BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

IN THE MATTER OF:	)	
	)	
D. M.	)	OAH No. 08-0153-PER
	)	Agency No. 2007-0907

FINAL DECISION

I. Introduction

D. M., a retired Public Employees' Retirement System (PERS) member, appeals the denial of her request for reimbursement of a medical procedure, blepharoplasty, to remove excess skin above her eyes. This procedure was performed after the 2003 AlaskaCare Retiree Health Plan informed her that the procedure would not be covered.[1] The Plan denied the procedure because Ms. M.' field of vision was not reduced to the point where the Plan considers the procedure to be medically necessary. Ms. M. believes the procedure was medically necessary and thus covered because it was not sought to cure a field of vision deficit but rather the inability to keep her eyelids raised and her eyes open without extreme concentration.

A hearing was held on June 2, 2008, and oral final argument on July 25, 2008.[2] Ms. M. represented herself; Assistant Attorney General Kathleen Strasbaugh represented PERS.[3] The record developed at the hearing consisted of testimony from three witnesses,[4] in addition to the PERS agency record (AR) consisting of 290 pages and exhibits A – D. The AR and exhibits were admitted in bulk at the hearing.[5]

Ms. M., because she is requesting review of the PERS decision, has the burden of proof as to all factual matters in her appeal, namely whether her blepharoplasty procedure was medically necessary under the terms and conditions of the Plan.[6] This means that Ms. M. needs

[1] Ms. M. has not filed a formal "claim" for benefits but the PERS has treated her request as a claim and has afforded Ms. M. all the same procedures associated with a claim and a denial of a claim.
[2] Prior to the final argument, each party submitted their proposed findings of fact and conclusions of law.
[3] Ms. Strasbaugh was in Juneau and participated via video conference. Ms. M. appeared in person at the hearing.
[4] Testimony was received from Ms. M., PERS employee Sheri Gray and the medical director for the Plan Administrator, Premera Blue Cross Blue Shield of Alaska (Premera), Thomas Paulson M.D.
[5] PERS objected to two excerpts taken from Reader's Digest and U.S. News and World Report submitted by Ms. M. with her Level I appeal. AR at 41. The objection was overruled but would be considered as PERS' position on the amount of weight assigned to the excerpts.
[6] 2 AAC 64.290(e) ("Unless otherwise provided … the burden of proof and of going forward with evidence is on the party who requested the hearing …, and the standard of proof is preponderance of the evidence…."). To prove a fact by a preponderance of the evidence, Ms. M. must show that the fact more likely than not is true.

to put evidence in the record or point to evidence already in the record showing that more likely than not her procedure was medically necessary and therefore covered under the Plan. The Plan relies, in part, upon generally accepted medical practices and standards when determining whether a service is medically necessary. Ms. M. has not presented persuasive medical evidence to corroborate her belief that the blepharoplasty was medically necessary. Accordingly the Plan's denial of her request for coverage is affirmed.

II. Facts

A. The Insurance Plan Document

Prior to July 1, 1993, retiree medical insurance was provided under a policy procured by the Department of Administration from a third party vendor. After that date, the Department was authorized to self-insure.[7] Once the Department self-insured, there was no "insurance policy" provided by a third party and contract terms and conditions were contained in the Retiree Insurance Information Booklet. The terms and conditions of coverage applicable to this matter are found in the Alaska Care Retiree Insurance Information Booklet, May 2003 (the Plan).[8]

The Plan is administered by the Director of the Department of Retirement of Benefits. The Plan administrator contracts with a third party claims administrator to adjudicate claims submitted under the Plan. Premera Blue Cross and Blue Shield of Alaska is the current claims administrator.

As the claims administrator, Premera reviews claims and is responsible for ensuring that only those procedures and services covered under the Plan are paid. If Premera denies a claim and a member believes the claim should be covered, there are four levels of appeal. The Level I appeal is reviewed by a Premera physician. The Level II appeal is an appeal to a three member Premera panel. The Level III appeal is an appeal to the Plan Administrator. At this level, an independent review organization reviews the file and provides a recommendation to the Plan

[7] AS 39.30.090 (Statutory authority for procurement of group insurance.); AS 39.30.091(Statutory authority for self-insurance). Effective July 1, 2007, the Commissioner of Administration was authorized to prefund medical benefits by establishing an irrevocable Alaska retiree health care trust. AS 39.30.097(a).

[8] The Plan document may be obtained online through the Department of Retirement and Benefits web site http://www.state.ak.us/drb/ghlb/retiree/insuranceretired.shtml.

Administrator. If the member disagrees with the Plan Administrator's decision the member may initiate a Level IV appeal to the Office of Administrative Hearings.[9]

To be covered under the Plan, a claim must be for "medically necessary services and supplies…."[10] The Plan will not cover services furnished "mainly for the personal comfort or convenience of the person…."[11] "Charges for plastic, cosmetic, and reconstructive surgery … which improve, alter, or enhance appearance are not covered…." except in limited circumstances not present here.[12]

Premera has developed an internal guide, which they call a "Corporate Medical Policy," for determining whether a claim is medically necessary. Premera's guide is intended to be based upon generally accepted medical principals and supported by the prevailing actual practice of health care providers and peer reviewed medical literature.[13] It is designed to address 95% of the claims for a given procedure.[14] Premera's guide considers an upper lid blepharoplasty may be medically necessary when the visual field is limited to 20 degrees or less and corroborated by photographs.[15]

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[9] The AR categorizes the appeals as Level I, Level II, etc. The Plan does not refer to four levels of appeal. It refers to claims administrator appeals, plan administrator appeals, and board/review group appeals. Plan Document at 93-94. A member may appeal a decision of the plan administrator to the Office of Administrative Hearings. AS 39.35.006.

[10] Plan Document at 17 (May 2003 Retiree Insurance Information Booklet).

[11] Plan Document at 18 – 19.

[12] The Plan will cover plastic, cosmetic or reconstructive surgery if it is to improve the function of a body part that is malformed as a result of birth defect, disease, or accident. Plan Document at 50 – 51. Ms. M. has neither alleged nor provided evidence to support a finding that her excess skin was disease related or the result of a birth defect or accident.

[13] Thomas Paulson, M.D., Testimony; *See e.g.*, AR at 57 ("[Premera] adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice.")

[14] Paulson Testimony.

[15] The Corporate Medical Policy for blepharoplasty provides in part:

> …[U]pper lid blepharoplasty … may be considered medically necessary when all of the following criteria are met:
>
> - visual field is limited to 20 degrees or less …
> - photographs demonstrate visual field limitation consistent with the visual field examination; and
> - any related disease process…is documented as stable.
>
> …
>
> Blepharoplasty … that is performed to improve a patient's appearance in the absence of any signs and/or symptoms of physical functional impairment is considered cosmetic.

AR at 58.

B. Ms. M.' Claim

Ms. M. is a 64 year old retired teacher and single head of household who is raising her granddaughter. As a retired teacher she is entitled to major medical insurance coverage.[16] Ms. M. suffered from excess skin on her upper eyelids which she found interfered with her ability to perform the simple functions of daily living. Ms. M. was beginning to wonder if she was unsafe driving. She found that the excess skin made it extremely difficult to keep her eyes open. She testified that to keep her eyes open required constant focus and effort which resulted in complaints of headaches and fatigue.

Ms. M. is not the type of person to run to the doctor for every little ache and pain. As she saw it, her problem was caused by the excess skin over her lids and the solution was simple: remove the excess skin. Ms. M. made an appointment with plastic surgeon, Jack D. Sedwick, M.D., to discuss removal of the excess skin.

Prior to her appointment, Dr. Sedwick sent Ms. M. to Jan Nyboer, M.D., for visual field testing. Dr. Nyboer noted Ms. M. complained of "heavy-tired lids" and observed that Ms. Medias exhibited "minimal blepharochalasis."[17] He tested Ms. M.' field of vision with her eyelids taped open and with no tape. The testing revealed that when taped, both eyes had a normal visual field. When untaped, Ms. M. had an upper eyelid visual field defect to 40 degrees.[18]

With the visual field testing completed, Dr. Sedwick examined Ms. M. on December 22, 2006. He characterized her chief complaint as "visual field defect" and concluded that she would "benefit" from the upper lid blepharoplasty.[19]

On January 4, 2007, Dr. Sedwick submitted a Benefit Advisory Request to Premera. Prior to completing its review, Premera requested medical records and photos of Ms. M.' face – frontal and lateral.[20] Photos were taken, and although Premera informed Dr. Sedwick that "[O]riginals would be best," he faxed the photos on January 19, 2007.[21]

Using the information provided by Dr. Sedwick, Premera determined that the procedure would not be covered under the Plan because Ms. M.' visual field was not limited to 20 degrees

[16] AS 14.25.168(a). Plan Document at 17 (May 2003 Retiree Insurance Information Booklet).
[17] AR at 45.
[18] AR at 45 – 49.
[19] AR at 43 – 44 (Ms. M. has "positive visual field tests and would benefit from this.").
[20] AR at 125.
[21] The record does not reveal if the originals were ever provided to Premera.

or less and thus it was not considered medically necessary under Premera's guide. Premera's decision was for coverage purposes only.[22] Premera left decisions about actual treatment to the patient and his or her provider.[23] Dr. Sedwick believed the visual field criterion of 20 degrees to be considered medically necessary was too strict and spoke to the physician who had denied the request, but there was no change in Premera's decision.[24]

Not proceeding with the blepharoplasty was not an option for Ms. M. It seemed simple to her: the excess skin caused her problem so remove the excess skin. On February 12, 2007, she had the procedure knowing Premera did not believe it was covered.[25] Ms. M. reasoned that if the procedure worked, then it would be covered because she would have established that it worked and thus was medically necessary.[26] She waited several weeks until she was sure the blepharoplasty was successful before seeking reimbursement for the procedure. Her request was denied and she appealed.

At the Level I appeal, it was noted that Ms. M. felt "that the surgery is medically necessary for safety and health, not vision or cosmetic reasons."[27] Her appeal was denied because she did not meet the objective field of vision criteria and thus, under the terms of the internal Premera guide the procedure was not considered medically necessary and would not be covered.[28]

At the Level II appeal, Ms. M. was invited to meet with the appeals panel and present additional information. None of the individuals reviewing Ms. M.' Level II appeal was involved in the prior decisions to deny coverage. [29] At this appeal level it was noted that Ms. M. went ahead with the surgery "due to safety reasons" and that she felt her "situation would have gotten worse and caused a serious accident."[30] The Panel looked at the written documents provided and took into consideration "the additional information [Ms. M.] presented at the hearing" before

[22] AR at 56.
[23] *Id.*
[24] Neil Kaneshiro, M.D. is the physician who reviewed and denied the approval request. The record does not indicate whether Ms. M.' complaints of exhaustion or headaches were considered by Dr. Kaneshiro. AR at 55.
[25] M. Testimony.
[26] AR at 87. M. Testimony.
[27] AR at 169.
[28] AR at 168 – 173.
[29] The Level II appeal was decided by a panel comprised of a Premera Assistant Medical Director, an Operations Manager and an Assistant General Counsel. AR at 235; Paulson Testimony.
[30] AR at 188.

concluding that her condition did not meet the medical necessity criteria of the Health Care Plan for blepharoplasty surgery.[31] Ms. M. then requested a Level III appeal.

Two independent review organizations conducted Ms. M.' Level III appeal: IMEDECS, Independent Medical Expert Consulting Services and MAXIMUS Center for Health Dispute Resolution. Neither organization revealed the identity of the physicians who conducted the Level III appeal and Ms. M. did not question their qualifications. The IMEDECS review occurred in August 2007 and was conducted by an actively practicing physician who was reported to be board certified in plastic surgery and had completed a craniofacial fellowship as well as a fellowship in surgery of the hand and upper extremity.[32] IMEDECS reported that the physician also holds the position of Chief, Division of Plastic and Reconstructive Surgery at an unidentified medical center and pediatric hospital.

The IMEDECS consultant noted that the photograph copies were of poor quality and did not allow a clear view of the eyes but did not find this hindered his review because, based on Dr. Nyboer's observation that there was "minimal blepharochalasis," it was unlikely that photos would have shown that Ms. Medias' upper lid skin rested on her lashes.[33] After reviewing the medical records and Ms. M.' appeal letters, the IMEDECS consultant concluded that Premera correctly denied coverage because Ms. M.' surgery was not considered medically necessary under the parameters of Premera's guide. The IMEDECS report references several reports and guidelines published by national organizations.[34]

On February 1, 2008, MAXIMUS completed its review.[35] The MAXIMUS physician was reported to be a practicing physician who is board certified in ophthalmology and familiar with the medical management of persons with Ms. M.' condition.[36] The MAXIMUS report acknowledged that Ms. M.' complaint was that the excess skin "closed her eyes and that keeping her eyes open required constant effort. She indicated that this problem affected her daily activities and made it dangerous for her to drive."[37] MAXIMUS framed the question presented

[31] AR at 93.
[32] AR at 110.
[33] AR at 111.
[34] *Id.*
[35] AR at 13 - 15.
[36] *Id.*
[37] AR at 14.

for its review as "whether the surgery was medically necessary for treatment of the member's condition."[38]

As with her previous two appeals and the IMEDECS review, the MAXIMUS review concluded that the procedure was not medically necessary. In reaching this conclusion the consultant noted, as did the IMEDECS consultant, Dr. Nyboer's observation of "minimal blepharochalasis."[39] The MAXIMUS report's conclusion was based on the consultant's observation that the photocopies of the photographs did not demonstrate "a truly excessive amount" of skin, that the "subjective heaviness reported by [Ms. M.] did not correlate with the minimal drooping of skin seen in the photographs," and that the consulting physician did not believe that the skin shown in the photographs would typically cause the degree of visual field obstruction reported on the tests performed by Dr. Nyboer.[40] The report did not mention the quality of the photocopies.

The Plan Administrator reviewed Ms. M.' file and the MAXIMUS review before affirming Premera's decision to deny benefits to Ms. M. because the procedure was not medically necessary under the terms of the Plan. This appeal followed.

Ms. M. believes the denial is in error because her procedure was denied by a guide developed to address field of vision deficit, not the condition she suffered from. She asserts that her complaints were ignored and that had her complaints been considered, her blepharoplasty would be found medically necessary and covered under the policy. Ms. M. adamantly denies that she had the procedure for cosmetic reasons. Moreover, Ms. M. believes the field of vision test results were not accurate because she was concentrating on keeping her eyes open when untaped.

Finally, Ms. M. offers that if she had gone to a specialist and had more tests to support her claim, it would have taken longer and increased the costs to the system only to have a doctor tell her what she already knew – to get her life back she would need the procedure. Because the procedure worked, it was medically necessary she believes it should be covered under the Plan.

[38] *Id.*
[39] *Id.*
[40] *Id.*

III. Discussion

The issue presented is whether Ms. M.' blepharoplasty procedure was medically necessary under the terms and conditions of her health care plan set forth in the Alaska Care Retiree Insurance Information Booklet, May 2003. Only procedures that are medically necessary are covered. A procedure that may benefit a member is not always covered as medically necessary under the plan. When determining whether a service is medically necessary the claims administrator will consider the member's health status, peer-reviewed medical literature, reports and guidelines from nationally recognized health care organizations, recognized professional standards, the opinion of health professionals in the health specialty involved, and any other relevant information.[41]

Whether a procedure is medically necessary under the Plan is a question of fact. Here, the facts to be considered include Ms. M.' health status and generally accepted medical practices for when blepharoplasty is considered medically necessary.

The 2003 Retiree Health Plan is interpreted in the same manner as any other insurance contract.[42] An insurance contract is interpreted to provide the coverage that a lay person would reasonably expect, given a lay interpretation of the policy language, and ambiguities are resolved in favor of the insured.[43] Provisions regarding coverage are interpreted broadly, and exclusions are interpreted narrowly.[44]

Premera's guide is its attempt as a claims administrator to objectify "medical necessity" based on the Plan's definition of medical necessity. According to Premera's guide, a blepharoplasty procedure may be medically necessary when the visual field is limited to 20 degrees or less, photographs demonstrate the visual limitation is consistent with the visual field examination and any related disease process is stable.[45] If blepharoplasty is not medically necessary then it is for cosmetic purposes and excluded from coverage unless it is to improve the

[41] Plan Document at 18.
[42] "Insurance contracts are interpreted 'by looking to the language of the disputed policy provisions, the language of other provisions of the policy, and to relevant extrinsic evidence. In addition, we also refer to case law interpreting similar provisions.'" *State v. Arbuckle*, 941 P.2d 181, 184 (Alaska 1997) (interpreting insurance contract covering state employee) (quoting *Cox v. Progressive Cas. Ins. Co*., 869 P.2d 467,468 n. 1 (Alaska 1994)).
[43] *Makarka v. Great American Insurance Co.*, 14 P.3rd 964, 966 (Alaska 2000); *Starry v. Horace Mann Insurance Co*., 649 P.2d 937, 939 (Alaska 1982).
[44] *State v. Arbuckle*, 941 P.2d 181, 184 n. 3 (Alaska 1997).
[45] AR at 58.

function of a body part that is malformed as a result of birth defect, disease, or injury.[46] Blepharoplasty that is performed to improve a patient's appearance in the absence of physical functional impairment is considered cosmetic.[47]

Premera defines "Physical functional impairment" as:

> a limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical function impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairments or potential impairments.[48]

The unchallenged testimony is that Premera's internal guide for blepharoplasty was developed using the Plan's paradigm for determining medical necessity. Premera's criterion for when blepharoplasty is medically necessary is based on generally accepted practices in the medical community and will resolve 95% of all blepharoplasty claims. For purposes of this decision, it is accepted that for 95% of all cases the field of vision criterion is an accurate indictor of when blepharoplasty is medically necessary. It is also accepted for purposes of this decision that the objective criterion for blepharoplasty sets the baseline level of function for purposes of determining physical functional impairment.

Ms. M. agrees that, as reported, her field of vision test results to not meet the "objective criterion" for medically necessary blepharoplasty. However, she believes that her results were inaccurate and if accurate she would meet the criterion. Regardless, Ms. M. believes her claim should not have been evaluated under the field of vision criterion and that if reviewed on its own merits, the procedure was medically necessary.

A. It is more likely than not that Ms. M.' field of vision test results were accurate as reported and she does not fall below the baseline.

Ms. M.' argument that her field of vision testing was inaccurate and had it been accurate she would have met the field of vision criteria is not persuasive. Dr. Nybor observed minimal blepharochalasis. Therefore it is unlikely that there was significant interference with Ms. M.' field of vision. Additionally, Ms. M. and her physician knew the objective criteria required for

[46] Plan Document at 50-52.
[47] AR at 58.

the procedure to be covered. Once Premera informed Dr. Sedwick and Ms. M. that the test results did not meet the objective criteria for medical necessity under the policy and if, as Ms. M. asserts the test results were inaccurate, it would have been reasonable for the tests to be repeated to ensure an accurate result that would have met the objective criteria. Because this was not done, the more persuasive evidence is that the results were accurate as reported.

The base line, *i.e.* 20 degrees or less field of vision, for Ms. M.' condition was established by peer review material, accepted guidelines and sound medical practice. Ms. M. has not provided any evidence other than Dr. Sedwick's chart note and her own testimony that the baseline is incorrect. The evidence relied upon by Ms. M. is insufficient to establish that it is more likely than not that the baseline should be other than that set forth in Premera's guide. Therefore, because Ms. M.' level of functioning did not fall below the baseline, she has not established by a preponderance of the evidence that her condition resulted in a physical functional impairment.

B. Ms. M. has not established by a preponderance of the evidence that her blepharoplasty was medically necessary under the terms and conditions of the Plan.

Ms. M.' primary contention is that her procedure was denied by a policy developed to address a condition unrelated to the one she suffered from and that she is part of the 5% not covered by the field of vision criterion.

Ms. M.' argument that the field of vision test should not be considered when determining the medical necessity of her procedure is not persuasive. Her field of vision was greater than 20 degrees. Ms. M. argues that the problem was her inability to keep her eyes open without continuous effort or concentration, not field of vision. However, inability to keep her eyes open necessarily involves her field of vision so here it is one in the same.

Moreover, Ms. M. overlooks that at each appeal level her complaints and safety concerns were considered and rejected as rising to the level of "medical necessity." At the Level I appeal, it was noted that Ms. M. felt "that the surgery is medically necessary for safety and health, not vision or cosmetic reasons."[49] At the Level II appeal it was noted that Ms. M. went ahead with the surgery "due to safety reasons" and that she felt her "situation would have gotten worse and

[48] *Id.*.
[49] AR at 169.

caused a serious accident."[50] At the Level III appeal it was noted that Ms. M.' complaint was that the excess skin "closed her eyes and that keeping her eyes open required constant effort. She indicated that this problem affected her daily activities and made it dangerous for her to drive."[51] At each appeal level her non-field of vision complaints were considered and rejected as rendering her procedure medically necessary. Therefore, her contention that her complaints were not considered is without merit.

Ms. M. convincingly testified that she did not have the blepharoplasty for aesthetic reasons, but rather to relieve her pain and discomfort associated with the stress and strain of keeping her eyes open. She also persuasively testified that the procedure resolved her complaints. Here, the need for blepharoplasty was due to a visual field defect but the defect did not rise to the level of being "medically necessary" under the accepted medical practice. Dr. Sedwick noted that he believed Premera's guide was too strict. The problem was that the defect did not rise to the level of medical necessity. Dr. Sedwick also believed that Ms. M. would "benefit" from the procedure. Unfortunately, without Dr. Sedwick's testimony to explain what he meant, this statement is given minimal weight because it is vague and subject to contradictory interpretations.

An insurance contract is interpreted to provide the coverage that a lay person would reasonably expect. A lay person would reasonably expect that a finding of medial necessity required more than an insured's opinion or belief that a procedure was medically necessary because the insured benefited from the procedure. Rather, a lay person would reasonably expect that a claim of medical necessity would be supported or corroborated by medical literature or an explanation by a health care professional as to why, in this case, the procedure was medically necessary. Corroborating evidence may or may not be objective evidence such as field of vision test results, but it must be present in the record.

Ms. M. choose to have the procedure knowing that Premera would not provide coverage. The relief experienced by Ms. M. after the surgery is evidence that the surgery was not without benefit. However, receiving a benefit from a medical procedure does not equate to medical necessity. Ms. M. has failed to identify sufficient evidence in the record to support a finding that

[50] AR at 188.
[51] AR at 14.

it is more likely than not that under generally accepted medial practice, for a person with her symptoms, blepharoplasty would be considered medically necessary.

V. Response To Proposal For Action

On August 22, 2008, Ms. M. filed a Proposal for Action requesting that the Administrative Law Judge take additional evidence and reject, modify, or amend a factual finding and interpretation. In support of her request, Ms. M. submitted two unsworn letters: one letter dated August 5, 2008, signed by Sheila A. Burke, M.D., and one letter dated August 18, 2008 signed by Dr. Sedwick. Dr. Burke's letter notes that the need for blepharoplasty was "simply a matter of functioning and allowing her safe driving."[52] Dr. Sedwick's letter reports that Ms. M.' headaches have improved since her procedure.[53]

At the April 11, 2008, Case Planning Conference, Ms. M. dismissed the need for medical testimony and elected to rely upon her medical records. A proposal for action should not be used as a means to seek an extension of time for the presentation of additional evidence on the merits of the claim where the moving party offered no explanation for failing to present evidence earlier.[54] Accordingly, Ms. M.' Proposal for Action fails.

V. Discussion

The blepharoplasty procedure was not medically necessary as defined by the Plan. Therefore, it is not covered under the plan. The PERS' February 13, 2008, denial of Ms. M.' request for coverage is affirmed.

DATED this 3rd day of September, 2008.

By: *Signed*
Rebecca L. Pauli
Administrative Law Judge

[52] August 5, 2008, Burke Letter.
[53] August 18, 2008, Sedwick Letter.
[54] *Neal & Co. v. Ass'n of Vill. Council Presidents Reg'l Hous. Auth*., 895 P.2d 497, 506 (Alaska 1995) (discussing standards for reconsideration under Ak. R. Civ. P. 77).

Adoption

This Order is issued under the authority of AS 39.35.006. The undersigned, in accordance with AS 44.64.060, adopts this Decision and Order 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 Rule of Appellate Procedure 602(a)(2) within 30 days of the date of this decision.

DATED this 3rd day of September, 2008.

By: *Signed*
Signature
Rebecca L. Pauli
Name
Administrative Law Judge
Title

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