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

In the Matter of	)	
	)	OAH No. 13-0063-MDS
M D	)	HCS Case No.
	)	Medicaid ID No.

DECISION

I. Introduction

The issue in this case is whether M D continues to require intermediate level nursing care. The Division of Public Assistance (Division) conducted an annual review, and on January 4, 2013 determined that M no longer requires either skilled or intermediate level nursing care.[1] This decision concludes that M continues to require intermediate level nursing care as defined by 7 AAC 140.510 because the shots that he receives are needed to treat a stable condition and are ordered by and under the direction of a physician. As a result, M remains eligible for TEFRA Medicaid (TEFRA).[2] The Division's determination terminating M's TEFRA eligibility is therefore reversed.

II. Facts

A. Mr. D's Medical Condition and Care Needs

M D is a 3-year-old boy who lives at home with his parents, K and N D.[3] M's primary diagnosis is a condition known as Familial Cold Autoinflammatory Syndrome (FCAS), which is a form of Cryopyrin Associated Periodic Syndrome (CAPS).[4] It is an extremely rare condition which affects fewer than one in one million people. FCAS is brought on by exposure to the cold and results in inflammation of the blood vessels. Symptoms begin about 30 minutes after exposure to cold.[5] The immediate symptoms are aches, pains, nausea, and rashes.[6] Without aggressive therapy, long term organ damage can occur resulting in cardiovascular disease, vision impairment, and hearing loss.

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[1] Exhibit D.

[2] It should be noted at the outset that this finding of continued TEFRA eligibility is not a "magic key" automatically entitling M to a panoply of daily benefits, as might be the situation in a case involving the Medicaid Home and Community-Based Waiver Services Program. All utilization control provisions applicable to "regular" Medicaid continue to apply, including requirements for prior authorization and medical necessity.

[3] Ex. E1.

[4] Exs. E2, F. All facts found in the remainder of this paragraph are from Ex. F unless otherwise stated.

[5] N D's hearing testimony.

[6] Hearing testimony of Benjamin Westley, M.D. Dr. Westley is board certified in internal medicine, pediatrics, and adult infectious diseases.

M's symptoms began in August 2011 when he was about 14 months old.[7] From approximately August 2011 until October 2012 M required daily injections of a drug known as Anakinra to control the inflammation caused by his FCAS.[8] M's mom was able to administer the Anikinra injections at home after receiving two days of training from M's physician's office.

While taking Anikinra, M was still having one to three "breakthroughs," or symptom flares, each month.[9] In addition, Anikinra is believed to cause certain cancers. For these reasons, by October 2012 the Ds, and M's doctor, Benjamin Westley, decided to try a newer and more expensive drug called Ilaris (generic name Canakinumab).[10] Now, M only needs a Canakinumab injection once every eight weeks.[11]

The Canakinumab injections are administered at Dr. Westley's office.[12] The syringe must be prepared by Dr. Westley's nursing staff. Once the syringe is ready, the subcutaneous injection is then given by M's mom under the direct supervision of the nursing staff. The shots are administered in this way because they are somewhat traumatic for M, and he is more comfortable when his mother gives him the shot under nursing supervision, rather than when a nurse gives the shot directly.

M's parents must monitor the injection site for reactions after each shot.[13] Possible reactions may consist of vomiting, swelling, rashes, achy joints, and limping.[14]

In addition to monitoring the injection site, M's parents must monitor M himself very closely at all times to make sure he does not get cold.[15] They have to make sure he is always warmly dressed, use space heaters, and turn up the heat in their house to make sure he doesn't get cold. Also, because the drugs M takes for his FCAS compromise his immune system, M frequently gets head colds, ear infections, and the flu. When M gets these illnesses, as he often does, it further increases the amount of care he requires.

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[7] All facts this paragraph are based on N D's hearing testimony unless otherwise stated.
[8] Exs. E2, F, and N D hearing testimony.
[9] All facts this paragraph are based on N D's hearing testimony unless otherwise stated.
[10] Ex. I-21; N D and Dr. Benjamin Westley hearing testimony.
[11] Ex. F; N D hearing testimony; Dr. Benjamin Westley hearing testimony.
[12] All facts found in this paragraph are based on Dr. Benjamin Westley's hearing testimony.
[13] Ex. F; Dr. Benjamin Westley hearing testimony.
[14] Ex. F.
[15] All facts this paragraph are based on Ex. E12 and N D's hearing testimony.

In general, M's FCAS has been very well controlled by the Canakinumab injections.[16] Dr. Westley believes M's symptoms will be in remission if he remains on Canakinumab therapy. He believes that treatment needs to be life-long in order to combat FCAS effectively.

The Canakinumab injections that M receives cost $25,000 per shot.[17] Both his parents have private health insurance through their employers. However, after the primary and secondary insurers have paid their portions of the cost, the Ds must still personally pay between $1,000 and $2,000 per shot. This case is about that portion of the cost of the shots which is not covered by the Ds' private insurance. If M continues to require an intermediate level of care, he remains eligible for TEFRA and Medicaid will pay the uninsured portion. Otherwise, the Ds must pay the uninsured portion.

B. Level of Care Determination

The portion of Alaska's TEFRA program involving Level of Care (LOC) determinations (the only aspect of TEFRA eligibility at issue in this case) is performed by the Division of Senior and Disabilities Services (DSDS).[18] DSDS has in turn contracted with Qualis Health, a company headquartered in Seattle, Washington, to perform LOC assessments in TEFRA (and other) cases.[19]

Eric Wall, M.D. is a board certified physician who has been Qualis's Senior Medical Director for over five years.[20] He also has a limited clinical practice. His primary role at Qualis is to supervise 12 part-time physicians in performing utilization reviews and quality of care reviews. He was the second Qualis physician to review M's case. He reviewed Mr. D's medical records and is familiar with Mr. D's diagnosis and treatment history.

Dr. Wall testified that when M's LOC was last approved, the acuity of his symptoms and the frequency of his injections were greater, and there was also a greater need for monitoring.[21] More recently, however, M's injection schedule has decreased from daily to once every two months, his flare-ups have decreased, and his condition has stabilized. Accordingly, Dr. Wall believes that M no longer requires nursing services. Based on this, he believes that M no longer meets LOC. On cross-examination Dr. Wall stated that the decrease

[16] All facts this paragraph are based on Dr. Westley's hearing testimony unless otherwise stated.
[17] All facts found in this paragraph are based on N D's hearing testimony unless otherwise stated.
[18] *See* Division of Public Assistance *Aged, Disabled, and Long Term Care Medicaid Eligibility Manual* at Section 533(C)(5).
[19] *See* Division of Public Assistance *Aged, Disabled, and Long Term Care Medicaid Eligibility Manual* at Section 533(E)(3).
[20] All facts found in this paragraph are based on Dr. Wall's hearing testimony unless otherwise stated.
[21] All facts found in this paragraph are based on Dr. Wall's hearing testimony at 1:26 - 1:45.

in the frequency of M's injections is not the sole reason, but is a critical reason, for his belief that M no longer meets LOC.

C. Relevant Procedural History

M has participated in the TEFRA program since January 2012 or before.[22] At some time between October 2012 and January 2013 M's Care Coordinator submitted a TEFRA Plan of Care (POC) renewal application to the Division; the proposed POC was to run from January 2013 to January 2014.[23] Qualis performed its LOC review, and on January 4, 2013 the Division notified M's parents that his participation in TEFRA would end on November 30, 2013.[24] The notice letter stated in relevant part:[25]

> [Qualis] received documentation from your care coordinator to make a [LOC] decision . . . pursuant to State regulations 7 AAC 140.515, 7 AAC 160.990(79), 7 AAC 140.510, 7 AAC 160.990(38, 39), and Federal regulation 42 CFR 409.33. Licensed nurses at [Qualis] determined that M does not meet the [LOC] requirements for TEFRA Medicaid . . . . Upon physician review [Qualis] stated the following regarding M's current health status:
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>> Although your son will continue to require interventions and special attention for his condition, his current skilled nursing needs at home do not meet criteria for TEFRA in either the skilled or intermediate levels of care . . . .
>
> Based on the above, M no longer meets the level of care criteria for TEFRA Medicaid and his level of care approval is terminated . . . .

M's parents requested a hearing on January 11, 2013 to contest the Division's denial of his TEFRA LOC renewal application.[26]

On May 30, 2013 the Division issued a supplemental TEFRA termination notice.[27] The supplemental notice repeated the above verbiage and added the following:

> The basis for the decision that M no longer meets TEFRA coverage is amended to read:
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> Based upon the documentation submitted . . . in support of continuing TEFRA coverage of your son, he no longer requires daily nursing skilled services. Specifically, the records indicate [that] at some point in the past year M's daily injections were no longer needed and he is currently receiving an injection once

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22 Ex. E1.
23 Exhibit E. The exact date of the submittal of Mr. D's TEFRA renewal application is not at issue.
24 Ex. D.
25 Ex. D1. Because the adequacy of the notice is at issue, the notice is quoted at some length.
26 Exhibit C.
27 Ex. F.

every other month to manage his condition. Thus [a skilled nursing level of care] is no longer established.

The records further do not support TEFRA eligibility under the Intermediate Nursing Facility Level of Care because the daily attention and monitoring of his needs, would be required for any child his age and is not the type of attention or intervention that would be provided in an intermediate nursing facility as set forth in 7 AAC 140.510(b) or (c).

M's hearing was held on July 1, 2013. He was represented by Mark Regan of the Disability Law Center of Alaska. His parents attended the hearing, and N D testified. Dr. Westley participated by phone and testified on M's behalf. The Division was represented by Assistant Attorney General Megyn Greider and legal intern Alexis Cole. Cheri Herman attended the hearing and testified for the Division. Division employee Jeremy McFarland, and Qualis employees Eric Wall, M.D., Janet Cordell, R.N., and Grace Ingram, R.N. testified by phone for the Division.

The hearing was concluded on July 1, 2013. The record was left open for post-hearing briefing through July 29, 2013, at which time the record closed.

III. Discussion

A. TEFRA Medicaid Overview

TEFRA Medicaid (also known as "Katie Beckett Medicaid" based on the name of its first recipient) permits the states to ignore parental income and resources when determining Medicaid eligibility for certain disabled children. States are allowed, at their option, to provide benefits to children 18 years of age or less who qualify as disabled individuals under §1614 of the Social Security Act and who live at home rather than in an institution. Qualification is not based on medical diagnosis but rather on the level of care the child requires.[28]

B. Relevant Alaska Medicaid Statutes and Regulations

The Alaska statute authorizing the Division to provide TEFRA Medicaid is AS 47.07.020(b)(11). The statute contains four substantive criteria and a cost criterion. First, the recipient must be 18 or younger. Second, the recipient must qualify as a disabled individual under 42 U.S.C. 1382c(a). Third, the recipient must require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded. Fourth, it must be appropriate to provide care for the recipient outside of an institution. Finally, the

[28] The statutory provisions establishing TEFRA are in § 1902(e) of the Social Security Act (42 U.S.C. § 1396a(e)(3)). The federal regulation implementing TEFRA is 42 CFR § 435.225.

estimated cost to care for the recipient outside an institution must not be greater than the estimated cost to care for the recipient inside an appropriate institution. Only the third criterion (level of care) is at issue in this case.

Alaska's regulation implementing TEFRA is 7 AAC 100.424, titled "Disabled child living at home." With regard to level of care requirements, it states in relevant part:

> (a) A child with a disability who does not qualify for SSI because of parental income or resources is eligible for Medicaid under 7 AAC 100.002(d) (5) and this section if . . . . (5) the department has determined that the child needs a level of care offered in (A) an acute care hospital or long-term care, as determined under 7 AAC 140.505 [7 AAC 140.505 defines these terms as including skilled and intermediate level nursing care] . . . .

The lowest level of care that M can require while still qualifying for TEFRA is intermediate level nursing care. Alaska Medicaid regulation 7 AAC 140.510 defines intermediate level nursing services 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
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> > (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.
>
> (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, or care for a recipient nearing recovery and discharge whose condition is relatively stable but who continues to require professional medical or nursing supervision.

Note that 7 AAC 140.510 contains no requirement as to the frequency with which qualifying nursing services must be provided.

C. Applicable Burden of Proof and Standard of Review

Because the Division is the party seeking to change the status quo by terminating M's previously existing TEFRA benefits, the Division bears the burden of proof in this case.[29]

The standard of review in a Medicaid "Fair Hearing" proceeding, as to both the law and the facts, is *de novo* review.[30] The substantial evidence test is the standard of review that would be

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[29] 42 CFR § 435.930, 7 AAC 49.135.

[30] *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 Parker*, 969 A.2d 322 (N.H. 2009); *Murphy v. Curtis*, 930 N.E.2d 1228 (Ind. App. 2010).

applied to factual determinations only *after* a final decision is made by the agency and an appeal is made to the Superior Court. Likewise, the reasonable basis test is the standard of review for questions of law involving agency expertise only *after* a final decision is made by the agency and the case is appealed to the Superior Court.[31]

In this case, evidence was presented at hearing that was not available to the Division's reviewers. The administrative law judge and/or the Commissioner may independently weigh the evidence and reach a different conclusion than the Division staff, even if the original decision is factually supported and has a reasonable basis in law. The Commissioner, as chief executive of the department, is not required to give deference to factual determinations or legal interpretations of his staff or the staff's contractors.

D. The Notice Issue

The Division issued two termination notices in this case. The original notice was sent on January 4, 2013; the second, a supplemental notice, was sent on May 30, 2013.[32] The text of these notice is set forth at length in Section II(B), above. M asserts that these notices provided inadequate notice of the Division's reasons for terminating his TEFRA benefits.[33]

There are three regulations governing the sufficiency of notice in an Alaska Medicaid Fair Hearing case. First, federal regulation 42 CFR § 431.210(a) requires that notices issued in the administration of the Medicaid program which involve the suspension, reduction, or termination of benefits provide (1) a statement of what action the department intends to take; (2) the reasons for the action; (3) the specific regulation that supports the action; (4) an explanation of the individual's right to request a hearing; and (5) an explanation of the circumstances under which benefits will be continued if a hearing is requested. Examination of the two notices indicates that each contains the information required by 42 CFR 431.210(a).

Second, federal regulation 42 CFR § 431.206 requires that notices issued in the administration of the federal Medicaid program, which involve the suspension, reduction, or termination of benefits, provide (1) notice of the applicant or recipient's right to a hearing; (2) notice of the method by which the applicant or recipient may obtain a hearing; and (3) notice that the applicant or recipient may represent himself or be represented by legal counsel, a relative, a friend, or other spokesman. Examination of the two notices indicates that, while each contains the first two types of information, neither notice informs the recipient that he or

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31 *See Simpson v. State, Commercial Fisheries Entry Commission*, 101 P.3d 605, 609 (Alaska 2004).
32 Exs. D, G.
33 M D's post-hearing brief at p. 7, note 1.

she "may represent himself or use legal counsel, a relative, a friend, or other spokesman." Thus, although M in fact exercised his right to counsel, the Division's notices are technically inadequate because they do not contain all the information required by 42 CFR § 431.206.

Alaska's "Fair Hearings" notice regulation, 7 AAC 49.070, was amended effective April 4, 2013. Accordingly, the sufficiency of the Division's first notice was governed by the old regulation, while the sufficiency of the second notice is governed by the new regulation. Both the old and new versions of the regulations require (among other things) that the Division advise the recipient by whom he or she may be represented or assisted. Accordingly, each of the Division's notices is also technically inadequate under 7 AAC 49.070.

Normally, in a benefit termination case, the Division would be required to issue a new, fully-compliant notice before terminating benefits.[34] In this case, based on this proposed decision's disposition of the case on the merits, the inadequate notice issue is moot.[35]

E. M Continues to Require Intermediate Care as Defined by Alaska Medicaid Regulation 7 AAC 140.510

M remains eligible for TEFRA if he requires intermediate level nursing services. The Division's notices assert that M no longer requires intermediate level nursing services for two reasons.

First, the Division asserts that "the daily attention and monitoring of [M's] needs would be required for any child his age and is not the type of attention or intervention that would be provided in an intermediate nursing facility as set forth in 7 AAC 140.510(b) or (c)."[36] The testimony of N D and Dr. Westley establishes that M needs full-time (or nearly full-time) supervision in order to ensure his safety, and the Division's assertion that this level of monitoring would be required for any child his age is clearly incorrect. However, it is likewise clear that the in-home supervision required by M, while constant or almost constant, does not require professional medical or nursing oversight as required by 7 AAC 140.510(b). Accordingly, the high level of in-home supervision and care provided for M, while

[34] *See Allen v. State*, 203 P.3d 1155 (Alaska 2009).

[35] Under prior law, the notice deficiency would arguably have been cured since M did in fact avail himself of his right to counsel. However, in *Allen v. State,* 203 P.3d 1155 (Alaska 2009), the Alaska Supreme Court indicated that notice deficiencies in the public assistance context can no longer be "cured" simply by lack of prejudice, and can only be cured by issuance of a new, legally sufficient notice. Accordingly, if this proposed decision is not adopted as to its determination of the merits of the case (*i.e.* the level of care issue), it will be necessary for the Division to issue a new, legally adequate notice.

[36] Ex. G2.

commendable, does not qualify him to receive TEFRA. The injections are the sole basis on which he can qualify.

With regard to the injections, the Division argues that, because "M's daily injections [are] no longer needed and he is currently receiving an injection once every other month," he no longer requires an intermediate level of care.[37] In other words, the Division is asserting that while receiving injections *every day* may constitute an intermediate LOC, receiving injections once every other month does not.[38]

Before addressing this precise issue, it is helpful to review closely related matters that are not at issue. First, there is no factual dispute that the frequency of M's injections has decreased from once per day to once every two months. Second, there is no dispute that, although the *frequency* of M's injections has markedly decreased, his current injections are administered *under the direction of a physician*.[39]

Qualis employees Janet Cordell, R.N., Grace Ingram, R.N., and Eric Wall, M.D. all testified that, in their opinion, the need to receive an injection once every two months does not constitute a need for intermediate level nursing care. However, because intermediate level nursing care is defined by regulation, this is a legal issue rather than a medical issue. Careful scrutiny of the definition of intermediate care contained in Alaska Medicaid regulation 7 AAC 140.510(a) does not support the Division's assertion that an infrequent need for nursing care is the same as no need for nursing care. First, M's injections are "needed to treat a stable condition" in satisfaction of 7 AAC 140.510(a)(1). Second, M's injections are "ordered by and under the direction of a physician" in satisfaction of 7 AAC 140.510(a)(2). Finally, M's injections are "provided to a recipient who does not require the level of care provided by a skilled nursing facility" in satisfaction of 7 AAC 140.510(a)(3). Based on the regulation, this is all that is required to establish a need for intermediate-level nursing care. Under the regulation, it is the *quality* of the care (*i.e.* nursing or non-nursing), rather than the *frequency* of the care, that is determinative.[40]

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[37] Ex. G2.

[38] *See* the Division's post-hearing brief dated July 29, 2013 at p. 5 ("[M] receives injections only once every seven weeks, a frequency that all three of the medical experts from Qualis testified does not rise to skilled or intermediate level of care").

[39] Dr. Benjamin Westley's testimony in this regard was not disputed by the Division at hearing. Moreover, even had the Division disputed this issue, M's benefits could not be terminated on this basis because the Division failed to raise the issue in its denial notices.

[40] As previously stated in footnote 1, above, this finding of continued TEFRA eligibility does not automatically entitle M to a panoply of daily benefits, as might be the situation in a case involving the Medicaid Home and

F. The Division's Manual for Prior Authorization of Long Term Care Services Cannot Add Additional Substantive Requirements to 7 AAC 140.510

Reference was made at hearing to the list of factors for making level of care determinations contained in the Medicaid Criteria for Nursing Home Placement section of the Division's *Manual for Prior Authorization of Long Term Care Services (Manual).*[41] Prior to February 2010 the *Manual* was incorporated into level of care determinations by regulation.[42] However, on February 1, 2010 the regulations which previously incorporated the *Manual* (7 AAC 43) were repealed and reenacted (with changes) at 7 AAC 130.200 - 7 AAC 130.319. During this amendment process, the provision which had incorporated the *Manual* into regulation by reference, was dropped.[43] Accordingly, the *Manual* level of care factors may still be considered in the nature of an agency manual (*i.e.,* used strictly as an internal guidance tool, providing policy and procedural guidelines to Division staff members).[44] However, a rule of general application used to determine people's rights must be adopted by regulation to be valid.[45] Since the *Manual* no longer is, it no longer carries the force and effect of law.[46]

Community-Based Waiver Services Program. All utilization control provisions applicable to "regular" Medicaid continue to apply, including requirements for prior authorization and medical necessity.

41 Ex. K. This publication lists the "Intermediate Level of Care" factors as: (1) whether a patient requires 24 hour observation and assessment by a registered nurse or licensed practical nurse; (2) whether a patient requires restorative services, which include encouraging, assisting or supervising the patient in self-care, transfers, ambulation, positioning and alignment, range or motion, and/or handrail use; (3) whether the patient requires a registered nurse to perform services; (4) whether the patient's use of drugs requires daily observation; (5) whether the patient require assistance with activities of daily living, including maintaining Foley catheters, ostomies, special diet supervision, or skin care with incontinent patients; (6) whether the patient has a colostomy-ileostomy; (7) whether the patient requires oxygen therapy; (8) whether the patient requires either radiation or chemotherapy; (9) whether the patient has skin conditions such as decubitus ulcers, minor skin tears, abrasions, or chronic skin conditions; (10) whether the patient is diabetic and needs daily supervision of diet or medications; and (11) whether the patient has behavioral problems such as wandering, verbal disruptions, combativeness, verbal or physical abusiveness, or inappropriate behavior.

42 *See* former 7 AAC 43.190 (repealed February 1, 2010, Register 193).

43 *See* 7 AAC 160.900 (titled "Requirements adopted by reference").

44 *See Brilz v. Astrue*, 2008 WL 2345118 (W.D. Wash. 2008); *Moore v. Apfel*, 216 F.3d 864, 868-69 (9th Cir. 2000).

45 Several Alaska Supreme Court decisions have found "standards of general application," requiring promulgation of a regulation, where an agency pronouncement imposes bright-line rules or detailed criteria on the public at large. *See Noey v. Department of Environmental Conservation*, 737 P.2d 796 (Alaska 1987) (bright-line "rule of thumb" of five acres for subdivision approval); *Gilbert v. State, Dep't of Fish & Game*, 803 P.2d 391 (Alaska 1990) (detailed policy adopting a set of fisheries management goals); *Kenai Peninsula Fisherman's Co-op Association v. State*, 628 P.2d 897 (Alaska 1981) ("comprehensive management policy" for fisheries).

46 *Id; see also U.S. v. Ford Motor Co*., 516 F.Supp.2d 770 (W.D. Tex. 2007). Further, where (as here) an agency interpretation of a regulation supplements, revises, or makes the regulation more specific, the interpretation is itself considered to be a regulation, and in order to be valid, it must be adopted pursuant to the Administrative Procedure Act. *Jerrel v. State, Dept. of Natural Resources*, 999 P.2d 138, 144 (Alaska 2000). Alaska's Administrative Procedure Act is codified at A.S. 44.62.010 - A.S.44.62.950. Significantly, the APA requires that state agencies publish public notice of, and allow public comment on, all proposed regulations prior to their adoption. *See* AS44.62.190 (requiring public

G. In Addition, the Division's Manual Was not Cited in the Division's Notices and Therefore Cannot Serve as Basis for the Division's Determination

The Department of Health and Social Services' "Fair Hearings" regulations apply to the Medicaid TEFRA Program.[47] While the "Fair Hearings" regulations were amended during the pendency of this case, both the old and new regulations require that notices of adverse action state the reasons for the proposed action, "*including the statute, regulation, or policy upon which that action is based*." [Emphasis added].[48] Neither the Division's January 4, 2013 or May 30, 2013 notices reference the *Manual* as a basis for the determination that M does not satisfy intermediate level of care requirements. Accordingly, under 7 AAC 49.070, the Division's *Manual* factors cannot be used as a basis for the Division's action in this case.

IV. Conclusion

Because the shots that M receives are needed to treat a stable condition and are ordered by and under the direction of a physician, he continues to require intermediate level nursing care as defined by 7 AAC 140.510. Accordingly, M remains eligible for TEFRA Medicaid to pay for the unreimbursed services associated with those shots. The Division's determination terminating M's TEFRA eligibility is therefore reversed.

Dated this 29th day of August, 2013.

Signed
Jay Durych
Administrative Law Judge

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notice of the proposed agency action); AS 44.62.200 (specifying the content of the public notice); AS 44.62.210 (requiring a public hearing); AS 44.62.215 (requiring the keeping of a record of all public comments received).

[47] *See* 7 AA 49.010(a).

[48] *See* 7 AAC 49.070.

Non-Adoption Options

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, and adopts the proposed decision as revised:

> Because evidence cited in the proposed decision was not included in the decision by the Division, the case is remanded to the Division so evidence submitted at hearing can be reviewed by medical experts in determining level of care for Mr. Crow.

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 23rd day of September, 2013.

By: *Signed*
Name: Ree Sailors
Title: Deputy Commissioner, DHSS

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