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

In the Matter of	)	
	)	
X M	)	OAH No. 18-0844-MDS
	)	

DECISION

I. Introduction

X M was receiving three hours of weekly personal care services (PCS) under a short-term service level authorization. He requested an amendment to the plan, extending its duration and increasing authorized services. The Division of Senior and Disabilities Services (Division) denied the request and informed Mr. M that his PCS authorization had terminated. Mr. M requested a hearing.

Mr. M's rheumatoid arthritis causes joint swelling, chronic pain and stiffness, as well as other medical problems. Despite his ongoing health issues, the evidence shows that he is typically functionally able to perform most transfers and all locomotion tasks without physical assistance. The one exception is for Mr. M's transfers in and out of bed, particularly in the morning. He showed that he likely requires limited assistance for that task, twice per day. As to the other activities for which Mr. M sought new PCS time, he did not meet his burden to show that his condition has changed or that he requires hands-on assistance. The Division correctly denied authorization for those activities.

Accordingly, the Division's decision is partially reversed and partially affirmed.

II. Facts and Procedural History

Mr. M is 51 years old. His primary language is Hmong. He lives with his wife and minor children.[1] His wife is employed, which means Mr. M is often home alone when she is at work and the children are in school.

Mr. M's medical history includes a number of chronic health conditions, including rheumatoid arthritis, osteoarthritis erosive, venous thrombosis, clostridium difficile, hyperglycemia, and depressive disorder.[2] His autoimmune illness is chronic and progressive, and it can result in other medical problems, including deep vein thrombosis and pulmonary

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1 Exhibit D, p. 56.

2 Exhibit D, pp. 8-9, 18, 58.

embolism. Understandably, this creates a very difficult situation for Mr. M and his family, and Mr. M is often sad and frustrated by his pain and ongoing poor health.[3]

On February 13, 2018, Mr. M was assessed by Samantha Fili, a Division assessor, to determine his eligibility for the PCS program.[4] His adult daughter, C M, also was present. Based on the assessor's visual observations, functional testing, and statements by Mr. M and C M, the assessor determined that Mr. M was functionally able to perform the evaluated activities of daily living (ADLs) without any hands-on assistance. The assessor recognized that Mr. M was not fully independent with any tasks except the eating ADL. However, she concluded he was able to perform the other tasks if he received supervision and/or set-up help.[5] These ratings did not qualify Mr. M for any PCS assistance.

For the activities called instrumental activities of daily living (IADLs), the assessor concluded that Mr. M could independently prepare light meals. She determined that he also could perform the other rated tasks with difficulty (main meal preparation, light housework, grocery shopping and laundry), but she recognized that he required physical assistance for them.[6] However, because Mr. M's household includes a spouse who is capable of managing these tasks and is legally obligated to do so, the Division denied PCS assistance for any IADLs.[7]

During the assessment, Mr. M had difficulty raising his left hand over his head, and he reported that his arthritis prevented him from doing much with his left hand or arm. However, he could put both hands behind his back. He also could bend forward from a sitting position and touch his toes.[8] He had a swollen left foot, but he reported ambulating independently both inside and outside his home using his walker.[9] Ms. Fili observed Mr. M grip his walker with both hands and walk to and from his bedroom. He also was able to transfer from a sitting to a standing position independently by leaning forward on the walker and pulling himself up. Regarding toileting needs, Mr. M indicated that he required assistance transferring on and off the toilet and managing his pericare. When asked how he manages when his wife is at work and he is home alone, however, he stated that he takes his time and gets the task done.[10]

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3 M testimony; Exhibit D.
4 Exhibit D, p. 56.
5 Exhibit D, p. 73.
6 *Id.* at p. 81.
7 Exhibit A, p. 2; Exhibit D, p. 48; 7 AAC 125.040(a)(14).
8 *Id.*
9 *Id.* at p. 62.
10 *Id.* at p. 64.

After his February 2018 assessment, the Division notified Mr. M that he did not qualify for PCS assistance. Mr. M requested a fair hearing. He and the Division settled the dispute, agreeing that Mr. M should receive PCS on a limited, short-term basis while he was undergoing physical therapy.[11] That agreement resulted in a service level authorization for three PCS hours per week for a three-month period, from May 2, 2018 through August 2, 2018.[12] The authorized time was for assistance with transfers, locomotion (between locations and access to medical appointments), and escort. Time was allotted based on a need for limited assistance with each activity.[13] By the agreement's terms, the services would terminate on August 2nd unless Mr. M submitted a request and medical justification for extended services.[14]

From late March through late April 2018, Mr. M participated in physical therapy.[15] He planned to continue, but therapy was put on hold due to a blood clot in Mr. M's left leg, for which he was placed on blood thinning medication.[16] Mr. M is still working to resolve problems with that and a more recent blood clot, so his physical therapy has not resumed.

During most of Mr. M's physical therapy sessions, he did 15 minutes of exercise on a recumbent bicycle, and he performed exercises or activities that required him to stand, sit, and lay down.[17] He also did exercises involving catching and kicking a soccer ball. Though the records note that Mr. M often had an antalgic gait and he experienced some significant pain during therapy, he only required physical assistance with one activity on one occasion. On the last visit before his left leg blood clot was diagnosed, Mr. M required minimal physical assistance to ambulate into the therapy gym using his single-point cane.[18] There is no indication that he required physical assistance to transfer, ambulate, or perform other activities on any other occasions.

On July 10, 2018, Mr. M was seen in a hospital emergency department for chest pain, resulting in a diagnosis of pulmonary embolism.[19] On July 19, 2018, he saw his primary care provider, Dr. Y T, M.D., for a follow-up.[20] Dr. T documented his complaints, which included

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11 Exhibits A, F; Exhibit D, pp. 47-55; Fromm testimony.
12 Exhibits A, F; Exhibit D, pp. 47-55. C M became her father's personal care assistant.
13 Exhibit D, pp. 53-55.
14 Exhibit D, p. 48.
15 *See* Exhibit D, p. 31.
16 *See* Exhibit D, p. 24.
17 Exhibit E.
18 Exhibit E, p. 14.
19 Exhibit D, p. 11.
20 Exhibit D, p. 18

chronic weakness, dizziness, fatigue upon rising, episodic chest pain, depression, and chronic joint pain in his feet, knees, hands, and back.[21]

On the issues of weakness, dizziness, and fatigue upon arising, Dr. T concluded that these are chronic and minimally problematic. They have been ongoing for months or years, but she felt they had improved with Mr. M's recent weight gain.[22] She also wrote that Mr. M was moving around well, and he looked healthier than he had in the past year:

> 51-year-old Asian male, unable to speak English, discusses actively with his daughter, actually looks healthier now than in the past year, alert, cooperative[,] interactive, loud strong voice, stands quickly, moves quickly with no evidence of significant depression, moving quickly.[23]

Mr. M saw his rheumatologist, Dr. S S, M.D., on July 26, 2018.[24] Dr. S noted that, since 2013, Mr. M's pain has increased in his wrists, ankles, right elbow and several small joints of his hands. It is worse in the morning and with activity. During the appointment, Mr. M complained of occasional lightheadedness, some numbness in his legs, and multiple episodes of urinary incontinence.[25] Dr. S noted some tenderness and swelling in Mr. M's wrists, a flexion contracture in the right-hand fifth digit, tenderness in the knees, and generally strong lower extremities. He noted some daily active inflammatory symptoms, primarily in the wrists and hands.[26]

The records from that appointment do not address Mr. M's functional abilities or needs for assistance with specific activities. However, based on Mr. M's active rheumatoid arthritis and multiple comorbidities (left lower extremity DVT, pulmonary embolism, diabetes and some increased weakness and urinary incontinence), Dr. S drafted a letter letter generally recommending that Mr. M continue to receive PCA assistance.[27]

On August 1, 2018, the Division received a request from Mr. M to amend his PCS service plan.[28] The amendment sought to extend the service level authorization for a year, while providing increased time for transfers, locomotion (between locations and access to medical

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21 Exhibit D, pp. 18-19.
22 Exhibit D, p. 18.
23 Exhibit D, p. 20.
24 Exhibit D, p. 11.
25 Exhibit D, p. 11.
26 Exhibit D, p. 15.
27 *Id.*
28 Exhibit D, p. 6.

appointments), and escort. It also sought to add new time for the activities of toilet use and bathing.[29]

The Division determined that Mr. M's medical documentation did not support a continuing need for assistance or justify any new services. It denied the request on September 5, 2018 and informed Mr. M that his PCS authorization had terminated.[30] Mr. M requested a hearing.

The hearing took place by telephone on October 8, 2018. It was audio-recorded. A Hmong interpreter facilitated. Mr. M represented himself and testified on his own behalf. C M also testified. U Z from Mr. M's PCA agency also briefly testified. Terri Gagne represented the Division. Jerry Fromm, R.N., a Health Program Manager and registered nurse, testified for the Division. The record remained open after the hearing so Mr. M could submit additional documentation and the Division could respond. All submitted documents were admitted to the record, which closed on October 19, 2018.

III. The PCS Determination Process

The Medicaid program authorizes PCS for the purpose of providing assistance to a Medicaid recipient whose physical condition results in functional limitations that cause the recipient to be unable to perform, independently or with an assistive device, the activities covered by the program.[31] Covered activities are broken down into activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The ADLs are bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene, and bathing.[32] The IADLs are light meal preparation, main meal preparation, housework, laundry, and shopping.[33] In addition, PCS can be provided for medication assistance, maintaining respiratory equipment, dressing changes and wound care, medical escort, and passive range-of-motion exercises.[34] PCS are furnished by a Personal Care Assistant, usually abbreviated as "PCA."

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29 *Id.*
30 Exhibit F.
31 7 AAC 125.010(b)(1)(A).
32 7 AAC 125.030(b).
33 7 AAC 125.030(c).
34 7 AAC 125.030(d). The regulation contains specific conditions that a recipient must satisfy to receive these specialized services.

PCS hours are not provided for activities that can "be performed by the recipient."[35] Nor are they allowed for "oversight or standby functions."[36] In addition, the Division may not authorize PCS for needs that can be met by a recipient's representative, immediate family members, or natural supports.[37]

The Division assesses recipients using the Consumer Assessment Tool, or "CAT", as a methodology to score both eligibility for the PCS program and the amount of assistance needed for covered activities and services.[38] The list of available services, time allotted for each service based upon severity of need, and the allowable frequency for each service is set out in the *Personal Care Services: Service Level Computation* instructions, which are adopted by reference into regulation.[39]

As a gateway to eligibility for PCS, the CAT evaluates a subset of the ADLs and IADLs. If a person requires some degree of hands-on physical assistance with any one of these ADLs or IADLs, or has a medically documented need for supervision while eating, then the person is eligible for PCS services.[40] Once eligibility is established, time for additional ADLs, IADLs, and other covered services can be added to the authorization.

A. Activity of Daily Living Scoring

The CAT numerical coding system for ADLs has two components. The first component is the *self-performance code.* These codes rate how capable a person is of performing a particular ADL. The possible codes are: **0** (the person is independent and requires no help or oversight)[41]; **1** (the person requires supervision)[42]; **2** (the person requires limited assistance)[43]; **3**

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35 7 AAC 125.040(a)(4).

36 7 AAC 125.040(a)(10).

37 7 AAC 125.020(c). "Immediate family members" is not defined by regulation but has been interpreted as applying to family members such as spouses and parents of minor children. "Natural supports" is defined to mean individuals who voluntarily and without payment provide care and support similar to PCS help for a recipient. 7 AAC 125.199(8).

38 *See* 7 AAC 125.020(a)(1). The CAT is itself a regulation, adopted in 7 AAC 160.900(d)(6).

39 7 AAC 125.024(a); 7 AAC 160.900(d)(29). The *PCS Service Level Computation* chart is in the record at Exhibit F, pp. 3-4.

40 7 AAC 125.020(c)(1).

41 A self-performance code of 0 is classified as "Independent – No help or oversight – or – Help/oversight provided only 1 or 2 times during the last 7 days." *See* Exhibit D, p. 61.

42 Supervision includes "Oversight, encouragement or cueing provided 3+ times during last 7 days – or – Supervision plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days." *See* Exhibit D, p. 61.

43 Limited assistance with an ADL is defined as "Person highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3+ times – or – Limited assistance (as just described) plus weight-bearing 1 or 2 times during last 7 days." *See* Exhibit D, p. 61.

(the person requires extensive assistance)[44]; **4** (the person is totally dependent).[45] There are also codes which are not used in calculating a service level: **5** (the person requires cueing)[46]; and **8** (the activity did not occur during the past seven days).[47]

The second component of the CAT scoring system is the *support code*. These codes rate the degree of assistance that a person requires for a particular ADL. The possible codes are: **0** (no setup or physical help required); **1** (only setup help required); **2** (one-person physical assist required); **3** (two-or-more person physical assist required). Again, there are additional codes which are not used to arrive at a service level: **5** (cueing support required 7 days a week); and **8** (the activity did not occur during the past seven days).[48]

B. PCS Eligibility

There are three ways to qualify for PCS. First, a person can qualify if he or she requires a limited or greater degree of physical assistance in any one of the ADLs of transfers, locomotion, eating, toilet use, dressing or bathing (self-performance code 2, 3, or 4, and a support code of 2, 3, or 4). Second, a person can qualify if he or she requires some degree of hands-on assistance with any one of the IADLs (self-performance code 1, 2, or 3 and a support code of 3 or 4).[49] Finally, though the general rule is that mere monitoring, supervision, or cueing for an ADL or IADL will not confer eligibility for PCS, a medically documented need for supervision while eating does confer eligibility.[50]

The codes assigned to a particular ADL or IADL determine how much PCS time a person receives for each occurrence of a particular activity. For instance, if a person is coded as requiring extensive assistance (self-performance code 3) with bathing, he or she would receive

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44 Extensive assistance is defined as "While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: Weight-bearing support [;] Full staff/caregiver performance during part (but not all) of last 7 days." *See* Exhibit D, p. 61.

45 Total dependence is defined as "Full staff/caregiver performance of activity during ENTIRE 7 days." *See* Exhibit D, p. 61.

46 Cueing is defined as "Spoken instruction or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired." *See* Exhibit D, p. 61.

47 *See id*.

48 *Id*..

49 *See* Exhibit D, pp. 86. For the purposes of this discussion, "hands-on" assistance does not include supervision/cueing or set-up help.

50 7 AAC 125.020(c)(1).

22.5 minutes of PCS time every day he or she is bathed.[51] For covered services beyond assistance with ADLs and IADLs, specific rules apply that are discussed as appropriate.

IV. Discussion

When a recipient seeks to amend an existing PCS authorization, the recipient bears the burden of proof to show a change that justifies the additional time.[52] Changes to the recipient's physical condition must have occurred after the recipient's last assessment or amendment to the service level authorization.[53] When the Division reduces a recipient's PCS time, it must show that the recipient has experienced a change that alters his or her need for physical assistance with relevant activities.[54] The standard is preponderance of the evidence. Parties can meet this burden using any evidence on which reasonable people might rely in the conduct of serious affairs, including sources such as written reports of firsthand evaluations of the patient.[55]

Mr. M's amendment request sought increased PCS time for transfers, locomotion (between locations and access to medical appointments), and escort; it sought new authorization for assistance with toileting and bathing. During the hearing, Mr. M added that he needs assistance with dressing, bed mobility, and personal hygiene. He submitted a letter from his new primary care provider, Dr. O O, M.D., who recommended PCS time for those additional activities, as well as for driving to appointments, cooking, and making telephone calls.[56] Dr. O recommended at least three hours of PCS assistance per day.

Dr. O's recommendation for three PCS hours per day cannot be given determinative weight. First, her letter is conclusory and does not provide sufficient information about the degree and frequency of physical assistance Mr. M requires for each ADL at issue. Under PCS program regulations, time is authorized based on the recipient's scores and needs for hands-on assistance with specific activities. In addition, the letter displays some misunderstanding of the PCS authorization process. Among the six activities for which Dr. O recommended physical

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51 7 AAC 125.024(a); 7 AAC 160.900(d)(29) (PCS Service Level Computation chart); Exhibit F, p. 3.

52 7 AAC 125.026(a).

53 7 AAC 125.026(c)(1).

54 7 AAC 125.026(a), (c). However, for recipients eligible to receive Medicaid Home and Community-based Waiver services, the Division may not reduce PCS authorization if the reduction would create a risk of institutionalization. 7 AAC 125.026(f).

55 2 AAC 64.290(a)(1).

56 Exhibit 1. The letter recommended PCS time for: (1) driving to appointments (average 3-6 appointments per month); (2) getting dressed (unable to perform at ease due to swollen limbs and severe and chronic joint pain); (3) cooking, due to inability to stand for prolonged periods of time (loses balance); (4) getting in and out of bed; (5) self care (brushing teeth, bathing); and (6) making phone calls due to lack of fluency in English.

help, some is simply not available under the PCS program (e.g., telephone translation services), some is not available to Mr. M due to his household composition (e.g., cooking), and some can be authorized based only on scores for other activities (e.g., escort). The areas in dispute are addressed below.

A. Transfers

Transfers refers to how a person moves between surfaces, including to and from a bed, chair, or wheelchair. It does not include transfers to or from the toilet or the shower/bathtub for bathing.[57]

The February 13, 2018 assessment rated Mr. M as requiring supervision and set-up help to transfer.[58] At that time, Mr. M and C M reported that Mr. M could transfer using his walker to pull himself up to a standing position. The assessor observed Mr. M perform this task independently by leaning forward, grasping the walker, and pulling himself forward and up.[59] The short-term PCS authorization approved PCS assistance for transfers based on a need for limited assistance.

Mr. M and his daughter both testified that his condition is progressive and Mr. M generally requires more help. However, they often were not specific about the kind of assistance he requires. Ms. M agreed that, on his good days, her father can manage his ADLs on his own. On bad days, however, she said he cannot. It is not clear from the record how often Mr. M has good and bad days, except that the documentation suggests he regularly experiences some significant chronic pain. With regard to transfers, Ms. M stated that her father regularly requires assistance getting out of bed in the morning. When she was his PCA, she would help him transfer out of bed and then follow him as he walked down the hallway to the kitchen.

Dr. Sanders's records from July 19th indicate that Mr. M could stand up quickly, and he was moving around well. There is no suggestion that he required hands-on assistance. Similarly, Mr. M's physical therapy records suggest no particular problems with transferring. Had Mr. M required physical help to stand or sit, it very likely would have been documented there.

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57 7 AAC 125.030(b)(2); Exhibit D, p. 61.
58 Exhibit D, p. 61.
59 *Id.*

The letter from Dr. S generally supports some continuing PCS assistance, but the letter and Dr. S's records do not expressly state that Mr. M requires hands-on assistance to transfer. Despite this, Dr. S notes that Mr. M's pain is frequently high when he gets up in the morning. This is consistent with C M's testimony about her father's need for help getting out of bed. Dr. O's letter also details six activities for which Dr. O urges PCS assistance. Transfers are not included by name, but Dr. O specifically states that Mr. M requires assistance getting in and out of bed.

Though the degree of assistance needed to transfer in and out of bed is not completely clear, the circumstances strongly suggest it involves hands-on or physical assistance, such as in the form of the guided maneuvering or limbs or other nonweight-bearing assistance at least three or more times per week. This qualifies Mr. M for some PCS assistance. Apart from this activity, however, Mr. M appears to be able to manage transfers if he receives set-up help. On bad days, when he has severe pain in his wrists and hands or numbness in his legs, he may also require supervision to ensure he does not fall. This assistance does not meet the standard for authorizing additional PCS time.

Mr. M more likely than not requires limited assistance to transfer twice per day, when he transfers in and out of bed.

B. Locomotion and Escort

Two aspects of locomotion are relevant here. Locomotion (between locations) pertains to moving from place to place on the same level of the recipient's home. Locomotion (access to medical appointments) involves moving to and from the recipient's residence to a vehicle used to access medical appointments.[60] PCS time for locomotion may not be authorized for a recipient who is self-sufficient with an assistive device. Time for escorting a recipient to and from a routine medical appointment (known as "escort") is permitted only if the recipient is authorized to receive PCS assistance with the ADL of locomotion.[61]

In February, the assessor observed Mr. M use his walker to move to and from his bedroom without assistance. She rated him as independent, but he required set-up help for the walker. The short-term PCS authorization approved PCS time for locomotion based on a finding of limited assistance.

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60 7 AAC 125.030(b)(3); Exhibit D, p. 62.

61 7 AAC 125.030(d)(4).

During the hearing, Mr. M and C M both stated that Mr. M generally can move from place to place inside and outside his home independently using his walker. This is consistent with the information in Mr. M's medical records, and it means Mr. M does not require hands-on assistance. Ms. M testified that she often walks behind her father on bad days or when he uses his cane, to spot him and assure he does not fall. This kind of assistance qualifies as supervision rather than limited assistance.

To get to a vehicle for medical appointments, Mr. M must descend four or five stairs. Ms. M testified that she sometimes carries her father on her back as he descends the stairs. Once at ground level, she said he again moves to and from the vehicle independently with his walker.

Mr. M's physical therapy records do not support this need for assistance. They document consistent complaints of knee pain, which is worse with weight-bearing and stair climbing.[62] Despite this, they indicate that Mr. M could ascend and descend stairs if he had an assistive device or rails, using a single-step strategy.[63] One of therapy's functional goals was for Mr. M to ascend and descend two flights of stairs daily. He did not meet this goal because his symptoms generally limited him to climbing less than 10 steps.[64] Though these records show ongoing difficulty with stairs, they do not suggest Mr. M regularly requires hands-on physical assistance to manage the four or five steps in or out of his home.

The totality of the evidence supports the conclusion that Mr. M typically can use his walker or a cane to move from place to place without physical assistance, including to and from his home to a vehicle used to access medical appointments. He takes blood-thinning medication because of his recent bloot clots, but there is no showing that the medication or the clots have resulted in a change of Mr. M's functional ability to perform these tasks, as evidenced by Dr. T's observations on July 19th.

Mr. M's other medical providers did not recommend PCS assistance for locomotion. Dr. O's letter states that Mr. M needs assistance driving to appointments. Presumably, this refers to a need for escort services. However, because Mr. M does not require at least limited assistance with locomotion, the regulations preclude PCS time for escort services.

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62 Exhibit ER

63 *See, e.g.,* Exhibit E, p. 10.

64 *See* Exhibit E, pp. 4, 6, 8, 10. This information contradicts Ms. M's testimony and is accepted as the more objective information.

C. Toilet Use

The ADL of toileting includes use of the toilet, including transfers on/off and locomotion to/from the bathroom, cleansing, changing pads and adjusting clothing.[65] Bathing or showering is not included. The assessment rated Mr. M as independent with this task.

For many of the same reasons discussed above, the evidence does not show that Mr. M likely requires hands-on help with toileting or that his ability to manage this task has recently changed. The transferring and locomotion aspects of the toileting ADL have been addressed. The other aspect of toilet use is hygiene care and arranging clothing. Here too, the evidence is that Mr. M likely can manage these activities without regular physical assistance.

Mr. M is alone for extended periods of time most days of the week. When needed, he manages his toileting tasks on his own. Mr. M has documented difficulties with pain and swelling in his hands and wrists, and he has trouble raising his left hand above his head. Despite this, during the assessment he demonstrated adequate range of motion to touch his toes and to put his hands behind his back. His medical records also discuss his smoking habit, which strongly suggests that he also has the dexterity and fine motor control to manage toileting hygiene and clothing.

C M indicated that her father is experiencing urinary incontinence more frequently, and he sometimes wakes up in a wet bed. Dr. S's records also document concerns about increasing urinary incontinence. This may show that Mr. M should consider incontinence protection products, but it does not necessarily mean he requires hands-on assistance with the tasks involved in the toilet use ADL. Mr. M has not met his burden on this ADL.

D. Bathing

The bathing ADL involves transfers in and out of the tub or shower and the actual bathing process.[66] The assessment rated Mr. M as requiring supervision and set-up help for this activity, because someone set up a little stepping stool that Mr. M used to get in and out of the shower. During the hearing, C M testified that her father can no longer transfer in and out of the shower on his own with the stepping stool. She attributed this to increasing numbness in his leg, possibly due to a blood clot. She did not clarify how Mr. M currently gets in and out of the tub.

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65 7 AAC 125.030(b)(6); Exhibit D, p. 15.

66 7 AAC 125.030(b)(8); Exhibit D, p. 66.

Mr. M has not met his burden to show he regularly requires physical assistance for this task. There is no dispute that he experiences some weakness, along with other symptoms of his arthritis, including some numbness in his leg. Since he can be unsteady and at risk of falling, he requires supervision and setup help for many tasks. However, after he had been diagnosed with a left leg blood clot and a pulmonary embolism, Dr. T concluded that his weakness was chronic, minimally problematic, and had been ongoing for a long time. She also wrote that Mr. M was moving around well. This suggests that Mr. M's condition and functional abilities have not recently worsened. Dr. O's letter urges PCS assistance with bathing, but without specifying Mr. M's functional abilities and without indicating that his assistance needs require hands-on help rather than supervision.

On this record, Mr. M has not shown the Division made a mistake in denying his request for PCS assistance with bathing. If his condition has significantly changed, he should consider requesting another assessment.

E. Dressing, Bed Mobility, Personal Hygiene, and other tasks.

Mr. M's amendment form did not request PCS time for the activities of dressing, bed mobility, personal hygiene, or tasks such as cooking and telephone translation services. Dr. O identified them in her September 21, 2018 letter. During the hearing, Mr. M argued that he requires assistance with dressing and bed mobility.

Mr. M is not eligible for PCS assistance with cooking because his spouse lives in his home. He is not eligible for telephone translation services because they are not covered by the PCS program. Dr. O's letter states that he needs assistance with personal hygiene, specifically, brushing teeth. However, neither Mr. M or his daughter asserted that he requires assistance with this or other personal hygiene tasks.[67]

Despite Mr. M's difficulty raising his left hand over his head, he otherwise appears to have adequate arm mobility to manage tasks like combing hair, brushing teeth, shaving, and washing/drying his face and hands, which are involved in the personal hygiene ADL. He also has sufficient hand dexterity and fine motor control for these tasks. This is shown by his functional abilities with other ADLs involving use of the hands and arms, his physical therapy records, and his smoking habit (though he is working to quit). If Mr. M is capable of opening a

[67] Bathing and toilet use hygiene are addressed separately from the ADL of personal hygiene.

cigarette carton, lighting a cigarette, and lifting it to and from his mouth, it is not clear why he could not brush his teeth.

For similar reasons, the evidence does not show that Mr. M likely requires regular hands-on help with dressing. Due to his joint pain, swelling and stiffness, this task likely is not easy for him, particularly on his bad days. He may be slow, and it may take him more time than he would like. Dr. O's letter appears to acknowledge this, stating that Mr. M is "unable to perform [getting dressed] at ease" due to his arthritis and joint pain.[68] However, the standard is not that dressing is easily or quickly performed, and the existing evidence does not establish that hands-on physical assistance is regularly required.

The remaining task is bed mobility. Bed mobility refers to how a person moves to and from a lying position, turns from side to side, and positions himself or herself while in bed.[69] Ms. M testified that, on his bad days, her father's pain prevents him from rolling over. She did not explain whether she or anyone else must physically help him turn in bed, or whether his pain is so severe that he simply cannot tolerate rolling to his side, even under his own power. The other testimony regarding bed mobility focused on Mr. M's need for assistance getting in and out of bed, particularly in the morning. That issue was addressed as part of the transferring ADL. Mr. M did not show that his physical condition or functional ability with regard to bed mobility tasks has changed since his last assessment or the date of the short-term service authorization.

In general, Mr. M's condition requires a significant amount of supervision and oversight, as well as set-up with various tasks. No matter how necessary and important, these services are not compensable under the PCS program. It is understandable that Mr. M's family has a difficult time offering the consistent supervision and set-up support that Mr. M appears to require. However, this does not meet Mr. M's burden to show he qualifies for PCS assistance.

V. Conclusion

Mr. M clearly experiences ongoing difficulty with swollen joints, chronic pain, and recent blood clots. As a result, he likely requires limited assistance to transfers in and out of bed, twice per day. Apart from this, however, the preponderance of the evidence is that Mr. M does not require limited assistance or a higher degree of hands-on help for transfers or locomotion (between locations and access to medical appointments). In addition, he did not show that he

[68] Exhibit 1.
[69] Exhibit D, p. 61.

regularly requires hands-on physical assistance with the other ADLs for which he requested authorization.

Accordingly, the Division's decision is partially reversed and partially affirmed. Mr. M should receive PCS assistance for transfers based on a need for limited assistance twice per day. The Division correctly denied Mr. M's other requests for PCS authorization.

DATED: November 8, 2018.

Signed
Kathryn Swiderski
Administrative Law Judge

C. The undersigned, by delegation from the Commissioner of Health and Social Services and in accordance with AS 44.64.060(e)(4), rejects, modifies or amends one or more factual findings as follows, based on the specific evidence in the record described below:

I have listened to the recording of the full hearing and reviewed all submissions to the record. Based on the totality of the evidence in the record, I find that Mr. Lo more likely than not is functionally able to transfer without physical assistance. I therefore reject the Proposed Decision's factual finding that Mr. Lo requires limited assistance with the AOL of transfers, twice per day. I amend that finding and determine that physical assistance with this task is not required. This conclusion is supported by a preponderance of the evidence, including the medical evidence from Mr. Lo's physicians. The medical evidence does not indicate that Mr. Lo requires hands-on assistance to transfer.

The amended factual finding means Mr. Lo does not require physical assistance with any activities at issue in this case. Therefore, the Division correctly determined that his temporary PCA service authorization should not be extended. That determination is affirmed.

With the exception of the amended factual finding and resulting affirmation of the Division's determination noted above, the Proposed Decision is adopted.

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 November, 2018

By: *Signed*
Name: Deborah Erickson, MBA
Title: Project Coordinator
Agency: Office of the Commissioner, DHSS

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]