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

In the Matter of	)	
	)	
U S M	)	OAH No. 19-0183-MDX
	)	Agency No.

DECISION

I. Introduction

U S M appeals a decision by the Division of Health Care Services (Division) placing her in the Alaska Medicaid program's Care Management Program (CMP). Ms. S M argues she should not have been flagged for exceptionally high usage of Medicaid services. She also argues that all of her usage was medically necessary.

The Division showed that Ms. S M's usage of certain Medicaid services between January 1, 2018 and June 30, 2018 was exceptionally high as compared to that of others in her peer group. It additionally showed that she used Medicaid services during the six-month review period at a frequency or in an amount that was not medically necessary. As a result, the Division was justified in placing Ms. S M in the CMP for twelve months pursuant to 7 AAC 105.600. Its decision is affirmed.

II. Facts[1]

A. Relevant Procedural History

The Division determined that Ms. S M used Medicaid services at a level that was not medically necessary during a six-month review period from January 1, 2018 through June 30, 2018.[2] On January 29, 2019, it notified her that it was placing her in the Care Management Program. Ms. S M requested a hearing.[3] The hearing took place on March 21, 2019. It was audio-recorded. Ms. S M appeared in person and represented herself. She was assisted by her brother, Z S. Ms. S M and Mr. S both testified. Laura Baldwin appeared in person and represented the Division. Diana McGee, the Division's Care Management Program manager, testified on behalf of the Division, as did Nurse Reviewer Josie Sneed, LPN, and Wes Amann,

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[1] The following facts are established by a preponderance of the evidence, based on the testimony at hearing and the exhibits submitted.

[2] Exhibit D.

[3] Exhibit C.

the CMP Coordinator for the Division's contractor, Conduent. All exhibits offered by either party were admitted to the record, which closed following the hearing.

B. Overview of the Medicaid Care Management Program

The Department of Health and Social Services "may restrict a recipient's choice of medical providers if the department finds that a recipient has used Medicaid services at a frequency or amount that is not medically necessary."[4] When such a finding is made, the Division may place the recipient in the Care Management Program, which assigns one primary care provider and one pharmacy. Those providers become responsible for overseeing the recipient's medical care. The Medicaid program will only pay for medical services and items the recipient receives from the designated provider and pharmacy, unless the assigned provider refers the recipient to another provider, or unless emergency services are necessary.[5]

The CMP is designed for recipients who have been identified as over-utilizing Medicaid services. It is intended to reduce medically unnecessary, uncoordinated, and/or duplicative care by improving the recipient's continuity of care. It ensures that a single primary care provider is taking a comprehensive look at the patient's needs, educating and advocating for the patient, and communicating between various specialists.[6] CMP coordinators are also available by telephone to assist patients and providers with issues that may arise, including obtaining referrals or pre-authorization.[7] The Division has found that this coordinated medical oversight is particularly beneficial to participants with chronic health problems and complex medical needs.[8]

Placement in the CMP is based on a two-phase review process. First, in a process known as a "Phase I review," the Division identifies Medicaid recipients who are using statistically high levels of Medicaid services. To do so, it uses specialized software that flags utilization rates significantly exceeding the norm for the recipient's peer group.[9] The software flags an

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[4] 7 AAC 105.600. As a requirement for continued receipt of Medicaid funding, federal law requires states have a plan in place "to safeguard against unnecessary utilization of [Medicaid] care and services." 42 CFR. § 456.1(a)(1). Each state's Medicaid agency "must implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services[.]" 42 CFR § 456.3(a).

[5] 7 AAC 105.600(f). However, referrals from the primary care provider are not required for behavioral or mental health care services, or for vision and dental services. McGee testimony.

[6] Exhibit B, p. 12; McGee testimony.

[7] McGee testimony.

[8] *Id.*

[9] McGee testimony; Amann testimony.

"exception" if a recipient's usage frequency for a particular indicator exceeds the peer group average for that indicator by two standard deviations or more.[10]

When a Phase I review reveals one or more "exceptions," a licensed health care provider then performs an individualized "Phase II" review.[11] This process includes the review of all medical records for Medicaid-paid services the member received during the review period "to determine how the recipient has used the disputed medical item or service and whether that usage was medically necessary."[12] The reviewer takes into consideration the recipient's age, diagnoses, complications of medical conditions, chronic illnesses, number of different physicians and hospitals used, and the type of medical care the recipient received.[13] If the Phase II reviewer determines that the recipient's use of a medical item or service was not medically necessary, the Division may place the recipient in the Care Management Program for a reasonable period of time, not to exceed 12 months.[14]

C. Ms. S M's Use of Medicaid Services during the review period

Ms. S M is 49-years-old. She weighs approximately 230 pounds. Her medical records document a history of hypertension, attention-deficit hyperactivity disorder (ADHD), gastroesophageal reflux disease, chronic back pain, peripheral neuropathy, diabetes, and obesity.[15] Ms. S M is treated for her chronic pain by a pain management specialist. For this treatment, she signed a contract agreeing to receive prescriptions for controlled pain medications only from that provider.[16]

Ms. S M lives with her husband in City A. To enter or exit the home, she must walk up or down a flight of stairs with 16 or 17 steps.[17] Access to her bedroom requires another set of stairs with 16 or 17 steps. Though Ms. S M lives in a household of two, other family members live in the general area, including Ms. S M's brother, a sister, and an adult daughter.

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[10] 7 AAC 105.600(b)(3).

[11] *See* 42 C.F.R. § 456.3; McGee testimony.

[12] 7 AAC 105.600(c); Amann testimony; Dixon testimony.

[13] 7 AAC 105.600(c).

[14] 7 AAC 105.600(d), (g). The Division is required to review the restriction annually. If it determines that the restriction should extend beyond 12 months, it must provide the recipient notice and an opportunity for a new fair hearing.

[15] Exhibit 2, p. 5; Exhibit 3; Exhibit G.

[16] Exhibit G, p. 60; S M testimony.

[17] S M testimony.

On or around February 12, 2018, Ms. S M saw her primary care provider, R C PA-C. She had an abscess or boil on her left medial thigh, in her genital area, but it was not causing a problem and it was not one of the topics she discussed with PA-C C. By February 16th, it had doubled in size and become painful. She knew it needed treatment. However, she could not get an appointment with PA-C C that day.

On Saturday, February 17, 2018, she became more anxious about the boil, in part because of concerns about infection. If it was infected, she worried it would rapidly spread and become a serious matter. She decided it needed treatment that day. She called two walk-in, urgent care clinics to see if she could be treated there, but decided not to pursue those options because she did not think she could get there before the offices closed at 6 or 7 p.m.[18]

Despite the above explanation, Ms. S M arrived at the Unknown Regional Hospital Emergency Department at 4:59 p.m., complaining of pain and swelling of the abscess/boil. She acknowledged the problem had been developing for days but stated that, in the last 24 hours, she had been experiencing a fever of 102 degrees. She added that her menstrual cycle had started the day before and the boil was interfering with her hygiene, as she could not use a tampon or pad without causing more pain. The hospital records document that Ms. S M's temperature was normal during her visit.[19] The emergency provider drained the abscess, prescribed an antibiotic, diagnosed a likely abscess of Bartholin's gland, and told Ms. S M to follow up with her primary care provider.[20]

On May 4, 2018, Ms. S M heard a click in her left knee and began experiencing pain. She saw her primary care provider, who ordered an MRI.[21] After imaging, she was diagnosed with a torn left meniscus and referred to an orthopedic specialist.[22] She scheduled the orthopedic follow-up care for July 12, 2018.[23] As the weeks passed, Ms. S M experienced increasing pain from the injury when she walked. In response, her pain management provider increased her pain medication dosage. Ms. S M felt she did not get adequate relief from a 10 milligram increase, and she expressed dissatisfaction with that initial care.

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[18] S M testimony.
[19] Exhibit G, p. 7.
[20] Exhibit G, pp. 1-12.
[21] Exhibit G, p. 20; S M testimony.
[22] Exhibit G, p. 19.
[23] Exhibit G, p. 20; S M testimony.

By late June 2018, Ms. S M's knee pain was making it increasingly difficult for her to walk. This posed particular problems for getting in and out of her house, due to the stairs, and for getting from her bed to the toilet. Because of her other medical conditions, Ms. S M indicated that she could not ambulate using crutches or other assistive devices. In addition, her husband was in an accident many years ago that resulted in his own medical limitations. He has some trouble with information processing, and he cannot lift more than ten pounds because of neck and spinal issues. He therefore could not physically assist when she needed help moving from place to place in the home.

On Saturday, June 23, 2019, Ms. S M's husband called for emergency medical responders after finding Ms. S M on the floor next to her bed, where she had fallen after trying to get herself to the bathroom. She was screaming with pain and could not walk.[24] The emergency responders transported her to the hospital around 5:45 p.m.[25] When she arrived, Ms. S M was somewhat drowsy because she had taken muscle relaxants along with her pain medication earlier in the day. She told the ED staff that her knee pain and swelling had been increasing for five days, and she was experiencing tremendous pain when she walked. She rated the pain at a 7 or 8 on a scale of one to ten. The ED doctor talked with Ms. S M's primary care provider, PA-C C, who confirmed the meniscus tear and prior referral to an orthopedist.

During the June 23rd emergency department visit, Ms. S M and her husband expressed frustration with Ms. S M's pain management provider, stating it had not sufficiently increased her pain medication dosage. The ED doctor urged her to discuss this concern with the pain provider, but also warned Ms. S M about the dangers of taking pain medicines along with other medications like muscle relaxants or sleeping pills. The doctor provided a prescription for a bedside commode at Ms. S M's request, since she had discussed her difficulty getting to the bathroom.

Ms. S M's husband asked that Ms. S M be admitted to the hospital. He feared she would not be able to make it up the stairs in her home, and she would need physical help he could not provide. The treating doctor refused this request because Ms. S M's medical condition did not

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24 Exhibit 2, p. 1; S M testimony.

25 Exhibit G, pp. 13-22.

meet admission criteria. Staff provided the hospital social worker's phone number so Ms. S M could request in-home services.[26]

The next day, Sunday, June 24, 2018, Ms. S M's husband or daughter again called for emergency medical assistance out of concern for Ms. S M's knee pain, difficulty walking, and a quarter-sized blister on her left big toe, which they thought might be showing signs of infection. Ms. S M incurred the toe injury when she fell the prior month, in May 2018. The family decided the toe injury had not been properly cared for, and they feared an infection could rapidly become very serious.[27] They had not mentioned this concern when Ms. S M was in the emergency department the day before, however. Ms. S M returned to the Unknown Hospital Emergency Department by emergency medical transport about 11 p.m.[28]

Ms. S M presented at the hospital with a red and purple ulcer on her great toe, and she complained of ongoing knee pain. However, she was in no apparent distress. She repeated that she could not get out of bed to get to the bathroom, noting that this was causing significant discomfort. The ED provider cleaned and dressed the toe wound, provided antibiotics and a prescription for hydrocodone (among other medications), and diagnosed Ms. S M with a left knee effusion and a toe with cellulitis. She was discharged home in good condition.

On June 27, 2018, Ms. S M's husband again called for emergency medical assistance. Ms. S M had not gone to the bathroom for over 24 hours, and she was in pain because of her inability to manage her toileting needs. Mr. M felt she required care he could not provide, and other family members were not available to assist.[29] Emergency medical responders again transported her to the Unknown Regional Emergency Department, arriving about 1:30 in the afternoon.[30]

At the hospital, Ms. S M complained of worsening left knee pain. However, her primary problem was her inability to get to a toilet or manage her need to urinate or have a bowel movement. The ED staff catheterized her, which resolved the urination problem. Ms. S M and her husband again requested admission to the hospital, stating that Ms. S M required physical

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[26] Exhibit G, p. 17.
[27] S M testimony.
[28] Exhibit G, pp. 27-40.
[29] Exhibit 2, p. 1; S M testimony.
[30] Exhibit G, pp. 41-59.

assistance that was not available at home. The ED doctor declined the request, and Ms. S M was discharged home with instructions to see her primary care provider within 3-5 days.

D. Phase I Review of Ms. S M's Use of Medicaid Services

Ms. S M's unusually high use of Medicaid services came to the Division's attention as part of the purely statistical analysis in the Phase I review. In this computerized review, the Division compared Ms. S M's usage of Medicaid services between January 1, 2018 and June 30, 2018 to that of her peer group, which is "adults aged 40-49."[31] This "Phase I review" identified exceptional usage of medical services in two different areas as compared to the peer group. These were: number of controlled prescriptions and number of different controlled drugs 2-5.[32]

The average number of controlled prescriptions for adult Medicaid recipients aged 40-49 during the study period was 5.1545. The upper limit of normative usage – defined as the study group average plus two standard deviations – was 17.0066 controlled prescriptions. Ms. S M had 25 such prescriptions during the study period.[33] The average number of different "controlled drugs 2-5" for members of Ms. S M's peer group was 2.5909, and the upper limit of normative usage was 6.6883. Ms. S M was just above the upper limit, at 7 during the relevant period.[34]

During the Phase I review, members are assigned "exception points" based on level of use of the various indicators, and their level of usage is then ranked in comparison to usage by other members of the study group. For the six-month review period at issue, Ms. S M's usage ranked 26th out of the 381 individuals in her peer group.[35]

E. Phase II Review of Ms. S M's Medical Records

Because the Phase I review revealed exceptions – that is, categories of statistically high use of Medicaid services – the Division initiated a Phase II review.[36] For that review, Licensed Practical Nurse Josie Sneed, a Clinical Reviewer Consultant for the Division's contractor, Conduent, reviewed Ms. S M's medical records for all Medicaid-reimbursed services received during the review period. The purpose of this review was to determine whether Ms. S M's usage of Medicaid services was due to medical necessity or whether it reflected inappropriate use.[37]

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31 Exhibit E, p. 1.
32 *Id.* at p. 2.
33 *Id.*
34 *Id.*
35 Exhibit E, pp. 1-2.
36 Amann testimony; 7 AAC 105.600(c).
37 Exhibit F; Sneed testimony.

Ms. Sneed issued a Phase II Report on December 28, 2018, concluding that Ms. S M used Medicaid services at a frequency or in an amount that was not medically necessary. She identified problems including: inappropriate use of the emergency department for non-emergent care; non-compliance with medication or treatment modalities; and high prescription medication activity.[38] She concluded that Ms. S M needs to create an ongoing relationship with one provider to better meet all her medical needs. Ms. Sneed recommended assigning her to the Care Management Program.[39]

In a report called a Phase II Addendum, issued on March 1, 2019, Ms. Sneed cited Ms. S M's four emergency department visits during the review period as substantiating the Division's concerns and conclusions about overuse of Medicaid services.[40] In addition to the concerns expressed in the earlier Phase II report, the addendum found that Ms. S M had closely adjoining dates of service with different providers for the same or similar complaint, and she used a significantly higher number of pharmacies than her peer group norm to fill prescriptions. It added that Ms. S M's more than 12 prescribers and three pharmacies likely placed her at increased risk of adverse medication outcomes. It reiterated the conclusion that Ms. S M's medically unnecessary usage of services during the review period warrants placement in the Care Management Program.[41]

III. Discussion

A. CMP Legal Framework and Appropriateness of Each Review Phase

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."[42] 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."[43]

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

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38 Exhibit F, p. 2.
39 Exhibit F.
40 Exhibit F, pp. 3-6.
41 Exhibits D, F; Sneed testimony.
42 42 U.S.C. 1396n(a)(2)(A).
43 42 U.S.C. 1396n(a)(2)(B).

recipient's choice of medical providers if it finds the recipient has used Medicaid services at a frequency or amount that is not medically necessary. A usage review is triggered when:

> [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.[44]

As described previously, the Phase I review compares the recipient to his or her "peer group norm" for various indicators during the review period. The indicators include, for example, the number of office visits, number of ER visits, number of pharmacies, number of drug prescriptions, and the number of days covered by various types of prescription drugs, including narcotics.[45] Here, the Phase I review found that Ms. S M's usage during the six-month review period satisfied the exceptional use criteria as to two separate indicators.

Ms. S M agreed she had an unusually high number of controlled prescriptions during the review period as compared to her peer group. She understood why the Phase I review flagged that usage as exceptional, and she did not dispute that finding. She strongly disagreed with the determination that her number of different controlled drugs 2-5 exceeded the peer group norm by two standard deviations or more.

The Division explained that its data regarding Ms. S M's number of controlled drugs 2-5 would separately count prescriptions for the same medication if the medication was made by different manufacturers. It also would separately count prescriptions for the same medication if it was prescribed at different dosages. This likely occurred in Ms. S M's case, since her ADHD treatment plan requires her to take 30 mg of Adderal in the form of a 20 mg pill and a 10 mg pill.

Though she agreed she had an exceptionally high number of controlled prescriptions during the review period, Ms. S M argued that her case never should have been referred for a Phase II review. She claimed a recipient must have two or more exceptions before a Phase II review is justified. This incorrectly summarizes the law. The regulations do not require two or more areas of exceptional usage in the Phase I review to justify further inquiry; one area of statistical overuse is sufficient. Ms. S M did not contest the finding that flagged her high number of controlled prescriptions. Therefore, even assuming she should not have "excepted out" in the

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[44] 7 AAC 105.600(b)(3).

[45] *See* Exhibit E.

second category, the Division correctly referred her case for a Phase II review based on her exceptionally high number of controlled prescriptions.

Consistent with CMP regulations, Licensed Practical Nurse Sneed conducted the Phase II review. She reviewed all Ms. S M's medical records from the review period and identified serious concerns about her use of Medicaid services during that time. Nurse Sneed expressed particular concerns with Ms. S M's four emergency department visits, including three visits in five days for the same or similar complaints. Nurse Sneed concluded that the four ED visits were not medically necessary, and they reflected uncoordinated care. She determined that Ms. S M showed a need for an ongoing relationship with a primary care provider to better provide for her medical needs.

B. The Division Appropriately Placed Ms. S M in the CMP

The Division asserts that emergency services are medically appropriate only in response to the sudden and unexpected onset of an illness or accidental injury that requires immediate attention to safeguard the recipient's life. It defines "immediate medical attention" to mean medical care that cannot be delayed for 24 hours or more after the onset of the illness or occurrence of the injury.[46]

Under this definition, Ms. S M clearly did not require emergency services for the abscess or boil on February 17, 2018. The boil had been developing for several days, there is no evidence it posed a threat to Ms. S M's life, and its treatment likely could have been delayed another 24 hours after the February 17, 2018 ED visit. The evidence also shows that Ms. S M could have seen a primary care provider or walk-in clinic to treat the boil on February 17th, but she opted not to. Her anxiety about the potential for infection, and her difficulty managing menstrual hygiene, did not necessitate emergency department level care on February 17th.

Similarly, Ms. S M did not require emergency services, as defined above, for at least two of her emergency department visits in June - on June 23rd and 24th. Her knee pain and difficulty walking were well-established by then. They were not sudden or unexpected problems, and their treatment could have been delayed another day. The ulcer on her toe also had been present for days or weeks, did not show signs of a systemic infection, and could have been treated by Ms. S M's primary care provider on a later date. Ms. S M's difficulty getting to a toilet primarily

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[46] *See* 7 AAC 105.610(e)(2). This definition pertains to recipient cost sharing and applies when the Division determines whether Medicaid will pay for emergency department care to individuals already in the Care Management Program.

presented a social services issue rather than a medical problem. Even so, that problem was not sudden or unexpected, given her ongoing knee pain.

By the time Ms. S M's bladder was overfull and she could no longer urinate on June 27th, her catheterization treatment likely could not have been delayed another day. Yet, even this is a somewhat questionable determination, given that Ms. S M's bladder problem was entirely the result of her decision not to eliminate when she needed to. If physical assistance to a toilet was not available from family, friends or EMTs, Ms. S M did not explain why she could not have solved her toileting problem with tools like a bedpan or adult incontinence products, which would not have required weight bearing on her knee.

In at least one other case involving a CMP placement decision, a broader definition applied to the determination of medical necessity of emergency services.[47] There, the placement decision included consideration whether emergency services were necessary not only to safeguard the recipient's life, but also to prevent serious impairment to the recipient's health.[48] Even under this less restrictive standard, the Division has shown that Ms. S M received medical services that were not medically necessary during the review period. This is true of the February 2018 visit to drain the boil, and the first two ED visits in June 2018. The primary purpose of all the June emergency room visits was Ms. S M's knee pain and resulting problems accessing a toilet. The lack of adequate physical assistance during that time, and/or the lack of a bedside commode, a bedpan, or adult absorbent pads, was understandably distressing. However, it did not constitute a *medical* emergency, and emergency department care generally was not necessary to prevent serious impairment to Ms. S M's health.

The Division showed that Ms. S M's medical needs on February 17, 2018, and at a minimum on June 23rd and 24th, were not emergent and could have been handled by a primary care provider or her pain specialist. The June incidents also reflect repeated treatment for the same or similar complaint, resulting in unnecessarily duplicative and uncoordinated care. Ms. S M's many controlled prescriptions and her use of pain medications along with muscle relaxants or sleeping pills further show a need for better coordinated care.

Ms. S M argued that each of her emergency department visits was medically necessary, asserting that her lack of adequate in-home help with toileting justified the three June visits. She

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47 *In re C.P.*, OAH No. 18-1319-MDX (Commissioner, DHSS, 3/7/19).

48 *See* AS 47.07.900(8)(A). *See also* AS 18.08.200(6); 42 USC 1396u-2(b)(2)(C).

warned against "armchair quarterbacking" her decisions with the benefit of hindsight, which showed that her symptoms generally did not threaten her life or present a risk of serious impairment to her health. However, she did not adequately explain why she could not have resolved her toileting problem with simple technologies, or how she expected repeated emergency department care to resolve her need for in-home toileting assistance. In addition, Ms. S M's explanations were not always credible - both regarding her claimed inability to see a primary care provider or urgent clinic in February, and regarding her symptoms of systemic infection in February and June.

To warrant placement in the CMP, the Division need not show that every ED visit during the review period was medically unnecessary; it need only show that Ms. S M received some medically unnecessary services. The evidence supports the Division's conclusion that Ms. S M did not require emergency department care on February 17, 2018, and on June 23 and 24, 2018. It also showed that she sought repeated care for the same or similar complaints in June 2018, resulting in unnecessary and uncoordinated care, and that her use of multiple medications (including narcotic pain medications and muscle relaxants) placed her at risk of adverse medication reactions.

Though the Division need not tie its Phase II determination to the specific exception(s) flagged in Phase I, Ms. S M's medically unnecessary emergency care visits resulted in at least one additional prescription for a controlled medication, which violated the terms of her pain contract. The totality of the evidence supports the Division's conclusion that Ms. S M over-utilized Medicaid services during the review period, and she likely would benefit from the coordinated care and oversight offered by the CMP.

C. Ms. S M's concerns about the CMP are not grounds for overriding the placement decision under 7 AAC 105.600.

Ms. S M objects that the Division should have looked at a different or longer review period, calling the six-months from January through June 2018 one of the worst of her life. She also objects to CMP placement on principle, finding it intrusive and unfair in light of her relative medical stability since June 30, 2018. She explained that, once she got the issues from that time period resolved, her usage of Medicaid services declined. These objections fail, however, because both the program and its look-back period are expressly authorized by regulation.

Ms. S M also objects to the assignment of a new primary care provider, since she has an established relationship with PA-C C. The Division explained that it could have assigned that

provider, but he has not agreed to take CMP clients. The Division expressed its willingness to work with Ms. S M regarding assignment of new provider, since the circumstances here likely will require a change. There is no suggestion that this is likely to impair Ms. S M's access to appropriate Medicaid services, however.

IV. Conclusion

The Division is justified in placing Ms. S M in the Medicaid Care Management Program pursuant to 7 AAC 105.600 based on her overutilization of Medicaid services during the review period. Accordingly, the Division's decision to place Ms. S M in the Care Management Program for a period of twelve months is affirmed

Dated: April 26, 2019

Signed
Kathryn Swiderski
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 15th day of May, 2019.

By: *Signed*
Signature
Cheryl Mandala
Name
Administrative Law Judge
Title

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