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

In the Matter of	)	
	)	
D B	)	OAH No. 17-1066-MDS
	)	Agency No.

DECISION

I. Introduction

D B applied for Medicaid Home and Community-Based Waiver ("Waiver") services. The Division of Senior and Disabilities Services (Division) denied his application. Mr. B requested a hearing to challenge the denial.[1] Mr. B's hearing was held on November 27, 2017. Mr. B represented himself. Victoria Cobo represented the Division. Rae Norton, an assessor employed by the Division, testified on its behalf.

Mr. B is a paraplegic. Mr. B, however, can physically function without requiring physical assistance in most of his activities of daily living. As a result, he does not satisfy the eligibility requirements for Medicaid Waiver services. The Division's denial of his application is affirmed.

II. Facts

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

Mr. B is 24 years old. He had a bad motor vehicle accident in October 2016, which rendered him a paraplegic, with a complete loss of functionality from the midchest down. He received medical treatment for the accident in Seattle, and returned to Alaska in December 2016. He is wheelchair bound, but does have full use of his arms.[2]

Mr. B was assessed to determine his eligibility for Medicaid Waiver benefits in April 2017. At the time of the assessment, he was not receiving physical therapy, any special medical treatments, or any other therapies.[3] The assessor found that he was able to reposition himself in bed without assistance, was able to transfer from his bed to the wheelchair without assistance, was able to push his wheelchair without assistance, was able to use the toilet with only limited

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[1] Ex. C.
[2] Ex. E, pp. 1, 3.
[3] Ex. E, pp. 13 – 15.

physical assistance, and was able to eat without assistance.[4] The results of the assessment were that Mr. B did not qualify for Waiver benefits.[5]

After the assessment was conducted, Mr. B's health took a serious short-term downturn. He developed a serious skin breakdown, which landed him in the hospital with stage 2 decubitus ulcers. He was hospitalized on July 10. On July 27, 2017, when he was healed with only minor residual redness remaining, he was discharged to an assisted living facility.[6]

Mr. B finished the application paperwork for Medicaid Waiver benefits on September 11, 2017. The Division notified him on October 5, 2017, that it was denying his application based upon the results of the assessment which it performed back in April 2017.[7]

Mr. B requested a hearing to challenge the denial of his application. At his hearing, the assessor testified. Her testimony was consistent with the results of the April 2017 assessment. When she was asked about Mr. B's hospitalization in July, her response was that the hospitalization did not make him eligible for Waiver benefits, because he was essentially healed at the time of his discharge, and because he was not receiving physical therapy.[8]

Mr. B testified. His testimony established that he can move around and sit up in bed without assistance, and that his only transfers are from the bed to the wheelchair and back, which he can do without assistance. He can push his wheelchair himself within the home, but needs help negotiating the outside ramp. He can eat without assistance. He does need assistance using the toilet. He has to be picked up from the toilet, and his pants have to be pulled up for him. He does not currently receive any physical therapy. The last time he received physical therapy was before he returned to Alaska after his motor vehicle accident.[9]

III. Discussion

A. Method for Assessing Eligibility

An applicant must require a nursing facility level of care to qualify for Medicaid Waiver benefits. That level of care[10] requirement is determined by an assessment which is documented by the Consumer Assessment Tool (CAT).[11] The assessment measures an applicant's medical

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[4] Ex. E, pp. 6 – 7, 9.
[5] Ex. E, p. 29.
[6] *See* Medical records filed on November 27, 2017; Mr. B's testimony.
[7] Ex. D.
[8] Ms. Norton's testimony.
[9] Mr. B's testimony.
[10] *See* 7 AAC 130.205(d)(4); 7 AAC 130.215.
[11] 7 AAC 130.215(4).

care needs, and his or her ability to function physically: it records an applicant's needs for professional nursing services, therapies, and special treatments,[12] whether an applicant has substantially impaired cognition or problem behaviors,[13] and the applicant's ability to perform specific measured activities of daily living (ADLs), and what type of assistance he or she needs, if any, with those activities.[14] Each of the assessed items contributes to a final numerical score. For instance, if an individual required 5 days or more of therapies (physical, speech/language, occupation, or respiratory therapy) per week, he or she would receive a score of 3.[15] Alternatively, if a person requires extensive physical assistance (self-performance code of 3) or is completely dependent (self-performance code of 4) with three or more of five specified ADLs (bed mobility, transfers, locomotion within the home, eating, and toileting), that person would also receive a score of 3.[16]

A person can also receive points for combinations of required nursing services, therapies, substantially impaired cognition (memory/reasoning difficulties), or difficult behaviors (wandering, abusive behaviors, etc.), and if they require either limited or extensive assistance with the five specified activities of daily living.[17] If an applicant's score is a 3 or higher, the applicant is medically eligible for Waiver services.[18]

B. Eligibility

An applicant for Waiver services has the burden of proof by a preponderance of the evidence.[19] The relevant date for purposes of assessing the state of the facts is, in general, the date of the agency's decision under review.[20]

Mr. B does not have any documented nursing needs, mental or behavioral impairments, no specialized medical care, and does not receive any therapies, such as chemotherapy, radiation therapy, occupational or physical therapy, three or more days per week.[21] Although he was hospitalized in July 2017, he was discharged without continuing medical treatment or therapies

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12 Ex. E, pp. 13 – 15.
13 Ex. E, pp. 16 - 17.
14 Ex. E, pp. 6 -7, 9, 18.
15 Ex. E, p. 29.
16 Ex. E, p. 29.
17 Ex. E, p. 29.
18 Ex. E, p. 29.
19 7 AAC 49.135.
20 *See* 7 AAC 49.170; *In re T.C.,* OAH No. 13-0204-MDS (Commissioner of Health & Soc. Serv. 2013) (http://aws.state.ak.us/officeofadminhearings/Documents/MDS/HCW/MDS130204.pdf).
21 Ex. E, pp. 13 – 17; Mr. B's testimony; Ms. Norton's testimony.

at the end of July, which was several months before the Division denied his application. Accordingly, his only path to Waiver eligibility is if he requires a minimum of extensive assistance with three or more of the scored ADLs (bed mobility, transfers, locomotion, eating, and toileting).

Mr. B's assessment shows that he is independent with four of the five scored ADLs: bed mobility, transfers, locomotion, and eating.[22] Mr. B does not dispute that he can perform these activities himself.

This leaves only one of the scored ADLs at issue: toileting. Mr. B's medical condition, being his paraplegia, and his testimony supports a finding that he should have been scored as requiring extensive assistance (self-performance code of 3) with toileting because he needs weight-bearing assistance (being pulled up from the toilet) when he uses the toilet. Mr. B does not require extensive assistance with any of the other scored ADLs. To qualify for Medicaid Waiver benefits, he must need extensive assistance with three of the scored ADLs, whereas he only requires extensive assistance with one scored ADL - toileting. As a result, Mr. B has not met his burden of proof, and is not eligible for Medicaid Waiver benefits.

IV. Conclusion

The Division's denial of Mr. B's application for Medicaid Waiver benefits is affirmed.

DATED this 14th day of December, 2017.

Signed
Lawrence A. Pederson
Administrative Law Judge

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[22] Ms. Norton's testimony; Ex. E, pp 6 – 7, 9.

Adoption

The undersigned, by delegation from 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 28th day of December, 2017.

By: *Signed*
Signature
Lawrence A. Pederson
Name
Administrative Law Judge
Title

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