The Division will calculate the specific amount of PCA time for which Ms. Q is eligible based on these findings.

[5] Ex. E3.

[6] Ex. E12.

[7] Meniere's disease is a disorder of the inner ear that causes spontaneous episodes of vertigo — a sensation of a spinning motion — along with fluctuating hearing loss, ringing in the ear (tinnitus), and sometimes a feeling of fullness or pressure in your ear. *See* the Mayo Clinic's website at http://www.mayoclinic.org/diseases-conditions/menieres-disease/basics/definition/con-20028251 (date accessed July 20, 2015).

[8] Narcolepsy is a disorder characterized by sudden and uncontrollable, though often brief, attacks of deep sleep, sometimes accompanied by paralysis and hallucinations. *See* American Heritage Medical Dictionary (Houghton Mifflin Company, 2007).

[9] Cataplexy is the result of an absence of the neurotransmitter hypocretin (also known as orexin) in the hypothalamus. *See* article by Dr. N Cao and Dr. Christian Guilleminault in Scholarpedia 3(1):3317 (2008), accessed on line at http://www.scholarpedia.org/article/Cataplexy (date accessed July 20, 2015). A cataplectic attack is sudden in onset and is localized to a specific muscle group or parts of the body. *Id.* The subject is lucid (consciousness is maintained) at the onset of cataplexy. *Id.* As the attack continues the person may experience sleepiness, hallucinations, or sleep-onset REM period. *Id.* A full-blown attack may result in complete muscle paralysis with postural collapse and possible injury. *Id.* The more common cataplectic attacks involve the head and fB, neck, upper limbs, and more rarely the lower limbs ("knee buckling"), and the person may drop objects held in hands. *Id.* Attacks can last from a few seconds up to ten minutes, and may occur several times per week. *Id.* Emotions that may trigger attacks include laughter (most common), fear, anger, frustration, annoyance, nervousness, and embarrassment. *Id.*

[10] Raynaud's disease causes some areas of the body, such as your fingers and toes, to feel numb and cold in response to cold temperatures or stress. *See* the Mayo Clinic's website at http://www.mayoclinic.org/diseases-conditions/raynauds-disease/basics/definition/con-20022916 (date accessed July 20, 2015). In Raynaud's disease, the smaller arteries that supply blood to the skin narrow, limiting blood circulation to affected areas. *Id.* Women are more likely than men to have Raynaud's disease, and it is more common in people who live in colder climates. *Id.*

[11] Ex. 17 p. 1; Ex. E5.

Ms. Q sustained a brain injury at birth due to problems during her delivery.[12] This is believed to have caused her epilepsy. She had brain surgery in 1982 which lessened her epileptic seizure activity. In or after 1985 she had some mercury-containing dental fillings replBd, and she has not had epilepsy-related seizures since that time.[13] However, prior to 1985, she sustained a number of injuries due to falls during epilepsy-related seizures.[14] Further, as discussed below, Ms. Q continues to sustain injuries from falls due to cataplexic / narcoleptic episodes or seizures.

In 1963 Ms. Q had viral myocarditis, which gave her an enlarged heart and a heart murmur.[15] She still has occasional chest pains, sometimes with sweating and difficulty breathing, because of this. In 1976 Ms. Q developed a hiatal hernia and GERD, which now requires that she sleep with her head in an elevated position. In 1978 Ms. Q developed IBS. This has caused or contributed to her incontinence problems and abdominal cramps.

In 1982 Ms. Q had right carpal tunnel release surgery.[16] In 1984 Ms. Q sustained a gunshot wound to her left shoulder.[17] She still has shoulder pain as a result of this injury. In 1988 she sustained torn ligaments in her knees. Her knees still hurt from this; the pain is greater in the right knee than the left knee.

In 1989 Ms. Q underwent a cholecystectomy.[18] Also in 1989 Ms. Q ruptured a vertebral disk, which required spinal fusion surgery at the C5-C6 level.[19] In 1992 she ruptured another vertebral disk, which required spinal fusion surgery at C6-C7. As a result, she has pain and stiffness (limited ROM) in her shoulders, neck, and back.

In 1990 Ms. Q developed asthma.[20] In 1992 Ms. Q was assaulted and her jaw was splintered. Although her jaw was surgically repaired, and she had TMJ surgery in 1993,[21] it still causes her discomfort. In 1993 one of Ms. Q's toes was broken, and in 1994 she was again assaulted and six of her ribs were broken. In 1995 Ms. Q developed arthritis in her neck shoulders, hands, and hips, probably as a result of her prior traumatic injuries. The arthritis in Ms. Q's left

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12 All factual findings in this paragraph are based on Ex. 30, p. 1 unless otherwise stated.

13 It is important to note that, although Ms. Q's *epileptic-related* seizures are now controlled, her cataplexic / narcoleptic episodes, which are also often referred to as "seizures, *are currently uncontrolled*, as discussed below.

14 Ex. 28 p. 2. Exhibit 28 appears to be the same document as Exhibit 1. Accordingly, all information contained in Exhibit 28 is also contained in Exhibit 1.

15 All factual findings in this paragraph are based on Ex. 28-2 unless otherwise stated.

16 Ex. 18 p. 1.

17 All factual findings in this paragraph are based on Ex. 28-2 unless otherwise stated.

18 Ex. 18 p. 2.

19 All factual findings in this paragraph are based on Ex. 18 p. 1 and Ex. 28 p. 3 unless otherwise stated.

20 All factual findings in this paragraph are based on Ex. 28, p. 3 unless otherwise stated.

21 Ex. 18 p. 2.

hand makes it difficult for her to use her manual wheelchair. Ms. Q also had an appendectomy in 1995.[22]

In 1996 Ms. Q fell, tearing her right rotator cuff and ligaments in her rights shoulder.[23] She still has pain and stiffness from these injuries, which make it difficult for her to raise her arms over her head. Also in 1996 Ms. Q underwent a cancer-related lymph node resection.[24] In 1999 Ms. Q developed hypothyroidism, which causes her mood swings and occasional confusion. Also in 1999 Ms. Q developed Type 2 diabetes. The diabetes caused vision problems which required corrective surgery in 2000 and 2003. Ms. Q now wears glasses, but there are still certain distances at which she cannot see very well.

In 2000 Ms. Q developed hypertension.[25] Although the symptoms are mostly controlled by medication, she will still sometimes get chest pains when under stress. Also in 2000 Ms. Q developed obstructive sleep apnea. She uses a CPAP machine, but still has trouble sleeping well.

Significantly, in 2000 Ms. Q developed narcolepsy / cataplexy.[26] She is allergic to the medication prescribed to treat these conditions. As a result, she has fallen numerous times and sustained numerous injuries. During one episode she spilled hot water on herself while cooking. During another episode she started a fire (again while cooking). Her PCAs have witnessed and attested to the fact that Ms. Q has these episodes,[27] as has the former pastor of her church.[28]

A letter dated June 6, 2001 from D T. F, M.D. states in relevant part as follows:[29]

> It is my finding that Ms. Q has situational depression second to her medical illness which is narcolepsy / cataplexy. Ms. Q does not have Factitious Disorder, nor is she malingering.

A letter dated September 18, 2001 from Y H. N, M.D., diplomate of the American Board of Sleep Medicine, states in relevant part as follows:[30]

> U Q has been evaluated and is being followed . . . for complaints of excessive sleepiness and "drop attacks" compatible with a diagnosis of Narcolepsy with Cataplexy. She has responded only partially to therapy with stimulants and REM suppressing agents . . . [and] is still having persistent apparent cataplexy episodes.

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22 Ex. 18-1.
23 All factual findings in this paragraph are based on Ex. 28, p. 3 unless otherwise stated.
24 Ex. 18 p. 2.
25 All factual findings in this paragraph are based on Ex. 28, p. 4 unless otherwise stated.
26 All factual findings in this paragraph are based on Ex. 28, p. 4 unless otherwise stated.
27 *See* e-mail from former PCA T B (Ex. 4 p. 1).
28 *See* letter from Pastor W. C X dated November 9, 2014 (Ex. 5).
29 Ex. 20.
30 All factual findings in this paragraph are based on Ex. 19 unless otherwise stated. The formatting of the original letter has been modified here for brevity.

> These result in abrupt loss of muscle tone and sudden falls in which she has been injured . . . . Therefore at the present time I consider U Q to be completely and permanently disabled from Narcolepsy with Cataplexy unresponsive to conventional treatment.

In 2003 Ms. Q had an acromioplasty.[31] In 2004 Ms. Q became insulin-dependent with her diabetes.[32] As a result of her diabetes she now has neuropathy in her left foot and left hand, and is beginning to get it in her right hand also. Because of the neuropathy in Ms. Q's left foot, she cannot tell whether her foot is touching the ground, and as a result her balance is not very good. Also in 2004 Ms. Q was diagnosed with breast cancer and had a partial mastectomy; the scars from this surgery are sometimes painful and/or itchy.[33]

In 2005 Ms. Q developed Menieres' Disease, which makes her dizzy and unbalanced.[34] As a result of this, Ms. Q began using a wheelchair. Also in 2005 Ms. Q began experiencing hearing loss, and she now wears hearing aids in both ears.[35]

In 2006 Ms. Q developed tendonitis of the right shoulder and had shoulder surgery.[36] She still has shoulder pain. In 2007 she had diagnostic imaging which showed degenerative changes in her cervical and thoracic spine.

In 2008 Ms. Q was diagnosed with an inguinal hernia.[37] In 2010 she was diagnosed with splenic and aortic calcification and emphysema. In 2011 she broke her tailbone in a narcolepsy-induced fall. Also in 2011 she had an operation which was meant to alleviate her GERD, but which instead made her symptoms worse. In 2012 she had shock-wave lithotripsy.[38]

A letter from chiropractor / kinesiologist Dr. D J dated November 11, 2014 states that Ms. Q has been unable to stand unassisted since 2008, and recommends that Ms. Q receive PCA assistance with all her chores.[39]

Records of the No Name emergency medical services (EMS) department indicate that EMS responded to incidents related to Ms. Q's cataplexy / narcolepsy on June 11, 2014 and on July 8, 2014.[40] Critical incident reports (CIRs) filed with the Division by Ms. Q's caregivers indicate that

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31 Ex. 18 p. 1.
32 All factual findings in this paragraph are based on Ex. 28, p. 5 unless otherwise stated.
33 Ex. 18 p. 1.
34 All factual findings in this paragraph are based on Ex. 28, p. 5 unless otherwise stated.
35 *See also* letter from audiologist K K dated October 29, 2014 (Ex. 10).
36 All factual findings in this paragraph are based on Ex. 28, pp. 5 - 6 unless otherwise stated.
37 All factual findings in this paragraph are based on Ex. 28, p. 6 unless otherwise stated.
38 Ex. 18 p. 2.
39 Ex. 12.
40 Ex. 23 pp. 2 - 5.

Ms. Q suffered injuries due to cataplexy / narcolepsy-related falls on May 23, May 27, June 4, and July 8, 2014.[41] In addition, another CIR documents one or more seizure-related falls during the period from June 16, 2014 through July 1, 2014.[42]

On November 6, 2014 Ms. Q was seen by K C, M.D., one of her treating physicians.[43] Dr. C's notes from that encounter state in relevant part as follows:

> She has done extensive physical therapy a few years ago to try to walk, but due to her surgery and loss of balance she cannot ambulate independently. She also has memory issues related to her brain surgery and her history of epilepsy so she needs assistance with her medications, appointments, and such. In review of her denial I cannot help but think that they reviewed the wrong person as I have known her for almost 10 years. I have never seen her walk or be independent like [the assessor] states, and I disagree with many of the statements in the assessment. She has always been seen in a motorized wheelchair in our office from day one. She has seen physical therapy who indicates that it is not safe for her to walk due to lack of balance. She is at risk of falling without her wheelchair . . . . Review of notes from the state assessment indicates that they feel she can walk and that she is faking it. I have physical therapy reports . . . from 2008 to present indicating that she cannot walk nor has she walked in many years. I have seen her in public as well and have never seen her out of her wheelchair . . . .
> . . . .
>
> Neurological: . . . . The patient shows no coordination, no useful balance is noted. She cannot stand without 50% assistance from two other adults. Generalized muscle atrophy is noted . . . .

In a letter dated November 11, 2014, Dr. C wrote in relevant part as follows:[44]

> She is wheelchair bound due to a temporal lobe resection. She has tried physical therapy to help with her balance and ambulation without success. Given her multiple health problems, it is my opinion that personal assistance is both reasonable and necessary to aid her with the following activities of daily living so she can remain in her own home: toileting and personal hygiene to include bathing and grooming, blood pressure to be read and recorded once per day, insulin injections 3-4 times daily, diabetic testing 3-4 times daily, taking her medications three times daily, assistance with her CPAP machine, shopping to include pushing the basket and reaching for items on high shelves, transportation to and from doctor appointments, shopping, and other necessary errands, assistance with laundry, application of Emu oil daily for pain in her shoulders and knees, application of Clotrimazole and Betamethazone creams daily as needed for pressure sores and rashes, range of motion exercises to neck, trunk, and all extremities for thirty minutes twice daily, six meals per day following a 1,000 calorie, low fat, low sodium, low carbohydrate diet,

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41 Exs. F50, F51, F57, F58, F60, F61, F71, and F72.

42 Exs. F74, F75.

43 All factual findings in this paragraph are based on Ex. 18, pp. 1 - 7 unless otherwise stated.

44 Ex. 17 pp. 1 - 3 (some original formatting modified here for purposes of brevity).

> soak in the tub 1-2 times daily for arthritic joints, and for rashes and pressure sores, pool therapy for one hour twice per week for exercise and to maintain strength . . . .
>
> As she continues to age, the trauma to her right brain will begin to mimic symptoms of a stroke, and she will need prompting to remember to take her medications and check her blood sugar.
>
> U had brain surgery that has profoundly affected every aspect of her life and *this will not change or get better* . . . . [Emphasis added].

A T is one of Ms. Q's former PCAs / chore services providers.[45] She has opined, in a letter dated November 13, 2014, that Ms. Q requires some level of assistance with all IADLs, and with all ADLs except for eating.

E F is the Fire Chief for the No Name Fire Department.[46] In a letter dated November 17, 2014, Chief F states in relevant part as follows:

> As the fire chief of the city in which Ms. Q lives, I can provide evidence that we have routinely responded to her residence for medical emergencies and other safety-related concerns. Dates that come up with a quick search of [our records] are 7/7/2009, 11/17/2009, 3/1/2011, 4/22/2011, 1/4/2013, and 4/11/2014 . . . .
> . . . .
>
> A call earlier this year demonstrated the need for care. Ms. Q was without a care provider and was attempting to bathe herself. The bath chair collapsed under her, pinning one of her legs under [the] chair with her full body weight resting on it. Rapid response by the fire department to that call mitigated the physical trauma . . . . If there has been a PCA [there] at the time, [the PCA] could have . . . aided Ms. Q . . . .
>
> I see a lot of patients. Our fire department interacts with the community on a daily basis. I have seen people who do not have a real need to receive services take advantage of state and federal programs. Ms. Q is not one of those people . . . . [It is] my professional opinion that Ms. Q is in need of PCA assistance.

A letter from C C, D.O. (one of Ms. Q's physicians), dated November 19, 2014, states in relevant part as follows:[47]

> My patient U Q . . . is disabled and has not improved despite all attempts. There is no reasonable way to think that she would improve in the future. She requires the assistance of a PCA to aid in her ADLs . . . .

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45 All factual findings in this paragraph are based on Ex. 16 unless otherwise stated.
46 All factual findings in this paragraph are based on Ex. 26 unless otherwise stated.
47 All factual findings in this paragraph are based on Ex. E29 unless otherwise stated.

During an examination by a physical therapist on January 15, 2015 Ms. Q was noted to have a limited range of motion (ROM) in her shoulders, limited strength in both arms, a "remarkable" limitation in ROM of her left leg, and abnormal neurological tone in her left foot.[48] She scored a 100% disability on the Oswestry Low Back Pain questionnaire, and was unable to perform the "get up and go" test. The physical therapist recommended daily assistance with ROM exercises / stretching, as well as continued participation in an aquatics program.

At hearing, Ms. Q's former PCA, K O, testified in relevant part:

1. She was Ms. Q's PCA from March 2014 until about 2 weeks after the assessment of June 6, 2014 (she was Ms. Q's PCA for about four months during 2014). She still works as a PCA, but she no longer works for Ms. Q's PCA agency.

2. She recalls an incident in which, when she arrived at Ms. Q's house at 8:00 a.m., Ms. Q was not in her wheelchair, and came crawling out of her bedroom, stating that she had been stretching her back (Ms. O' assertion being that Ms. Q can actually walk).

3. She never had to provide Ms. Q with hands-on assistance with any of her ADLs.

4. She only performed chore services (assistance with IADLs) for Ms. Q.

5. She thinks Ms. Q could perform light housekeeping tasks, and prepare light meals, by herself.

At hearing, Ms. Q's new PCA, J X, credibly testified in relevant part:

1. She has worked as Ms. Q's "Monday through Friday" PCA since approximately mid-December 2014.

2. There was an incident about six weeks prior to the hearing when Ms. Q had a "spell" and fell out of her wheelchair. Ms. X filed a critical incident report (CIR) with the Division.

At hearing, B J, Ms. Q's PCA agency representative, credibly testified that:

1. Former PCA K O reported to her agency that Ms. Q was asking her to report that she was performing services that she was not really performing.

2. However, on the same day, another PCA, K M, reported to Ms. J that Ms. Q *did* in fact require assistance, and *was not* trying to obtain PCA time / services to which she was not entitled.

At hearing, Ms. Q testified in relevant part as follows:

[48] All factual findings in this paragraph are based on Ex. 30, pp. 1 - 2 unless otherwise stated.

1. Her former PCA K O would say that she felt she was treated like a slave when working as a PCA. Ms. O has personal animosity toward her, and for that reason provided false testimony against her at the hearing.

2. Ms. O didn't quit as Ms. Q's PCA, as Ms. O testified. Rather, she (Ms. Q) fired Ms. O as her PCA.

3. Her condition has gotten worse, rather than better, since the last assessment.

4. She has worn a brace on her left foot since April 2012 because her foot is curling inward.[49]

5. It is not safe for her to drive because of her narcolepsy and cataplexy, and she has not had a driver's license for about ten years.[50]

B. The Division's Findings From its 2012 and 2014 Assessments

Ms. Q was previously assessed as to her eligibility for Medicaid Home and Community-Based Waiver services, and PCA services, on October 16, 2012 by Marianne Sullivan, R.N.[51] Then as now, the Division used the Consumer Assessment Tool or "CAT," a system for scoring a person's need for nursing assistance and physical assistance (described in detail in Part III of this decision) to record and score the assessment.[52] Based on her 2012 assessment, the Division found that Ms. Q required the following levels of assistance with her ADLs:[53] body mobility - independent (CAT score 0/0); transfers - required extensive physical assistance (CAT score 3/2, frequency 2/7); locomotion - required extensive assistance (CAT score 3/2, frequency 5/7); dressing - required limited assistance (CAT score 2/2, frequency 2/7); eating - independent (CAT score 0/0); toilet use - required extensive physical assistance (CAT score 3/2, frequency 4/7); personal hygiene - required limited assistance (CAT score 2/2, frequency 1/7); and bathing - required extensive physical assistance (CAT score 3/2, frequency 1/7).

At the same 2012 assessment, Ms. Sullivan found that Ms. Q required the following levels of assistance with her IADLs:[54] independent as to telephone use and financial management (CAT score 0/0); required physical assistance with light meal preparation, main meal preparation, light housework, and grocery shopping (CAT score 2/3); and totally dependent with routine housework and laundry (CAT score 3/4).

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49 See also Ex. 28 p. 16.
50 See also Ex. 28 p. 16.
51 Exs. F1 - F31.
52 Exs. F1 - F31.
53 All factual findings in this paragraph are based on Exs. F6 - F12 unless otherwise stated.
54 All factual findings in this paragraph are based on Ex. F26 unless otherwise stated.

Based on the 2012 assessment, Ms. Sullivan concluded that Ms. Q was eligible for waiver services and also for a significant amount of PCA services.[55]

The assessment which resulted in the filing of the present case was performed on June 6, 2014, again by nurse-assessor Marianne Sullivan, R.N. of DSDS.[56] In completing the CAT, Ms. Sullivan reported that Ms. Q has the following care needs, abilities, and limitations:[57]

Significant Problems Since Last Assessment:[58] Ms. Sullivan reported that Ms. Q had three falls, three emergency room (ER) visits, and no hospitalizations since her prior assessment.

Functional Assessment:[59] Ms. Sullivan reported that Ms. Q is able to touch her hands together over her head, but not behind her back; that she cannot touch her feet while sitting; that she cannot plB her hands across her chest and stand up; and that she has a strong grip with her right hand but a weak grip with her left hand.

Physical Therapy:[60] Ms. Sullivan reported that Ms. Q is not currently receiving occupational therapy, respiratory therapy, or speech / language therapy, but that she is receiving physical therapy two days per week. Ms. Sullivan also found that Ms. Q had no current prescription for range of motion exercises, walking for exercise, or foot care.

Bed / Body Mobility:[61] Ms. Sullivan reported that Ms. Q told her (1) that she sleeps in a regular bed; (2) that she can reposition herself in bed; and (3) that she had the start of a bed sore on her "bottom," but did not want Ms. Sullivan or her PCA to see it. Ms. Sullivan reported that she observed Ms. Q reposition herself while in her wheelchair (scored 0/0).

Transfers:[62] Ms. Sullivan reported she was told by Ms. Q that she can transfer herself when her PCA is not there to assist her, but only with great difficulty and by "throwing" herself from one surface to the other. Ms. Sullivan reported that Ms. O told her that Ms. Q didn't need any assistance with any transfers. Ms. Sullivan reported that she observed Ms. O put a gait belt on Ms. Q, pull her to a standing position, and "thrust her onto couch;" Ms. Sullivan also wrote that Ms. Q did not provide any weight-bearing support with her legs during this procedure (scored 0/0, frequency 0/0).

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55 Exs. F29 - F30.
56 Ex. E.
57 Ex. E.
58 Ex. E6.
59 Ex. E7.
60 Ex. E8.
61 Ex. E9.
62 Ex. E9.

Locomotion:[63] Ms. Sullivan reported she was told by Ms. Q that (1) she uses a motorized wheelchair when she leaves the house, but cannot use it inside the house because it is too big; (2) she uses a manual wheelchair inside her home, and when alone is able to propel the wheelchair backwards by using her right hand in combination with her left leg. Ms. Sullivan reported that she observed Ms. Q propel her manual wheelchair backwards in the way that Ms. Q had described (scored 0/0).

Dressing:[64] Ms. Sullivan reported she was told by Ms. Q that she can help dress her upper body, but that in general she needs assistance to get dressed. Ms. Sullivan reported that she was told by Ms. O that Ms. Q requires no hands-on assistance with dressing (scored 0/0).

Eating:[65] Ms. Sullivan reported she was told by Ms. Q that (1) if food is prepared ahead of time, she is able to warm it up in a microwave herself; (2) she is able to self-administer her own insulin and perform her own blood sugar tests; and (3) although she is messy, she is able to eat and drink on her own (scored 0/0).

Toileting:[66] Ms. Sullivan reported she was told by Ms. Q that (1) she needs assistance to get to the bathroom, but that once she is there, she can use the toilet independently; and (2) she has urinary incontinence every day, and bowel incontinence once or twice per week. Ms. Sullivan reported that Ms. O told her that she gets Ms. Q into the bathroom and positions her by the toilet, but that once this is done, Ms. Q can transfer on and off the toilet by herself and clean herself. Based on this, Ms. Sullivan concluded that Ms. Q requires only set-up assistance with toileting (scored 0/1).

Personal Hygiene:[67] Ms. Sullivan reported she was told by Ms. Q that (1) she cannot brush her own hair because she cannot raise her arms over her head; but (2) she can brush her teeth and wash her hair. Ms. Sullivan reported that Ms. O told her that Ms. Q needs no hands-on assistance with any personal hygiene tasks. Ms. Sullivan reported that Ms. Q was well-groomed at the assessment, and that she observed Ms. Q bring her hands to her face and drink water from a glass during the assessment (scored 0/0).

Bathing:[68] Ms. Sullivan reported she was told by Ms. Q that (1) she has a step-in bathtub with grab bars and a hand-held shower head; (2) she has a shower chair, but it is breaking apart; and

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63 Ex. E10.
64 Ex. E11.
65 Ex. E12.
66 Ex. E12.
67 Ex. E13.
68 Ex. E14.

(3) her PCA must transfer her in and out of the bathtub / shower; but (4) once on her shower chair she is able to wash her body herself. Ms. Sullivan reported that Ms. O told her that Ms. Q needs only set-up assistance with bathing (scored 0/1).

Ms. Sullivan's 2014 assessment found that Ms. Q required the following assistance with her IADLs:[69] independent as to telephone use and financial management (CAT score 0/0); independent with difficulty, requiring physical assistance as to light meal preparation, main meal preparation, light housework, routine housework, grocery shopping, and laundry (CAT score 1/3).

Professional Nursing Services:[70] Ms. Sullivan found that Ms. Q has no current need for professional nursing services. Specifically, Ms. Sullivan found that Ms. Q is currently receiving no injections or intravenous feedings, is not using any type of feeding tube, does not require nasopharyngeal suctioning or tracheotomy care, is not receiving treatment for open lesions, ulcers, burns, or surgical sites, and has not begun using oxygen within the last 30 days.[71] Ms. Sullivan further found that Ms. Q does not currently have any unstable medical conditions, and specifically, that she does not use a catheter or ventilator / respirator, is not comatose, and does not have an uncontrolled seizure disorder.[72] In addition, Ms. Sullivan found that Ms. Q is receiving physical therapy two days per week, but is not receiving speech therapy, occupational therapy, or respiratory therapy, and does not require professional nursing assessment, observation, and/or management at least once per month.[73] Ms. Sullivan also found that Ms. Q does not receive medications via tube, does not require tracheostomy care, does not use a urinary catheter, and does not require venipuncture, injections, barrier dressings for ulcers, chest physical therapy by a registered nurse, or oxygen therapy performed by a nurse to treat an unstable chronic condition.[74] Finally, Ms. Sullivan found that Ms. Q does not currently undergo chemotherapy, radiation therapy, hemodialysis, or peritoneal dialysis.[75]

Cognition:[76] Ms. Sullivan found that Ms. Q has short-term memory problem, but that her long-term memory is OK, and that she is generally able to recall names and faces, the location of

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69 All factual findings in this paragraph are based on Ex. E29 unless otherwise stated.

70 Exs. E16 - E18.

71 Ex. E16.

72 Ex. E17. Under the CAT, it is necessary to have a minimum of one uncontrolled seizure per week in order to qualify for waiver services on that basis (see Exs. E16, E17, and E32). Ms. Q clearly has uncontrolled seizures as a result of her cataplexy / narcolepsy; the issue here is whether the preponderance of the evidence shows that she has an uncontrolled seizure *at least once per week*.

73 Ex. E17.

74 Ex. E18.

75 Ex. E18.

76 Ex. E19.

her room, and the current season. Ms. Sullivan rated Ms. Q as having the cognitive skills necessary to perform her daily decision-making independently. Finally, Ms. Sullivan determined that Ms. Q's cognitive status does not require professional nursing assessment, observation, or management at least once per month.[77]

Behavioral Problems:[78] Ms. Sullivan found that Ms. Q does not wander, is not verbally abusive, is not physically abusive, does not engage in socially inappropriate or disruptive behavior, and does not resist care. Ms. Sullivan also found that Ms. Q does not need professional nursing assessment, observation, or management at least once per month due to any behavioral problems.[79]

Medication Management:[80] Ms. Sullivan reported that Ms. Q takes 19 different medications and supplements on a daily basis, and two more on an as-needed basis; that she prepares and administers her own medications; and that she is always compliant with medications.

Communication:[81] Ms. Sullivan found that Ms. Q has significant difficulty hearing, but can usually understand others and make herself understood; Ms. Sullivan further found that Ms. Q wears glasses and can see adequately with them.

Mood:[82] Ms. Sullivan found that Ms. Q has insomnia, persistent anger with herself or others, sad / pained / worried facial expressions, tearfulness, and repetitive movements.

Based on the foregoing CAT scores, Ms. Sullivan found that Ms. Q does not currently require skilled level or intermediate level nursing care, and does not otherwise qualify for waiver services based on cognitive issues, behavioral issues, and/or her level of need for assistance with her activities of daily living (ADLs).[83]

On July 9, 2014, a different registered nurse reviewed nurse-assessor Sullivan's waiver services eligibility decision.[84] The nurse-supervisor agreed that Ms. Q is not currently eligible to participate in the waiver services program.[85]

Finally, the nurse-assessor's eligibility decision underwent a second-level review by a registered nurse and/or licensed physician employed by the Division's independent contractor

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77 Ex. E19. Ms. Sullivan did, however, complete the Division's supplemental screening tool (SST) for cognitive difficulties for Ms. Q (Ex. E1). Ms. Q received a total score of zero points on the cognitive SST.

78 Ex. E20.

79 Ex. E20. Ms. Sullivan did, however, complete the Division's supplemental screening tool (SST) for behavioral problems for Ms. Q (Ex. E2). Ms. Q received a total score of zero points on the behavioral SST.

80 Ex. E23.

81 Ex. E25.

82 Ex. E28.

83 Exs. E32, E33.

84 Exs. F33 - F40.

85 Exs. F33 - F40.

Qualis Health.[86] Qualis concurred with the nurse-assessor's determination that Ms. Q had "materially improved" and no longer required a nursing home facility level of care.[87]

C. Relevant Procedural History

Ms. Q has been receiving PCA services since 2004[88] and waiver services since 2011 or before.[89] On September 14, 2014 the Division notified Ms. Q that she was no longer eligible for waiver services, and that her waiver services would be terminated in thirty days.[90] On October 23, 2014 the Division notified Ms. Q that she was no longer eligible for PCA services, and that her PCA services would be terminated on November 2, 2014.[91] Ms. Q requested a hearing to contest the Division's determinations.[92]

Ms. Q's hearing was held on January 7, 2015 and January 29, 2015. All parties participated by phone. Ms. Q represented herself and testified on her own behalf. Ms. Q's new PCA, J X, her alternate / relief PCA, Elin M, and her care coordinator, Susan Reed, also testified on Ms. Q's behalf. Tammy Smith represented the Division. Marianne Sullivan, R.N. (who conducted Ms. Q's assessment), B J, T H, and Ms. Q's former PCA K O, each testified for the Division. The record was left open for ten days, following the hearing, for post-hearing filings. The record closed on February 9, 2015.

III. Discussion

A. Applicable Burden of Proof and Standard of Review

Pursuant to applicable state and federal regulations, the Division bears the burden of proof in this case.[93] The standard of review in a Medicaid "Fair Hearing" proceeding, as to both the law and the facts, is *de novo* review.[94] In this case, evidence was presented at hearing that was not originally available to the Division's reviewers. The administrative law judge may independently weigh the evidence and reach a different conclusion than did the Division, even if the original decision is factually supported and has a reasonable basis in law.

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86 Exs. D2 - D4.
87 Exs. D2 - D4.
88 Ex. 28, p. 5.
89 Ex. F1.
90 Ex. D.
91 Ex. G.
92 Ex. C.
93 42 CFR § 435.930, 7 AAC 49.135.
94 *See* 42 CFR 431.244; *Albert S. v. Dept. of Health and Mental Hygiene*, 891 A.2d 402 (2006); *Maryland Dept. of Health and Mental Hygiene v. Brown*, 935 A.2d 1128 (Md. App. 2007); *In re Qer*, 969 A.2d 322 (N.H. 2009); *Murphy v. Curtis*, 930 N.E.2d 1228 (Ind. App. 2010).

B. Relevant Medicaid Waiver Services Statutes and Regulations

States participating in the Medicaid program must provide certain mandatory services under the state's medical assistance plan.[95] States may also, at their option, provide certain additional services, one of which is the Home and Community-Based Waiver Services program[96] ("waiver services").[97] Congress created the waiver services program in 1981 to allow states to offer long-term care, not otherwise available through the states' Medicaid programs, to serve eligible individuals in their own homes and communities instead of in nursing facilities.[98] Alaska participates in the waiver services program.[99]

There are three basic ways in which an applicant or recipient can qualify for waiver services. First, an individual is eligible for waiver services if he or she requires the level of care specified in 7 AAC 130.205. For older adults and adults with disabilities (such as Ms. Q), that level of care must be either "intermediate care" as defined by 7 AAC 140.510, or "skilled care" as defined by 7 AAC 140.515.[100] Intermediate care, a lower level of care than skilled care, is defined by 7 AAC 140.510 in relevant part as follows:

> (a) The department will pay an intermediate care facility for providing the services described in (b) and (c) of this section if those services are (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.

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95 *See* 42 USC §§ 1396a(a)(10)(A); 1396d(a)(1) - (5), 1396a(a)(17), and 1396a(a)(21); *see also* 42 CFR 440.210 & 440.220.

96 The program is called a "waiver" program because certain statutory Medicaid requirements are waived by the Secretary of Health and Human Services. *See* 42 U.S.C. § 1396n(c). Before a state receives federal funding for the program, the state must sign a waiver agreement with the United States Department of Health and Human Services. *Id.* The agreement waives certain eligibility and income requirements. *Id.*

97 *See* 42 USC § 1396a(a)(10)(A).

98 *See* 42 USC § 1396n(c)(1); 42 CFR §§ 435.217; 42 CFR §§441.300 - 310. Federal Medicaid regulation 42 CFR § 440.180, titled "Home or Community-Based Services," provides in relevant part:

> (a) Description and requirements for services. "Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of Part 441, subpart G of this chapter . . . .
>
> (b) Included services. Home or community-based services may include the following services . . . (1) Case management services. (2) Homemaker services. (3) Home health aide services. (4) Personal care services. (5) Adult day health services. (6) Habilitation services. (7) Respite care services. (8) Day treatment . . . (9) Other services requested by the agency and approved by CMS *as cost effective and necessary to avoid institutionalization*. [Emphasis added].

99 AS 47.07.045, the Alaska statute that authorizes Medicaid Waiver Services, states in relevant part:

> Home and community-based services. (a) The department may provide home and community-based services under a waiver in accordance with 42 USC 1396 – 1396p (Title XIX Social Security Act), this chapter, and regulations adopted under this chapter, if the department has received approval from the federal government and the department has appropriations allocated for the purpose. To supplement the standards in (b) of this section, the department shall establish in regulation additional standards for eligibility and payment . . . .

100 7 AAC 130.215.

> (b) Intermediate nursing services are the observation, assessment, and treatment of a recipient with a long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance rather than rehabilitation . . . .
>
> (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.

The Division is required to incorporate the results of the Consumer Assessment Tool (CAT) in determining whether an applicant requires intermediate or skilled nursing care.[101]

The second way an individual may qualify for waiver services is by showing that the individual's requirements for physical assistance with his or her activities of daily living (ADLs) are sufficiently high.[102] Under the CAT, an individual can qualify for waiver services by demonstrating a need for extensive assistance with at least three designated ADLs, known as "shaded" ADLs, even without demonstrating a need for professional nursing care.[103] An individual may also qualify for waiver services by having a certain minimum level of nursing needs, *combined with* a certain minimum level of need for physical assistance with ADLs.[104]

Before a recipient's waiver services may be terminated, the Division must conduct an annual assessment to "determine whether the recipient continues to meet the [applicable] standards . . ."[105] To remove a recipient from the program, the assessment must find:

> that the recipient's condition has materially improved since the previous assessment; for purposes of this paragraph, "materially improved" means that a recipient who has previously qualified for . . . . an older Alaskan or adult with a physical disability [waiver], no longer has a functional limitation or cognitive impairment that would result in the need for nursing home plBment, and is able to demonstrate the ability to function in a home setting without the need for wavier services.[106]

Finally, in an order issued within the last year in the class action[107] case *Krone et. al. v. State of Alaska, Department of Health and Social Services et. al.*, Case No. 3AN-05-10283CI, an Anchorage Superior Court judge held that, "in order to determine if a recipient is 'materially

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101 7 AAC 130.215.
102 Ex. E32.
103 Ex. E32.
104 Ex. E32.
105 AS 47.07.045(b)(1).
106 AS 47.07.045(b)(3).
107 Although a Superior Court decision generally does not constitute binding precedent for the Office of Administrative Hearings (except in the particular case being appealed), a class action like the *Krone* case is binding in all cases involving class members, one of whom is Ms. Q.

improved,' for purposes of AS 47.07.045(3)(C), the State must compare the results of the current assessment with those of the most recent assessment that concluded that the recipient was eligible for the Waiver program;" that "[t]he State may not conclude that a recipient is no longer eligible based only on the results of the current assessment;"[108] that "[t]he State may not base its annual determination of whether a recipient is 'materially improved' solely upon the scoring obtained from the CAT;" and that "[t]he State must consider all reasonably available information relevant to that determination."

C. The PCA Program - Overview

The Medicaid program provides personal care assistant (PCA) services to eligible persons; "[t]he purpose of personal care services is to provide to a recipient *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 . . . ."[109] [Emphasis added]. Accordingly, "[t]he department will not authorize personal care services for a recipient if the assessment shows that the recipient only needs assistance with supervision, cueing, and setup in order to independently perform an ADL or IADL."[110]

D. The Consumer Assessment Tool (CAT)

An applicant or recipient's eligibility for PCA services, and (if eligible) the amount of PCA services for which the applicant or recipient qualifies, are determined by the Department's Consumer Assessment Tool (CAT), which is adopted by regulation at 7 AAC 160.900(d)(6).[111] Similarly, level of care determinations for those waiver services applicants and recipients who seek services under the "adults with physical disabilities" or "older adults" categories must incorporate the results of the CAT.[112] The CAT covers both the recipient's need for nursing services, as well as the recipient's ability to perform his or her activities of daily living (ADLs). The ADLs scored by the CAT are body mobility, transfers (non-mechanical), transfers (mechanical),

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108 *Krone* order dated October 1, 2014 at page 6.

109 7 AAC 125.010(a).

110 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.*

111 7 AAC 125.020(b).

112 *See* 7 AAC 130.230(b)(2)(B).

locomotion (in room, between levels, and to access apartment or living quarters), dressing, eating, toilet use, personal hygiene, and bathing.[113]

The CAT numerical scoring system for ADLs has two components. The first component is the *self-performance score.* These scores rate how capable a person is of performing a particular ADL.[114] The possible scores are **0** (the person is independent and requires no help or oversight); **1** (the person requires supervision); **2** (the person requires limited assistance); **3** (the person requires extensive assistance); and **4** (the person is totally dependent). There are also codes that are not treated as numerical scores for purposes of calculating a service level: **5** (the person requires cueing); and **8** (the activity did not occur during the past seven days).[115]

The second component of the CAT scoring system for ADLs is the *support score*. These scores rate the degree of assistance that a person requires in order to perform a particular ADL. The relevant scores 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).

The CAT also scores certain activities known as "instrumental activities of daily living" (IADLs).[116] These are light meal preparation, main meal preparation, light housekeeping, routine housekeeping, laundry, and grocery shopping. Finally, the CAT scores one other IADL-like activity which is not technically an IADL (oxygen maintenance).

The CAT scores IADLs slightly differently than ADLs.[117] The self-performance scores 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).

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113 The CAT also scores the recipient's ability to perform Instrumental Activities of Daily Living (IADLs). However, although IADL scores are important for determining the recipient's eligibility for Medicaid Personal Care Assistant (PCA) services, the recipient's IADL scores are not considered in determining eligibility for waiver services.

114 According to the federal Medicaid statutes, the term "activities of daily living" includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring. *See* 42 USC § 1396n(k)(6)(A). In Alaska, pursuant to AS § 47.33.990(1), "activities of daily living" means "walking, eating, dressing, bathing, toileting, and transfer between a bed and a chair."

115 *See*, for example, Ex. E8.

116 Ex. E28.

117 *Id.*

The *support scores* for IADLs are also slightly different than the support scores for ADLs.[118] The relevant support scores for IADLs are **0** (no support provided); **1** (supervision / cueing provided); **2** (setup help); **3** (physical assistance provided); and **4** (total dependence - the person was not involved at all when the activity was performed).

A person is eligible to receive PCA services if he or she receives self-performance scores of 2, 3, or 4, and support scores of 2, 3, or 4 as to *any one* ADL.[119] Alternatively, a person can qualify for PCA services by being independent with difficulty as to at least one IADL, by needing assistance with at least one IADL, or by being dependent as to at least one IADL (*i.e.* by having self-performance scores of 2, 3, or 4), *and* by requiring physical assistance for support or being totally dependent for support (*i.e.* by having support scores of 3 or 4).[120]

E. Does Ms. Q Require Intermediate or Skilled Nursing Care?

As discussed above, there are several ways in which a waiver services applicant or recipient can qualify for (or remain qualified for) waiver services. The first way is to demonstrate a need for either skilled nursing care or intermediate level nursing care.[121] Because skilled care is a higher level of care than intermediate care, the minimum level of nursing care for which Ms. Q must demonstrate a need, in order to remain eligible for waiver services on that basis, is intermediate care.

The intermediate care regulation (7 AAC 140.510) has three subsections (see text of regulation quoted in Section III(B), above). Ms. Q clearly satisfies *some* of the criteria stated in the regulation. For example, Ms. Q has one or more long-term illnesses or disabilities. Her condition is relatively stable, and her treatments emphasize maintenance of her condition rather than rehabilitation. However, one of the mandatory requirements, under 7 AAC 140.510(a) and (c), is that the recipient *either* require services ordered by and under the direction of a physician, *or* be receiving 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.

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118 *Id.*

119 7 AAC 125.020. The CAT PCA scoring matrix at page 31 of the CAT attempts to restrict the ADLs through which one may qualify for PCA services to transfers, locomotion, eating, toilet use, dressing, and bathing. This is contrary to the express terms of the regulation, which indicates that a person can qualify to receive PCA services by receiving a score of 2/2 or better as to "any" ADL. Accordingly, the limitation stated in the CAT may not be valid.

120 *See* 7 AAC 125.020(a). The minimum standard applicable to IADLs, "independent with difficulty," is defined by 7 AAC 125.020(a)(4) as a situation in which "the recipient can perform the activity without the help of another individual, but does so with difficulty or takes a great amount of time to perform it."

121 7 AAC 140.510, 7 AAC 140.515.

In a letter dated November 11, 2014, Dr. C prescribed pool therapy for Ms. Q for one hour, twice per week, for exercise and to maintain strength. However, this prescription was not in effect at the time of the Division's assessment or waiver termination letter. There is no evidence in the record indicating that Ms. Q had a prescription for any type of therapy *in effect* from the time of the Division's assessment through the date of its termination notice.

The Division's nurse-assessor, reviewing nurse, and independent contractor all agreed that Ms. Q does not require nursing services as defined by the relevant regulations. My own independent review of the record likewise indicates that Ms. Q currently has no nursing needs as defined by the applicable regulations. Accordingly, the Division correctly determined that Ms. Q does not qualify for waiver services based on a need for skilled or intermediate level nursing care. The next issue is whether Ms. Q qualifies for waiver services under the scoring matrix employed by the Division's Consumer Assessment Tool.

F. Does Ms. Q Qualify for Waiver Services Based on the Consumer Assessment Tool's Scoring Matrix?

The Consumer Assessment Tool's scoring summary is located at page 29 of the CAT.[122] As indicated by that summary, there are several scoring combinations through which one may demonstrate a need for a nursing facility level of care (NFLOC) or otherwise qualify for waiver services. The first way, discussed immediately above, is to require skilled or intermediate level nursing care, as defined by the regulations and the CAT. However, under the CAT, an individual may also qualify for waiver services, even without demonstrating a need for skilled or intermediate level nursing care, if the individual has certain other serious medical problems, and/or if his or her need for assistance with activities of daily living (ADLs) is sufficiently high.[123] The CAT divides the possible scoring combinations into six different areas, designated "NF1" through "NF6."

1. NF1

There are five different ways to meet NFLOC under NF1. The first way (under NF1(a)) is to require nursing services seven days per week. As discussed above, Ms. Q does not receive or require nursing services seven or more days per week. The second way (under NF1(b)) is to require use of a ventilator or respirator at least three days per week. As discussed above, Ms. Q does not use a ventilator or respirator. The third way meet NFLOC (under

122 Ex. E32.
123 Ex. E p. 32.

NF1(c)) is to require care due to uncontrolled seizures at least once per week.[124] If the applicant / recipient requires such care, "then the person will be found medically eligible for NF level of care and will be scored a 3 or presumed to have a score of 3 or more."[125]

It is clear that Ms. Q has had seizures related to her narcolepsy / cataplexy since 2000 (see discussion at Section II, above). A letter dated September 18, 2001 from Y H. N, M.D. states that Ms. Q has "drop attacks" related to narcolepsy with cataplexy; that she has been unresponsive to conventional treatment and is still having persistent episodes; and that these result in sudden falls in which she has been injured. It is also clear that Ms. Q is still having these attacks; Ms. Q testified that she has uncontrolled seizure-like episodes due to her narcolepsy and/or cataplexy, during which she is paralyzed and sometimes falls out of her wheelchair. Her PCAs have witnessed and attested to the fact that Ms. Q has these episodes, as has the former pastor of her church. The critical question, under NF1(c)), and under Section A(10) of the CAT.[126] is whether Ms. Q requires "direct assistance from others," to "safely manage" her uncontrolled seizures, at least once per week.

As discussed in Section II, above, records of the No Name emergency medical services (EMS) department indicate that EMS responded to incidents related to Ms. Q's cataplexy / narcolepsy on June 11, 2014 and on July 8, 2014. Critical incident reports (CIRs) filed with the Division by Ms. Q's caregivers indicate that Ms. Q suffered injuries due to cataplexy / narcolepsy-related falls on May 23, May 27, June 4, and July 8, 2014. In addition, another CIR documents one or more seizure-related falls during the period from June 16 through July 1, 2014. Thus, credible evidence documents six different seizures, and six seizure-related falls, within the period from May 23 through July 8, 2014. This is an average of one seizure (with fall) per week during that six week period. In fact, two of the seizures occurred within one week of the Division's assessment of June 6, 2014.

In summary, credible evidence shows that Ms. Q had cataplexy / narcolepsy-related seizures at least once per week during the period at issue in this case. Further, Ms. Q's medical records and CIRs show that she suffered injuries from the falls caused by these seizures. This in turn shows that Ms. Q requires "direct assistance from others," to "safely manage" her uncontrolled seizures. Accordingly, Ms. Q meets NFLOC under NF1(c) of the CAT's scoring

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[124] The exact language at page 29 of the CAT is "In Section A, Item 10 (uncontrolled seizure), did you code this response with a 1, 2, 3, or 4 (care needed at least once /week)?

[125] CAT at page 29 (Ex. E32).

[126] Ex. E17.

matrix, and is presumed to have a nursing score of three under NF7 of the CAT's scoring matrix. Ms. Q therefore remains eligible to receive waiver services.

G. How Much PCA Time (if any) is Ms. Q Eligible to Receive in This Case?

Initially, it is important to remember that, under the current PCA regulations, the amount of time awarded is set automatically based on the recipient's self-performance code.[127] For example, a CAT code of three as to non-mechanical transfers (a transfer that uses hands-on assistance but does not use an assistive device such as a lift) gives a recipient 3.75 minutes of PCA time *regardless of the actual amount of time it takes to perform the transfer;* a CAT code of four as to non-mechanical transfers gives a recipient 5 minutes of PCA time *regardless of the actual amount of time it takes to perform the transfer.*[128] Under the PCA regulations, neither the Division, nor the administrative law judge, has the discretion to increase the PCA time arrived at through these formulas.

1. Body Mobility

For the ADL of body mobility, PCA time is allowed when a person requires physical assistance to reposition himself / herself in a bed or chair, or to perform range of motion and stretching exercises.[129] In 2012 Ms. Sullivan found that Ms. Q was independent with body mobility (CAT score 0/0). In 2014 Ms. Sullivan again found that Ms. Q is independent with body mobility (CAT score 0/0. Ms. Q testified that she can reposition herself in bed as long as her pain is not overwhelming, but that there have been times that she soiled herself in bed because no caregiver was there and she was unable to get out of bed and get to the bathroom by herself.[130] She also stated that she needs help getting situated when sitting.[131] However, in order to obtain PCA assistance with body mobility, the recipient must show a need for assistance at least three times per week. The evidence does not show that Ms. Q requires assistance with body mobility at this frequency. Ms. Q is thus not currently eligible for PCA assistance with body mobility.[132]

2. *Transfers*

For the ADL of transferring, PCA time is allowed when a person requires physical assistance to move between one surface and another (including to or from a bed, chair, or wheelchair), and/or when a person requires physical assistance to move from a lying or sitting

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127 *See* Division of Senior and Disability Services' *Personal Care Assistance Service Level Computation* sheet.
128 *Id.*
129 7 AAC 125.030(b)(1).
130 U Q's hearing testimony; Ex. 28 p. 12.
131 U Q's hearing testimony; Ex. 28 p. 17.
132 Ms. Q and her PCA may wish to begin keeping a care log. Such a log can be helpful in establishing a recipient's level and frequency of need for assistance at the time of the recipient's annual assessment.

position to a standing position.[133] In 2012 Ms. Sullivan found that Ms. Q required extensive physical assistance with transfers a total of 14 times per week (CAT score 3/2, frequency 2/7). In 2014 Ms. Sullivan found that Ms. Q is independent with transfers (CAT scored 0/0).

Ms. Q testified at hearing that she requires assistance transferring to and from her wheelchair, bed, and chair.[134] She also stated that her PCAs are supposed to use a gait belt to help her transfer, but that many PCAs refuse to help her transfer because they are worried that they will hurt their backs.[135] She stated that, because of this, she must sometimes "push through the pain" to transfer by herself, and that she can sometimes stand as long as she is holding onto something that does not move.[136] However, because of her balance problems, she sometimes falls and injures herself during transfers.[137] Further, her licensed physical therapist, R M, has stated that Ms. Q requires weight bearing assistance in order to safely perform any transfer.[138]

Ms. Q was found to require extensive assistance with transfers at her prior assessment, and she testified that her medical condition and functional abilities have not improved. Dr. C stated this as well. Accordingly, the preponderance of the evidence indicates that Ms. Q currently requires extensive assistance with transfers (CAT score 3/2).

With regard to frequency, neither party presented evidence that Ms. Q's required transfer frequency had either increased or decreased. Accordingly, Ms. Q's transfer frequency should remain at its 2012 level (CAT score 3/2, frequency 2/7).

3. Locomotion / Walking

For the ADL of locomotion, PCA time is allowed when a person requires assistance with walking (whether with the support of a walker, cane, gait belt, braces, crutches, or manual wheelchair), either between different locations in the recipient's home, outside the home to keep a medical or dental appointment, and/or when walking and simple exercises have been prescribed by a physician.[139] In 2012 Ms. Sullivan found that Ms. Q required extensive assistance with in-room locomotion (CAT score 3/2, frequency 5/7). In 2014 Ms. Sullivan found that Ms. Q is completely independent with in-room locomotion (CAT score 0/0).

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133 7 AAC 125.030(b)(2).

134 U Q's hearing testimony; Ex. 28 p. 17. This is consistent with a written statement from her former PCA, N D (Ex. 2).

135 U Q's hearing testimony; Ex. 28 p. 12. When a PCA does assist Ms. Q with transfers, the PCA provides weight-bearing assistance (Ex. 28 p. 13).

136 U Q's hearing testimony; Ex. 28 p. 8; Ex. 28 p. 12.

137 U Q's hearing testimony; Ex. 28 p. 13.

138 Ex. 3.

139 7 AAC 125.030(b)(3).

Ms. Q testified that she has been wheelchair-bound since November 2004, and that every time she has tried to walk, she has fallen.[140] She also testified that the arthritis is so bad in her left hand that it is painful and difficult for her to propel her manual wheelchair, and that she sometimes gets the wheelchair stuck (between pieces of furniture and/or walls), and then requires assistance getting unstuck.[141] With regard to locomotion to access medical appointments, Ms. Q testified she needs PCA assistance with pushing her manual wheelchair.[142] Dr. C's records indicate that Ms. Q uses a motorized wheelchair to access medical appointments.

In summary, Ms. Q can only use her wheelchair indoors by enduring unreasonable amounts of pain, and even then, she sometimes gets stuck inside her small house. Further, there is no evidence that Ms. Q's overall condition has improved since 2012 so as to support a decreased score. Accordingly, the preponderance of the evidence indicates that Ms. Q still requires extensive assistance with in-room locomotion (CAT score 3/2).

With regard to frequency of assistance, neither party presented evidence that Ms. Q's required locomotion frequency had either increased or decreased. Accordingly, Ms. Q's frequency for assistance with in-room locomotion should remain at its 2012 level (CAT score 3/2, frequency 5/7). However, because the evidence shows that Ms. Q can use her motorized wheelchair *outside* the home, the Division's score of 0/0 for *outside* locomotion is affirmed.

4. Dressing and Undressing

For the ADL of dressing, PCA time is allowed for the donning, fastening, unfastening, and removal of the recipient's street clothing, support hose, or prosthesis.[143] In 2012 Ms. Sullivan found that Ms. Q required limited assistance with dressing 14 times per week (CAT score 2/2, frequency 2/7). In 2014 Ms. Sullivan found Ms. Q independent with dressing (CAT score 0/0).

Ms. Q testified at hearing that she needs someone to pull her pants on because her hands are already occupied holding onto something to keep herself from falling.[144] She further testified that her PCAs must sometimes help her put on her shirts, jackets, socks, and shoes.[145] In light of the fact that Ms. Q's doctor states that her condition has not improved, her testimony on this point is credible. Accordingly, the preponderance of the evidence indicates that Ms. Q still requires limited assistance with dressing (CAT score 2/2).

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140 U Q's hearing testimony; Ex. 28 p. 8; Ex. 28 p. 10.
141 U Q's hearing testimony; Ex. 28 p. 9; Ex. 28 p. 13.
142 U Q's hearing testimony; Ex. 28 p. 17.
143 7 AAC 125.030(b)(4).
144 U Q's hearing testimony; Ex. 28 p. 8.
145 U Q's hearing testimony; Ex. 28 p. 14; Ex. 28 p. 17; Ex. 28 p. 19.

With regard to frequency of assistance, neither party presented evidence that Ms. Q's required frequency of assistance with dressing had increased or decreased. Ms. Q's frequency for dressing assistance should thus remain at its 2012 level (CAT score 2/2, frequency 2/7).

5. Eating

For the ADL of eating, PCA time is allowed for feeding through a feeding tube, enteral feeding, and supervising the eating and drinking of a recipient who has swallowing, chewing, or aspiration difficulties.[146] In 2012 Ms. Sullivan found that Ms. Q was independent with eating (CAT score 0/0). In 2014 Ms. Sullivan likewise found that Ms. Q is independent with eating (CAT score 0/0). Ms. Q did not challenge her CAT scores for eating at hearing. Further, the evidence indicates that Ms. Q can still eat and drink independently. The Division's self-performance and support scores for eating are therefore affirmed (CAT score 0/0).

6. Toilet Use

For the ADL of toilet use, PCA time is limited by regulation to time spent moving to and from the toilet, transfers on and off the toilet, general hygiene care of a colostomy, ileostomy, or external catheter, and inserting and removal of a nonmedicated suppository, digital stimulation, or other routine incontinence care.[147] The CAT's definition of "toilet use" is somewhat broader, encompassing post-toileting hygiene and clothing adjustments.[148] In 2012 Ms. Sullivan found Ms. Q required extensive assistance with toileting 28 times per week (CAT score 3/2, frequency 4/7). In 2014 Ms. Sullivan found Ms. Q requires setup help with toileting (CAT score 0/1).

Ms. Q testified at hearing that it is difficult and painful to use the toilet by herself, but that she has forced herself to do it herself due to modesty, and that she really should get help with transfers on and off the toilet to prevent further injuries.[149] Dr. C, Dr. C, Dr. J, and PCA T have all opined that Ms. Q requires some level of physical assistance with ADLs, to include toileting. Further, the Division's prior assessment found that Ms. Q required extensive assistance with toilet use, and Dr. C has specifically stated that Ms. Q's condition is not improving, but rather is getting worse. Accordingly, the preponderance of the evidence indicates that Ms. Q still requires extensive assistance to enable safe toilet use.

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146 7 AAC 125.030(b)(5).

147 7 AAC 125.030(b)(6).

148 The CAT form defines toilet use as "[h]ow person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, *cleanses* . . . manages ostomy or catheter, adjusts clothes" (Ex. E9).

149 U Q's hearing testimony; Ex. 28 p. 17.

With regard to frequency of assistance with toileting, there is no evidence that Ms. Q requires a greater or lesser frequency than she did back in 2012. Accordingly, Ms. Q's toileting frequency should also remain as it was in 2012 (CAT score 3/2, frequency 4/7).

7. Personal Hygiene

For the ADL of personal hygiene, PCA time is allowed for washing and drying the face and hands, nail care, skin care, mouth and teeth care, brushing and combing the hair, shaving when done separately from bathing, and shampooing the hair when done separately from bathing.[150] In 2012 Ms. Sullivan found that Ms. Q required limited assistance with personal hygiene a total of seven times per week (CAT score 2/2, frequency 1/7).[151] In 2014 Ms. Sullivan found that Ms. Q is independent with personal hygiene (CAT score 0/0, frequency 0/0).

Ms. Q testified that she needs her PCA to apply lotion to her back due to itchy skin, and to help her clean up after an episode of incontinence.[152] Ms. Q also stated that she is usually incontinent three to four times per day.[153] She further stated that she requires assistance brushing / combing her hair each day because she can't raise her arms high enough to do it herself.[154]

Ms. Q's testimony regarding her need for assistance with several personal hygiene tasks was credible, particularly in light of her right side carpal tunnel release surgery, left shoulder gunshot wound repair, right shoulder tendonitis repair, and spinal fusion surgery at C6-C7. Further, there is no evidence in the record indicating that Ms. Q's condition has improved since her prior assessment. Accordingly, the preponderance of the evidence indicates that Ms. Q still requires limited assistance with personal hygiene tasks.

With regard to frequency of assistance, the Division presented no evidence to show that Ms. Q's required frequency of assistance with personal hygiene has decreased since her 2012 assessment. Ms. Q did not assert that she requires an increase in frequency of assistance with personal hygiene. Accordingly, Ms. Q's frequency of assistance with personal hygiene should remain at its prior level of seven times per week (CAT score 2/2, frequency 1/7).

8. Bathing

For the ADL of bathing, PCA time is allowed for "the taking of a full-body bath, shower, or sponge bath and the required transfers in and out of the bathtub or shower."[155] In 2012 Ms. Sullivan

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150 7 AAC 125.030(b)(7).
151 Exs. F10, F18.
152 U Q's hearing testimony; Ex. 28 p. 7; Ex. 28 p. 14.
153 U Q's hearing testimony; Ex. 28 p. 14.
154 U Q's hearing testimony; Ex. 28 p. 14; Ex. 28 p. 19.
155 7 AAC 125.030(b)(8). The definition of bathing contained in the CAT is essentially identical (*see* Ex. E11).

found that Ms. Q required extensive assistance with bathing (CAT score 3/2, frequency 1/7). In 2014 Ms. Sullivan found Ms. Q requires only setup assistance with bathing (CAT score 0/1).

Ms. Q testified that, although her wheelchair barely fits in the bathroom, she is usually able to transfer into the bathtub, and take a shower by herself, as long as a PCA has previously setup everything she needs. However, she stated that sometimes, when her pain is bad, she requires PCA assistance to wash her hair; she also needs the PCA to stand by while she bathes in case she has a narcoleptic episode.[156] Given Ms. Q's medical diagnoses, her testimony is credible.

Ms. Sullivan's assessment of Ms. Q's current level of need for assistance with bathing was based on a "best-day, low-pain" scenario. However, it is clear that Ms. Q also has bad days, on which she requires physical assistance from her PCA with bathing. And again, there is no evidence in the record that Ms. Q's medical condition has improved since her last assessment. Accordingly, the preponderance of the evidence indicates that Ms. Q still requires extensive assistance with bathing (CAT score 3/2).

With regard to frequency, there is no evidence to indicate that Ms. Q's needed frequency of assistance with bathing has either increased or decreased since her 2012 assessment. Accordingly, the preponderance of the evidence indicates Ms. Q's frequency of assistance with bathing should remain at its prior level of seven times per week (CAT score 3/2, frequency 1/7).

9. Light Meals

The PCA regulations define the IADL of light meal preparation as the preparation, serving, and cleanup in the recipient's home of any meal that is essential to meet the health needs of the recipient, and that is not the main meal of the day.[157] The Division's prior (2012) assessment found that Ms. Q required assistance with light meal preparation (CAT score 3/2). The Division's current (2014) assessment found that Ms. Q is independent with difficulty for light meal preparation (CAT score 1/0).

At hearing, Ms. Q testified that, although it is difficult, she can use her microwave oven, *but that she needs assistance with other aspects of light meal preparation*.[158] This is consistent with what could reasonably be expected from a 66-year-old wheelchair-bound person with Ms. Q's medical diagnoses. Accordingly, the preponderance of the evidence indicates that Ms. Q still requires assistance with light meal preparation (CAT score 3/2).[159]

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156 U Q's hearing testimony; Ex. 28 p. 7; Ex. 28 p. 18 Ex. 28 p. 19.
157 7 AAC 125.030(c)(1).
158 U Q's hearing testimony; Ex. 28 p. 10; Ex. 28 p. 19.
159 Note that the CAT scores IADLs slightly differently than ADLs (see discussion in Section III(B), above).

10. Main Meals

The PCA regulations define the IADL of main meal preparation as the preparation, serving, and cleanup in the recipient's home of one main meal per day that is essential to meet the health needs of the recipient.[160] The Division's prior (2012) assessment found that Ms. Q requires assistance with main meal preparation (CAT score 2/3). The Division's current (2014) assessment found Ms. Q to be independent with difficulty as to main meal preparation (CAT score 1/3).

At hearing, Ms. Q credibly testified that she is unable to prepare her own meals because (1) while in her wheelchair, she cannot see over the top of the stove to cook; (2) she cannot reach high enough to get many things out of her kitchen cupboards and refrigerator; and (3) if she were to have a narcoleptic episode, she might burn herself on the stove or start a fire.[161] Again, this is consistent with what could reasonably be expected from a 66-year old wheelchair-bound person with Ms. Q's medical diagnoses. Accordingly, the preponderance of the evidence indicates that Ms. Q still requires assistance with main meal preparation (CAT score 2/3).

11. Light Housework

The PCA regulations define the IADL of "light housekeeping" as (1) picking up, dusting, vacuuming, and floor-cleaning of the living spaces used by the recipient; (2) the cleaning of the kitchen and dishes used for preparation of the recipient's meals; (3) the cleaning of any bathroom used by recipient; (4) making the recipient's bed; (5) removing the recipient's trash; and (6) caring for the recipient's service animal.[162] The Division's prior (2012) assessment found Ms. Q to require assistance with light housework (CAT score 2/3). The Division's current (2014) assessment found Ms. Q to be independent with difficulty with her light housework (CAT score 1/3).

At hearing, Ms. Q testified that she is generally unable to perform housework because she is in a wheelchair, and because she has a hard time reaching things.[163] She stated that she can sweep, but that it hurts her back to do it from her wheelchair.[164] Ms. Q's testimony in this regard is consistent with what could reasonably be expected from a 66-year-old wheelchair-bound person with Ms. Q's medical diagnoses; it seems somewhat ludicrous to expect someone to clean their house from a wheelchair. Accordingly, the preponderance of the evidence indicates that Ms. Q still requires assistance with her light housework (CAT score 2/3).

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160 7 AAC 125.030(c)(2).
161 U Q's hearing testimony; Ex. 28 p. 7; Ex. 28 pp. 10 - 11; Ex. 28 p. 19.
162 7 AAC 125.030(c)(3).
163 U Q's hearing testimony; Ex. 28 p. 7; Ex. 28 p. 10; Ex. 28 p. 19.
164 U Q's hearing testimony; Ex. 28 p. 11.

12. Routine Housework

The Division's prior (2012) assessment found Ms. Q to be dependent on others for routine housework (CAT score 3/4). The Division's current (2014) assessment found that Ms. Q is independent with difficulty as to routine housework (CAT score 1/3).

Although *the CAT* differentiates between "light housework" and "routine housework," *the PCA regulation* includes all the constituent activities of these two "CAT categories" within a single definition of "light housekeeping."[165] Because Ms. Q has already received a score of 2/3 for the IADL of "light housekeeping" (above), the same score is appropriate for routine housework.

13. Grocery Shopping

The PCA regulations define the IADL of grocery shopping as shopping in the vicinity of a recipient's residence for groceries and other household items required for the health and maintenance of the recipient, and prescribed drugs and medical supplies required by the recipient.[166] The Division's prior (2012) assessment found Ms. Q to require assistance with grocery shopping (CAT score 2/3). The Division's current (2014) assessment found Ms. Q to be independent with difficulty as to grocery shopping (CAT score 1/3).

At hearing, Ms. Q testified that she requires PCA assistance with grocery shopping because she cannot reach things from low shelves or high shelves from her wheelchair, and also because she cannot push a shopping cart while in her wheelchair.[167] This testimony is consistent with what could reasonably be expected from a 66-year-old wheelchair-bound person with Ms. Q's medical diagnoses. Accordingly, the preponderance of the evidence indicates that Ms. Q requires assistance with grocery shopping (CAT score 2/3).

14. Laundry

The PCA regulations define the IADL of laundry as the changing of a recipient's bed linens and the in-home or out-of-home laundering of a recipient's bed linens and clothing.[168] The Division's prior (2012) assessment found Ms. Q to be dependent on others for her laundry (CAT score 3/4). The Division's current (2014) assessment found that Ms. Q is independent with difficulty with her laundry (CAT score 1/3). At hearing, Ms. Q testified that she cannot reach all of the buttons on her stackable washer and dryer set, and that the dryer (which is evidently on top) is

165 7 AAC 125.030(c)(3).
166 7 AAC 125.030(c)(5).
167 U Q's hearing testimony; Ex. 28 p. 10; Ex. 28 p. 16; Ex. 28 p. 19.
168 7 AAC 125.030(c)(4).

too high to allow her to take clothes in and out of it or clean the lint trap from her wheelchair.[169] She also needs help putting her clothes away because she can't hang / put away many of them from her wheelchair.[170] A finding of dependency on others for laundry would be consistent with what could reasonably be expected from a 66-year-old wheelchair-bound person with Ms. Q's medical diagnoses. Accordingly, the preponderance of the evidence indicates that Ms. Q is dependent on others for the IADL of laundry (CAT score 3/4).

15. PCA Assistance with Medication / Medication Management

Pursuant to 7 AAC 125.030(d), PCA assistance is available for:

> (1) assisting the recipient to self-administer routine oral medication, eye drops, and skin ointments; that assistance may include reminding the recipient and placing a medication within the recipient's reach;
>
> (2) assisting the recipient with the administration of medication; the task may be performed only by a [PCA] working for a consumer-directed personal care agency;

PCA time is allowed for "medication assistance / administration" if the recipient receives a score of 1, 2, 4, 5, or 6 in Section G(1)(a) at page 20 of the CAT.[171] Here, Ms. Q received a score of zero on her 2012 assessment, and a score of zero on her 2014 assessment. However, Dr. C, one of Ms. Q's treating physician, has opined that Ms. Q has memory issues related to her brain surgery and her history of epilepsy and therefore needs assistance with her medications. Ms. Q stated that she needs reminders and setup help with her medications two to three times per day.[172] Ms. Q also requires the assistance of her PCA to administer eye drops, apply ointments to places that she cannot reach, and assist with her CPAP machine.[173] Based on this, I find it more probable than not that Ms. Q should have received a score of four on this item in her current assessment. Accordingly, Ms. Q is eligible for PCA time for medication administration because she received a score of four as to this item.[174]

The *amount* of PCA time allowed for medication assistance is computed based on the recipient's personal hygiene score.[175] If the recipient's personal hygiene self-performance score is 0, 1, or 8, the recipient receives no time for medication assistance. If the recipient's personal hygiene

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169 U Q's hearing testimony; Ex. 28 p. 10; Ex. 28 p. 16; Ex. 28 p. 19.
170 U Q's hearing testimony; Ex. 28 p. 16.
171 Exs. B34, B35, E20.
172 U Q's hearing testimony; Ex. 1 p. 13.
173 U Q's hearing testimony; Ex. 28 p. 13; Ex. 28 p. 15; Ex. 28 p. 20.
174 Exs. E20, F20.
175 All findings and conclusions in this paragraph are based on the Division's Personal Care Assistance Service Level Computation Chart at Exs. B34 - B35.

self-performance score is 2 or 5, the recipient's personal hygiene time is multiplied by .5 to compute medication assistance time. If the recipient's personal hygiene self-performance score is 3, the recipient's personal hygiene time is multiplied by .75 to compute medication assistance time. Finally, if the recipient's personal hygiene self-performance score is 4, the recipient's personal hygiene time is multiplied by 1.0 to compute medication assistance time.

This decision concludes that Ms. Q should have received a personal hygiene score of 2/2 (see above). Accordingly, under the Division's regulations, Ms. Q is entitled to PCA time for assistance with medications in an amount equal to 50% of her PCA time for personal hygiene.

16. PCA Assistance with Checking Vital Signs and Glucose Levels

PCA time for assistance checking vital signs and glucose levels is also based on the applicant or recipient's personal hygiene score.[176] However, pursuant to 7 AAC 125.030(d)(3), PCA assistance with checking vital signs and glucose levels requires a prescription from the recipient's physician, physician's assistant, or advanced nurse practitioner.

Ms. Q testified that her doctor tells her to check her blood pressure and pulse daily, and to check her glucose levels before every meal.[177] In addition, Dr. C's letter dated November 11, 2014 constitutes a prescription for checking blood pressure and glucose levels.[178] However, this prescription was issued about five months after Ms. Q's assessment, and about one month after the Division issued its determination letter regarding Ms. Q's new PCA service level. Ms. Q did not provide evidence demonstrating that she had a current prescription, for PCA assistance with checking vital signs and glucose levels, *in effect as of the time the Division made its decision.* Accordingly, the Division was correct not to award PCA time for checking Ms. Q's vital signs and glucose levels.

17. PCA Assistance with Non-Sterile Dressings / Bandages

Pursuant to 7 AAC 125.030(d)(4), PCA time may be provided for assistance with non-sterile bandage or dressing changes. Ms. Q did not dispute the Division's finding that she had no need for PCA assistance with non-sterile bandage or dressing changes at the time of her assessment.[179] Accordingly, based on the evidence in the record, the Division's finding that Ms. Q does not currently require PCA assistance with non-sterile bandage or dressing changes is affirmed.

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176 *See* Ex. D11.

177 U Q's hearing testimony; Ex. 28 p. 18; Ex. 28 p. 20.

178 The Oxford English Dictionary defines "prescription" in relevant part as "[a]n instruction written by a medical practitioner that authorizes a patient to be provided a medicine or treatment." *See* Oxford English Dictionary, accessed online at http://www.oxforddictionaries.com/us/definition/american_ english/prescription (date accessed July 22, 2015).

179 U Q's hearing testimony; Ex. 1 p. 17.

18. PCA Assistance with Sterile Dressing Changes and Wound Care

Pursuant to 7 AAC 125.030(d)(8), PCA time may be provided for assistance with sterile dressing changes and wound care, except that "dressings involving prescription medication and aseptic techniques may be provided only by a personal care assistant working for a consumer-directed personal care agency." Ms. Q testified that she did not have any wound requiring use of sterile technique at the time of the assessment.[180] Accordingly, the Division's finding that Ms. Q does not currently require PCA assistance with sterile dressing changes is affirmed.

19. PCA Assistance with Medical Documentation

Pursuant to 7 AAC 125.030 (d)(3), PCA time is available for "taking and documenting the recipient's temperature, pulse, blood pressure, and respiration *if ordered by the recipient's physician, physician assistant, or advanced nurse practitioner*, and setting up for diabetic testing and documentation" (emphasis added). In this case, Ms. Q testified that she needs her PCA to check her blood pressure, and record the results, once per day.[181] Dr. C's letter dated November 11, 2014 constitutes a prescription for assistance documenting blood pressure and glucose levels. However, this prescription was issued about five months after Ms. Q's assessment, and about one month after the Division issued its determination letter regarding Ms. Q's new PCA service level. Ms. Q did not provide evidence demonstrating that she had a current prescription, for PCA assistance with documentation, in effect as of the time the Division made its decision. Accordingly, the Division was correct not to award PCA time for assistance with medical documentation.

20. PCA Escort to Medical Appointments

Pursuant to 7 AAC 125.030(d)(9), PCA time is available 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." This is usually only provided when, due to cognitive or behavioral issues, the recipient is unable to communicate effectively with her doctor. In 2012 the Division provided Ms. Q with 20 minutes of PCA escort time per week. In 2014, the Division found that Ms. Q no longer qualified for PCA time for medical escort.

Ms. Q testified that she had 126 appointments with doctors and therapists during the past year.[182] She stated that she needs her PCA to remind her of issues to discuss with her doctors, and to remind her of the advice or instructions given to her by her medical providers.[183] Also, she needs

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180 U Q's hearing testimony; Ex. 28 p. 18; Ex. 28 p. 20.
181 U Q's hearing testimony; Ex. 28 p. 15; Ex. 28 p. 18.
182 U Q's hearing testimony; Ex. 28 p. 17.
183 U Q's hearing testimony; Ex. 28 p. 17; Ex. 28 p. 20.

someone with her who is familiar with her cataplexy and narcolepsy in case she has an episode while travelling to or from the doctor's office.[184] Dr. C also stated that Ms. Q has memory issues related to her brain surgery and history of epilepsy, and needs assistance during appointments. Ms. Q's and Dr. C's statements on this issue are credible. Accordingly, the Division must recalculate Ms. Q's PCA time for escort to medical appointments.

21. PCA Assistance with Range of Motion Exercises

Pursuant to 7 AAC 125.030(e), the Division will pay for PCA assistance with range of motion (ROM) and stretching exercises if those services (1) are provided by a personal care agency enrolled in the agency-based program; and (2) are prescribed by a physician, a physician assistant, or an advanced nurse practitioner. In this case, it was not disputed that Ms. Q receives her PCA services through an agency-based program; the issue is whether she has a valid prescription.

Ms. Q testified that she needs PCA assistance with her pool therapy / ROM exercises, and that her doctor or therapist told her she needs this twice per week for one hour each session.[185] Ms. Q has had at least two incidents in which she went into a cataplexic / narcoleptic state while in the swimming pool, and had to be rescued by a lifeguard.[186] Licensed physical therapist K G submitted a letter, dated October 14, 2014, which confirms that Ms. Q requires this aquatic exercise to maintain her health, and which confirms that Ms. Q requires PCA assistance to get into and out of her swimsuit, and with all the transfers necessary to get Ms. Q in and out of her wheelchair and the swimming pool.[187]

The Division denied Ms. Q's PCA time for range of motion (ROM) exercises because she did not have a prescription for ROM exercises *at the time of her assessment.* It is true that Ms. Q had no prescription for ROM exercises at the time of her assessment. However, physical therapist K G's ROM prescription for two one-hour sessions per week is dated October 14, 2014, nine days prior to the Division's issuance of its PCA service level reduction notice. The Division's reassessment process is designed to take cognizance of the recipient's status through the date of the service level determination notice. Accordingly, Ms. Q is eligible to receive Medicaid payment for two hours per week of PCA assistance with range of motion exercises.

184 U Q's hearing testimony; Ex. 28 p. 18; Ex. 28 p. 20.
185 U Q's hearing testimony; Ex. 28 p. 8; Ex. 28 p. 18.
186 Exs. 7, 8, and 9.
187 Ex. 6 p. 1.

IV. Conclusion

Ms. Q has a history of cataplexic / narcoleptic seizures, which require direct assistance from others for safe management, occurring once per week during the week prior to the assessment, and during the period between the assessment and the termination notice. When an applicant or recipient has uncontrolled seizures with this frequency, the Division's Consumer Assessment Tool (CAT) conclusively presumes that the individual requires skilled or intermediate level nursing care. Accordingly, Ms. Q remains eligible to receive waiver services, and the Division's termination of Ms. Q's waiver services is therefore reversed.

With regard to PCA services, that Ms. Q has significant physical impairments which limit her ability to function independently, and she requires a greater level of assistance with her ADLs and IADLs than was originally determined by the Division. Accordingly, Ms. Q remains eligible to receive PCA services, and the Division's decision terminating her PCA services is therefore also reversed.

DATED this 5th day of August, 2015.

Signed
Jay Durych
Administrative Law Judge

Adoption

The undersigned, by delegation from of the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), 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 19th day of August, 2015.

By: *Signed*
Name: Jay D. Durych
Title: Administrative Law Judge, DOA/OAH

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