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

In the Matter of	)	
	)	
D Q	)	OAH No. 15-0790-MDX
	)	Agency No.

DECISION

I. Introduction

D Q appeals a decision by the Division of Health Care Services to place her into the Alaska Medicaid program's Care Management Program (CMP) for a twelve-month period beginning July 1, 2015, based on her usage of Medicaid services. This decision concludes that Ms. Q's utilization of medical services during the time period at issue in this appeal justifies her placement in the Care Management Program pursuant to 7 AAC 105.600.

II. Facts

A. Ms. Q's Medical Issues and Relevant Use of Medicaid Services

Ms. Q is 28 years old and lives in Anchorage, Alaska.[1] The usage review in this case ultimately focused on Ms. Q's usage of emergency care between March 1 and June 30, 2014. At that time, Ms. Q's documented medical history included dysmenorrhea, obesity and ovarian cysts.[2] During the period under review, Ms. Q was struggling with ongoing severe pelvic and abdominal pain.

On March 9, 2014, Ms. Q presented to the Emergency Department (ED) of Alaska Regional Hospital complaining of severe pelvic pain and abnormal bleeding which had been ongoing for six days.[3] The ED physician noted Ms. Q had recently had an inter-uterine device (IUD) placed, "and ran out of Percocet today."[4] Ms. Q reported to the ED nurse that the cramping was not unusual for her. To the contrary, "patient states that she always has cramping like this with her period."[5] Ms. Q was given narcotic pain medication and "encouraged to follow up with her [gynecologist] tomorrow."[6]

Two weeks later, on March 23, 2014, Ms. Q again presented to the Alaska Regional Emergency Department (ED) complaining that her pelvic cramping had been ongoing for two

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1 Ex. E, p. 1.
2 Ex. E, p. 1. Ms. Q testified that she has since been diagnosed with severe endometriosis, osteoarthritis in both hips, and a bulging disc in her lower back.
3 Ex. E, pp. 4, 7-11.
4 Ex. E, p. 8.
5 Ex. E, p. 10.
6 Ex. E, p. 8.

weeks.[7] She reported that her regular gynecologist was out of town and told her to follow up with Dr. B J, another local obstetrician, but that she had been unable to get an appointment with Dr. J for several months.[8] She reported that "she was told she should have the IUD checked to see if it is in place."[9] The Emergency Department checked the IUD as requested, prescribed narcotic pain medication, and told her to follow up with her primary care physician, Dr. R, as well as Dr. J.[10]

Ms. Q returned to the Alaska Regional Emergency Department on April 16, 2014, complaining that the pain which had started two months ago was still present.[11] She indicated she had seen her own gynecologist, Dr. I C, twice in the past few weeks including once several days earlier, and had been told she had right ovarian cysts, but did not believe those were the cause of her pain.[12] Ms. Q was noted to be "in no acute distress," and her workup was deemed "unremarkable."[13] The ED notes also indicate a "recent IUD removal" and, similarly to the March 9 visit, that she "ran out of pain meds yesterday."[14] During this visit, the ED physician consulted a prescribers' database and noted that Ms. Q had "had numerous [prescriptions] for narcotics filled (written by multiple providers.)"[15] Ms. Q was given narcotic pain medication, and instructed to follow up with Dr. C.[16]

On May 18, 2014, Ms. Q presented to the Alaska Regional Emergency Department because of a severe headache which had started the previous day.[17] She advised the treating physician that she "has similar headaches 2-3 times per week."[18] However, this one, unusually, had not resolved with Tylenol. She was diagnosed with a migraine, treated with narcotic pain medication, and told to follow up with her primary care physician.[19]

On June 21, 2014, Ms. Q went to the Emergency Department at Providence Alaska Medical Center (Providence) "for evaluation of menstrual bleeding and low center abdominal

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7 Ex. E, pp. 4, 12-16.
8 Ex. E, p. 12.
9 Ex. E, p. 12.
10 Ex. E, pp. 4, 12-13.
11 Ex. E, pp. 4, 17-23.
12 Ex. E, p. 17.
13 Ex. E, p. 21.
14 Ex. E, pp. 21-22.
15 Ex. E, p. 20.
16 Ex. E, pp. 4, 20.
17 Ex. E, pp. 4, 24-28.
18 Ex. E, pp. 4, 24.
19 Ex. E, pp. 25-26.

pain and cramping that began earlier today."[20] She indicated that she had a visit scheduled with Dr. C for June 30. Her examination revealed "really no blood except for scant old."[21] She was given narcotic pain medication, told to follow up with her primary care physician and gynecologist, and told to return to the ED if she experienced heavy bleeding.[22]

Ms. Q returned to the Providence Emergency Department just four days later, on June 25, 2014, again "for evaluation of abdominal pain and vaginal bleeding."[23] At this time, she reported having a visit scheduled with Dr. C the following day. She indicated she was bleeding only "a little bit," and was chiefly concerned about the pain, which had not improved despite taking narcotic pain medication. She was given pain medication in the ED as well as a prescription for a different narcotic to try for the pain, although she appears to have left the ED before she could take the prescription.[24]

B. The Division's Review of Ms. Q's Use of Medicaid Services

The Division of Health Care Services conducts periodic reviews of Medicaid recipients' use of medical services.[25] First, in a process known as a Phase I review, recipients' claims histories are reviewed and compared using specialized software to flag utilization rates that significantly are outside the norm for a recipient's peer group.[26] If a Phase I review finds one or more areas of significantly high usage rates – known as "exceptions" – a licensed health care provider then performs an individualized Phase II review to determine whether these exceptions occurred due to medical necessity.[27]

If the Phase II reviewer does not find medical justification for the exceptional use, the Division may place the recipient into the Care Management Program.[28] The Care Management Program assigns participants a single primary care provider and a single pharmacy to be responsible for oversight of the recipient's medical care. Other than in the case of a medical emergency, Medicaid will only reimburse CMP participants for care obtained from the primary provider or from specialists to whom a referral has been made. The program is intended to help recipients with continuity of care by ensuring that a single provider is taking a comprehensive

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20 Ex. E, p. 29.
21 Ex. E, p. 32.
22 Ex. E, pp. 32-33.
23 Ex. E, p. 36.
24 Ex. E, pp. 36, 39.
25 Testimony of N G.
26 Testimony of N G.
27 7 AAC 105.600(c); Testimony of N G; Testimony of K T.
28 AAC 105.600(d); Testimony of Diana McGee.

look at the patient's overall care, advocating for the patient, and communicating between various specialists.[29] The program offers coordinators who are available by phone to assist patients and providers with issues that may arise.[30]

In April 2015, the Division performed a Phase I review of Ms. Q's utilization of services during a four-month period of time.[31] The Phase I review of Ms. Q's usage of services between March 1, 2014 and June 30, 2014 identified exceptional usage in seven different areas when compared to her peer group of 19-29-year-old Medicaid recipients.[32] These were: (1) "number of group, clinic, facility;" (2) "number of rendering physicians;" (3) "number of ER hospital visits;" (4) "number of different OP hospitals," (5) "number of different DX-1 codes;" (6) "number of different prescribers all drugs;" and (7) "number of different drugs."[33]

During a Phase I Review, members are assigned exception points, and are ranked in comparison with other members of the study group. Out of the 10,922 individuals in her peer group, Ms. Q had the 65th highest number of exception points during the review period.[34]

The Division initiated a Phase II review of Ms. Q's medical usage due to her high number of exceptions. For that review, Licensed Practical Nurse K T reviewed all of Ms. Q's medical records for this period of time and analyzed those records for inappropriate use, with a particular focus on "concurrent care with other providers; closely adjoining dates of service with other providers; diagnoses and consistency of medical history provided; [and] prescription medication activity/compliance with recommended medical treatment."[35]

Ms. K's May 30, 2015 Medical Review Summary found that Ms. Q's level of usage in these areas "was at a level that was not medically necessary," giving rise to concerns about the following:

1. Inappropriate use of the Emergency Department for non-emergent conditions.
2. Closely adjoining dates of service with multiple providers.
3. Closely adjoining dates of service with multiple providers for the same/similar presenting complaint.
4. The need to establish continuity of care.[36]

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29 Testimony of Diana McGee.
30 Testimony of Diana McGee.
31 Ex. D; Testimony of N G.
32 Ex. D, pp. 4-5. The Phase I summary reports eight exceptions, but one – "Number of pharmacies" – was listed in error.
32 Ex. D, p. 6.
33 Ex., D, p. 1; pp. 4-5.
34 Ex. D, p. 4; Testimony of N G.
35 Ex. E, pp. 1, 3; Testimony of K T.
36 Ex. D, p. 6.

An addendum dated June 30, 2015 described in detail the concerns present in the records, particularly pertaining to inappropriate use of the Emergency Department for non-emergent conditions.[37] After describing the series of ED visits discussed above, Ms. K found that "a primary concern is [Ms. Q's] use of the Emergency Room for chief complaints that are best addressed in the primary care setting."[38] Ms. K observed that, during the four-month review period Ms. Q had been seen by fourteen different providers at nine separate facilities.[39] Ms. K opined that this pattern of use created risks to patient care, and suggested that centralized care would be beneficial in addressing this problem. Ms. K recommended Ms. Q for placement in the Care Management Program, concluding the program would benefit Ms. Q by "directly increas[ing] the likelihood of establishing, encouraging and maintaining appropriate access to care."[40]

C. Relevant Procedural History

Ms. Q requested a hearing to challenge the Division's decision placing her in the Care Management Program. The telephonic hearing was held on September 23, 2015. Ms. Q represented herself and testified on her own behalf. Angela Ybarra represented the Division. N G, K T, and Diana McGee testified on behalf of the Division.

During the hearing, Ms. Q testified that she had been diagnosed with endometriosis during the period covered by the Phase II review. Ms. Q initially indicated a desire to present testimony from a physical therapist and two physicians she said had knowledge of her condition. However, she had not notified them of the hearing and did not know if they would be available to testify without advance notice. After discussion, it was determined that Ms. Q could present this information through affidavits after the hearing.

The record was held open through October 7, 2015 for Ms. Q to submit any additional evidence, and for the Division to submit any evidence or argument related to the medical conditions about which Ms. Q testified. However, neither party submitted any additional evidence or argument. The record closed, and this decision follows.

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[37] Ex. E, pp. 3-6.

[38] Ex. E, p. 5. Ms. T testified that Ms. Q had had numerous other medical appointments – including some ED visits – during the review period, but that the Phase II addendum summarized only those visits that Ms. T found to be inappropriate. She did not include in her summary any medical visits – including some to the Emergency Department – which she deemed medically appropriate under the regulations.

[39] Ex. E, p. 3. Elsewhere in the addendum, Ms. T referenced "forty-eight" different providers. Ex. E, p. 5. This number is not consistent with the other evidence in the record, and is assumed to be a typographical error. *See* Ex. D, p. 4 (Report Item #2: 14 rendering physicians).

[40] Ex. E, p. 5.

III. Discussion

A. Legal Framework for Admission to CMP

Federal law allows states to restrict a Medicaid recipient's choice of provider if the agency administering the program finds that the recipient "has utilized [Medicaid] items and services at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the State."[41] Any restriction imposed under this provision must be "for a reasonable period of time," and must not impair the recipient's "reasonable access … to [Medicaid] services of adequate quality."[42]

Alaska's utilization guidelines, and the Care Management Program at issue in this case, are established through 7 AAC 105.600. That regulation allows the Department to restrict a recipient's choice of medical providers if it finds "that a recipient has used Medicaid services at a frequency or amount that is not medically necessary[.]" In terms of frequency of use, this restriction is allowed where:

> [T]he recipient, during a period of not less than three consecutive months, uses a medical item or service with a frequency that exceeds two standard deviations from the arithmetic mean of the frequency of use of the medical item or service by recipients of medical assistance programs administered by the department who have used the medical item or service as shown in the department's most recent statistical analysis of usage of that medical item or service.[43]

B. The Phase I and II Reviews Were Consistent with the Regulations

As described above, the Phase I review compares the recipient to his or her "peer group norm" for various indicators – such as the number of physicians seen, the number of office visits, the number of emergency room visits, or the total number of different medications prescribed – during the review period.[44] When a recipient's use of services as measured by a particular indicator significantly exceeds the norm, the recipient is deemed to have an "exception" – that is, an over-utilization of services – as to that indicator. Specifically, an exception occurs when the recipient's usage for a particular indicator exceeds the sum of the peer group's average *plus* twice the standard deviation for that indicator.[45]

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41 42 U.S.C. 1396n(a)(2)(A).
42 42 U.S.C. 1396n(a)(2)(B).
43 7 AAC 105.600(b)(3).
44 *See* Ex. D, pp. 4-5.
45 7 AAC 105.600(b)(3). The example provided in the Division's position statement is that, if the peer group average for a service was 4.51, and the standard deviation is 2.12, an exception would occur if the recipient's value exceeds 2 x 2.12 (the standard deviation) plus 4.51 (the average usage). Because (2 x 2.12) + 4.51 = 8.76, the recipient would have to be greater than 8.76 to receive an exception. Ex. A, p. 2.

Here, the Phase I review using these criteria found that Ms. Q's usage during the four-month review period satisfied the exceptional use criteria as to seven separate areas. These findings triggered a Phase II review under 7 AAC 105.600(c). That process requires a qualified health care professional to "conduct an individualized clinical review of the recipient's medical and billing history to determine how the recipient has used the disputed medical item or service and whether that usage was medically necessary" under the totality of the circumstances.[46]

Ms. K, a qualified medical professional, conducted the Phase II review in this case. Ms. K reviewed all of Ms. Q's medical records from the review period. Ms. K then excluded from her analysis of overuse all usage that she found medically necessary, including some emergency room visits. Even with those excluded, however, Ms. K identified serious concerns about Ms. Q's use of the emergency room as a substitute for consistent primary care. Ms. K's Phase II addendum is detailed and consistent with the records to which she refers in the review.

C. Ms. Q's Exceptional Number of ER Hospital Visits During the Review Period Justifies Placement in the Care Management Program

In her written documentation and in her testimony, Ms. K explained that the seven emergency room visits described above did not satisfy the criteria for "emergency" care under the Medicaid program regulations. Those regulations define "emergency" care to mean:

> Outpatient hospital services and physician services provided to a recipient in response to the sudden and unexpected onset of an illness or accidental injury that requires immediate medical attention to safeguard the recipient's life.[47]

The Emergency Department visits at issue here were not for "sudden and unexpected" conditions or symptoms – rather, almost all were for regularly-occurring painful symptoms. These symptoms, while undoubtedly distressing, were not "emergencies" under the regulations.[48] Additionally, on multiple occasions, Ms. Q returned to the Emergency Department repeatedly over a period of days or weeks for the same ongoing symptoms. So, rather than a condition for

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[46] 7 AAC 105.600(c) ("The reviewer shall consider (1) the recipient's age; (2) the recipient's diagnosis; (3) complications of the recipient's medical conditions; (4) the recipient's chronic illnesses; (5) the number of different physicians and hospitals used by the recipient; and (6) the type of medical care received by the recipient.")

[47] 7 AAC 105.610(E)(2). "Immediate medical attention" is further defined to mean "medical care that the department determines cannot be delayed for 24 hours or more after the onset of the illness or occurrence of the accidental injury." 7 AAC 105.610(E)(2).

[48] Testimony of K T. The exception to this finding is the May 18 visit for a severe headache accompanied by blurred vision, photophobia, nausea, and vomiting. Although Ms. Q had had many similar headaches, the others had resolved with Tylenol, while this one had not. She rated her pain at ten out of ten, was ultimately diagnosed with a migraine, and was discharged with a two out of ten pain rating after treatment. Ex. E, pp. 24-27. The Division did not establish that this visit was an inappropriate use of the Emergency Department.

which medical care must be received within 24 hours, Ms. Q was seeking care from the Emergency Department for ongoing chronic conditions.[49]

At the April 16 visit, for example, Ms. Q was described as seeking help at the Emergency Department for the same pain she had been experiencing for the past two months. It was also noted that she had seen her own gynecologist for this problem several weeks earlier, and then again "within the last few days."[50] In addition to being outside the scope of "emergency" under the regulations, Ms. K rightly found these visits illustrative of "the need to create an ongoing relationship with one provider to establish formal continuity of care to better meet" Ms. Q's medical needs.[51]

Continuity of care concerns are readily apparent from the records. At the March 23 visit, for example, Ms. Q indicated she had to come to the ED because of difficulty getting in to see a gynecologist. The emergency physician felt Ms. Q "certainly needs closer [gynecological] follow[-]up than 2 months from now," and noted that he had "encouraged her to involve her [primary medical doctor] in this process as well."[52] This description of events underscores the continuity of care concerns noted throughout Ms. K's review and testimony, and supports assignment to the Care Management Program.

Ms. Q did not contest the Division's evidence as far as the frequency or volume of her use of services. Rather, she argues that the visits were actually medically necessary. But Ms. Q's testimony on this issue was largely focused on a factual claim not supported by the record. Specifically, Ms. Q testified that, during the time period in question, she was diagnosed with "severe endometriosis," and that she had surgery for this condition in April 2014. The emergency visits and her use of pain medication, she argued, must be viewed in the context of that condition.

Ms. Q testified credibly that she has suffered from significant pain and has struggled to identify and manage her condition. The medical records certainly substantiate ongoing health concerns and ongoing problems with pain management. As Ms. K noted, however, the Emergency Department is not an appropriate source of care for chronic concerns, and repeated use of the Emergency Department for care that should be provided by a primary provider and/or

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49 *See* Testimony of K T.
50 Ex. E, p.17.
51 Ex. E, p. 4; Testimony of K T.
52 Ex. E, p. 13.

a focused specialist creates a real risk that the patient will not receive appropriate care for her condition.

Regarding the specific issue of endometriosis, Ms. Q testified credibly that she has had a diagnostic laparoscopy for severe endometriosis, describing both the process and the associated diagnosis in some detail. But the medical records in the record in this case do not support Ms. Q's testimony that the laparoscopy and associated endometriosis diagnosis occurred *during the review period*. For the reasons that follow, it is more likely than not that Ms. Q was mistaken about the time frames during her testimony, and that the diagnosis and surgery occurred after the review period.

First, records from each of the seven visits in the review include a section listing prior surgeries. Not one of those records mentions a surgery during – or even close to – the review period, and not one mentions endometriosis.[53] Further, the records' discussion of Ms. Q's ongoing attempts to obtain a diagnosis for her symptoms is inconsistent with her testimony about an endometriosis surgery during this time frame. At the April 16, 2014 visit, Ms. Q indicated she had seen Dr. C within the past few days, and complained to the Emergency Department that her providers had done nothing other than the pelvic ultrasound that identified the ovarian cysts.[54] While Ms. Q testified that she had surgery for endometriosis during the review period, she is specifically quoted in the April 16 medical record as complaining that "I haven't had anything done."[55] And Ms. K, who reviewed all of Ms. Q's medical records from the review period, made no mention of either endometriosis or surgery in her review.

Because of the uncertainty created by Ms. Q's testimony on this topic, the record in this matter was left open for two weeks after the hearing so that Ms. Q could submit supporting testimony or documentation. However, Ms. Q submitted nothing.[56] The absence of documentation precludes a determination that the Emergency Department visits described herein were related to a recent surgery, or a determination that these visits – and the resultant pattern of

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[53] Ex. E, p. 10 (March 9, 2014); p. 12 (March 23, 2014); p. 18 (April 16, 2014); p. 24 (May 18, 2014); p. 29 (June 21, 2014); p. 37 (June 25, 2014).

[54] Ex. E, p. 17.

[55] Ms. Q testified that she thought the surgery occurred sometime after her April 16 Emergency Department visit, but she could not say when. However, there is also no mention of such a surgery during the May or June Emergency Department records included in the review.

[56] Unfortunately, despite the Administrative Law Judge's invitation to clarify the record by submitting more comprehensive medical records or Medicaid documentation for the review period, the Division also submitted no additional information or documentation to shed light on this issue.

excessive use of services – were an anomaly related to a then-undiagnosed but now identified and resolved health problem.

Given the complete absence of any medical evidence on these issues, Ms. Q's testimony is insufficient to overcome Ms. K's conclusions that the exceptional use found in the Phase I review use was not medically necessary as defined in the regulations. For the majority of emergency room visits at issue here, the problem giving rise to the visit was part of an ongoing chronic condition for which Ms. Q is, or should be, receiving care and management from a primary provider. Likewise, in most instances, Ms. Q's symptoms had been present more than 24 hours – indeed, the symptoms had often lasted for weeks or longer. Accordingly, pursuant to 7 AAC 105.600, Ms. Q's exceptional Emergency Department usage for non-emergency conditions during that review period justifies her placement in the CMP.

D. Ms. Q's Exceptional Number of Different Prescribers During the Review Period Justifies Placement in the Care Management Program

CMP placement is also justified for this period based on the exception for number of different prescribers. In her review and her testimony, Ms. K raised concerns about Ms. Q's receipt of pain medication from multiple physicians across two different emergency departments, and about the lack of documentation "to indicate if providers were aware of their colleagues' prescription activity" with Ms. Q.[57] This issue implicates a separate appropriate justification for CMP placement in this case.

On each of the Emergency Department visits in question, Ms. Q received narcotic pain medication while at the emergency room; on all but one, she was given a prescription for additional narcotics.[58] On two of the seven visits, Ms. Q is quoted as saying that she had run out of narcotics on, or the day before, the emergency visit.[59] And on the April 16 visit, the ED physician noted that the prescription database showed Ms. Q having had "numerous prescriptions for narcotics filled (written by multiple providers)."[60] Ms. K noted that this history presents "risks to the patient associated with multiple providers who may or may not receive a complete medical history prior to prescribing."[61]

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57 Ex. E, p. 5.

58 Ex. E, p. 8 (March 9, 2014); pp. 13-14 (March 23, 2014); p. 20 (April 16, 2014); pp. 25, 27 (May 18, 2014); pp. 29, 33 (June 21, 2014); p. 39 (June 25, 2014).

59 Ex. E, p. 7 (March 9, 2014); p. 21 (April 16, 2014).

60 Ex. E, p. 20.

61 Ex. E, p. 5.

An intended benefit of the Care Management Program is to prevent "dangerous medication interactions and inconsistent treatment plans."[62] The prescribing history documented herein supports CMP placement on this basis.[63]

E. Ms. Q's Ongoing Medical Treatment Needs Are Not a Barrier to Participation in the CMP

It is apparent from the records that Ms. Q would have benefited from care management assistance and patient advocacy – the type of assistance available to patients enrolled in the CMP – during the review period.[64] Ms. Q has expressed concerns about maintaining current relationships with specialists from whom she has been receiving care for orthopedic and gynecological issues, and appears genuinely concerned that placement in the Care Management Program will become an insurmountable barrier to necessary health care.

But the Division has a continuing duty under 7 AAC 105.600 to ensure that a recipient has reasonable access to Medicaid services of adequate quality throughout any period of placement in the Care Management Program. And, given that the Care Management Program expressly allows referrals to specialists, appropriate specialty care – including existing relationships – should not be unduly impeded by the Division's decision. This seems particularly so given Ms. Q's testimony that during several visits to No Name Agency in recent months, providers there have encouraged her to keep seeing her gynecologist and her pain management specialist. There is no evidence in the record that Ms. Q's relationships with current treating specialists will be impeded by her assignment to the Care Management Program.

IV. Conclusion

The Division is justified in placing Ms. Q in the Medicaid Care Management Program pursuant to 7 AAC 105.600 based on her over-utilization of medical services during the review

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62 Testimony of Diana McGee.

63 Ms. Q testified that, after the review period, she began seeing a pain management specialist and receiving pain medication only through that specialist. While this is a positive development, an intervening change in care does not prohibit the Division from relying on the review period for CMP placement decisions. Moreover, Ms. Q also testified that her pain management specialist has recently left Alaska. Thus, she has a renewed need in this area which should be able to be met through the centralized care management process.

64 *See* Testimony of Diana McGee (primary care provider assigned under the Care Management Program acts as advocate for patient to ensure continuity of care and communication between providers).

period. Accordingly, the Division's May 30, 2015 decision to place Ms. Q in the Care Management Program is AFFIRMED.

DATED October 12, 2015.

By: *Signed*
Cheryl Mandala
Administrative Law Judge

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 27th day of October, 2015.

By: *Signed*
Name: Andrew M. Lebo
Title: Administrative Law Judge/OAH

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