BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE

In the Matter of	)	
	)	
Q P	)	OAH No. 18-1004-PER
	)	Agency No. 2018-0920

DECISION

I. Introduction

The AlaskaCare Retiree Health Plan provides health insurance for retired Alaska public employees and their dependents. Q P, the spouse of a retiree, submitted claims for chiropractic services. The Plan Administrator determined that the services were not medically necessary and denied the claims. Ms. P challenges that decision.

Because Ms. P has an identifiable neuromusculoskeletal disorder, her medical doctor recommended chiropractic services in response to flare-ups or exacerbations of her chronic neuromusculoskeletal disorder, and those chiropractic services have successfully alleviated or improved her symptoms after each visit, the chiropractic services provided to alleviate flare-ups or exacerbations of Ms. P's chronic, degenerative condition were "medically necessary" within the meaning of the Plan. The Plan does not have an exception excluding chiropractic services for flare-ups or exacerbations of chronic conditions. Accordingly, the Division's denial of claims for chiropractic services on August 21, 2017 and February 5, 2018 is REVERSED.[1]

II. Facts

Q P is the spouse of a retired member of the Public Employees' Retirement System (PERS). As the spouse of a retiree, Ms. P is entitled to health insurance benefits under the AlaskaCare Retiree Health Plan (the Plan). The Division of Retirement and Benefits (the Division) administers the Plan through a third-party administrator, currently Aetna Life Insurance Company (Aetna). The terms and conditions of coverage and benefits under the Plan are set out in the Retiree Insurance Information Booklet (the Booklet).[2]

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[1] Although Aetna has not paid for any chiropractic services for Ms. P since October 2015, there is no evidence in the record that claims were submitted or denied for chiropractic services on any other dates during the 180-day period before Ms. P filed her appeal letter.

[2] *See, e.g., In re D.M.,* OAH No. 08-0153-PER (OAH 2008) at 2 ("The terms and conditions of coverage applicable to this matter are found in the Alaska Care Retiree Insurance Information Booklet."). The AlaskaCare Retiree Insurance Information Booklet, May 2003, as amended, is available online at http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf.

Ms. P is a healthy, physically active woman, who works as a dental hygienist. She suffers from neck and back pain for which she has received chiropractic services for years. Those chiropractic services were covered under the Plan until approximately September 2015.[3]

In about July 2015, Ms. P began experiencing significant neck pain and discomfort.[4] She reported tingling, numbness, and weakness down her right arm.[5] Although chiropractic massage and gentle traction slightly reduced Ms. P's symptoms, her improvement was slower and less noticeable than her chiropractor, Dr. Gregory Egeland expected.[6] Dr. Egeland ordered an MRI, which revealed degenerative disc disease, spondylosis at C 5-6 and C 6-7, and narrowing of her cervical C 4-5, C 5-6, and C 6-7 disc spaces.[7] Dr. Egeland referred Ms. P to orthopedic surgeon, Dr. Davis Peterson.[8] Dr. Peterson prescribed a steroidal anti-inflammatory medication (Medrol Dosepak, pulse steroid dose) and recommended that Ms. P continue with the chiropractic traction with Dr. Egeland.[9] On a return visit with Dr. Peterson, Ms. P reported that the anti-inflammatory medication significantly reduced her pain, and that she was continuing with chiropractic treatments with Dr. Egeland.[10] Dr. Peterson concluded that although Ms. P had residual symptoms, her condition had markedly improved with conservative treatments.[11] Dr. Peterson warned Ms. P that she may be prone to future relapses and she should be careful to avoid hyperextension, overhead, or repetitive lifting activities.[12] If her symptoms worsened to progressive radiculopathy or incapacitating pain, Dr. Peterson opined that Ms. P might have to consider Anterior Cervical Discectomy and Fusion Surgery (ACDF) in the future.[13]

Ms. P's condition is chronic and degenerative.[14] Ms. P seeks treatment from Dr. Egeland sporadically when she exacerbates her condition or experiences a relapse or a "flare-up."[15] Sometimes the cause of her flare-ups is unknown.[16] Other times, Ms. P can identify a specific source of pain or an activity or incident that exacerbates or causes a relapse of her symptoms.[17]

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3 Agency Record (AR) at 58.
4 Dr. Gregory Egeland Testimony.
5 Egeland Testimony.
6 Egeland Testimony; *see also* AR at 96.
7 Egeland Testimony; AR at 93, 96.
8 Egeland Testimony; AR at 96.
9 AR at 97.
10 AR at 98.
11 AR at 98.
12 AR at 98.
13 AR at 98.
14 Egeland Testimony; Q P Testimony.
15 Egeland Testimony; P Testimony.
16 Egeland Testimony; *see also* AR at 172, 174, 179, 181.
17 Egeland Testimony; *see also* AR at 166, 167, 169, 176, 183, 185, 187.

Because there is no way to predict when or how often she will experience a flare-up, Dr. Egeland has Ms. P on an "as-needed" treatment plan.[18] Chiropractic treatment will not cure degenerative disc disease, and it may not prevent all flare-ups, but the treatments do limit or reduce flare-ups for Ms. P.[19] The "as needed" treatment has been successful for Ms. P.[20] When she has flare-ups, she goes to Dr. Egeland for an adjustment; the adjustment relieves her symptoms; and Dr. Egeland does not see Ms. P again until she experiences another flare-up or exacerbation.[21] The records show about one to three months between Ms. P's visits to Dr. Egeland.[22]

On May 2, 2016, Aetna sent Ms. P a letter advising her that "assuming all of the clinical information remains unchanged," spinal manipulations with therapeutic modalities would not be eligible for coverage under the Plan *from September 24, 2015 going forward*.[23] In the letter, Aetna explained that after applying its Clinical Policy Bulletin for Chiropractic Services to Ms. P's condition and specific circumstances, a Medical Director concluded that Ms. P's ongoing chiropractic treatment was not medically necessary.[24] In particular, the Aetna Medical Director concluded that the clinical documentation does not support that Ms. P is making continuous progress towards measurable goals in a reasonable timeframe.[25] Aetna informed Ms. P that if she disagreed with the decision, she could appeal by phone or in writing within 180 days of receiving the letter (or 6 months).[26]

On February 18, 2018, Ms. P sent a letter appealing the denial of claims for chiropractic services.[27] Ms. P questioned why Aetna had not paid any claims for chiropractic treatment since October 8, 2015.[28] She explained that regular chiropractic care is imperative for her health and that spinal adjustments keep her body functioning so she has a decent quality of life.[29] According to Ms. P, due to a sledding accident in her late teens she has arthritis in her cervical spine.[30] She

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18 Egeland Testimony.
19 Egeland Testimony.
20 Egeland Testimony; P Testimony.
21 Egeland Testimony.
22 AR at 166 – 188; Egeland Testimony.
23 AR at 58. Neither Aetna nor the Division has authority to prospectively deny claims that have yet to arise. Claims that have not yet been submitted are not ripe—they cannot be approved or denied. *See* Order on Summary Adjudication at 3 - 4, *In the Matter of P.A.*, OAH No. 06-0254-PER (April 10, 2007).
24 AR at 58 – 59. Although there is no evidence that physical therapy is at issue in this case, the letter also advised Ms. P that Aetna was also denying coverage for ongoing physical therapy under a different but similar Clinical Policy Bulletin. AR at 59.
25 AR at 59.
26 AR at 59.
27 AR at 56.
28 AR at 56.
29 AR at 56.
30 AR at 56.

stated that "getting a spinal adjustment approximately once a month keeps the pain at a level that [she] can tolerate, and still function during the day and sleep at night with no pharmaceutical help."[31] Ms. P's medical doctors have not recommended any other kind of treatment.[32]

Because the Plan requires that appeals be filed within 180 days, the Administrator reviewed claims for chiropractic treatment that were denied in the 180 days before Ms. P filed her appeal letter. The agency record contains Explanation of Benefits (EOB) denial letters for chiropractic services provided on August 21, 2017 and February 5, 2018.[33] Claims for those dates of service total $196 each, or $392 total.[34] The agency record also contains chart notes for chiropractic services provided by Dr. Egeland to Ms. P on August 21, 2017, October 13, 2017, November 11, 2017, December 27, 2017, and February 5, 2018.[35] None of the chiropractic services provided to Ms. P between August 21, 2017 and February 18, 2018 were paid for by the Plan.[36] Although Aetna has not paid for any chiropractic services for Ms. P since October 2015, there is no evidence in the record that claims were submitted or denied for chiropractic services on October 13, 2017, November 11, 2017, or December 27, 2017.

In response to Ms. P's appeal, Aetna referred Ms. P's claims to Robert Frank, DC for a Level I Clinical Review on March 8, 2018.[37] Dr. Frank concluded:[38]

> The submitted medical records indicate that this member has been under care for an extended period of time. The clinical records beginning August 21, 2017 through February 5, 2018, were not submitted for review. These records should contain clear and concise subjective information, complete and detailed objective findings, pertinent assessments and a specific plan at each encounter. Thus the medical necessity for chiropractic services for these dates of service is not evidenced.

On March 15, 2018, Aetna sent Ms. P a letter informing her that it was upholding its decision to deny coverage for chiropractic services as the medical necessity for those services is not evidenced.[39] Aetna explained that the Plan covers chiropractic services when the following criteria are met: (1) the person has a neuromusculoskeletal disorder; (2) the medical necessity for

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31 AR at 56.
32 AR at 56.
33 AR at 64 -- 71.
34 AR at 64 – 71, 73 –76.
35 AR at 172 – 180.
36 P Testimony; Egeland Testimony.
37 AR at 54.
38 AR at 54.
39 AR at 49 – 52.

treatment is clearly documented; and (3) improvement is documented within the initial 2 weeks of chiropractic care.[40] The letter goes on to explain:[41]

> If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is not covered unless the chiropractic treatment is changed.
>
> If no improvement is documented within 30 days despite a change in chiropractic treatment, continued chiropractic treatment is not covered.
>
> Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is not covered.
>
> Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered not covered.
>
> Chiropractic care in persons, whose condition is neither getting worse nor improving, is not covered. . . .

Ms. P requested an external review of the decision.[42] Ms. P provided a letter from Dr. Egeland with her request.[43] According to Dr. Egeland, Ms. P has a history of very effective results with chiropractic care and the care is medically necessary:[44]

> Mrs. P's treatment at the Ireland Clinic of Chiropractic, LLC meets all the required criteria, and she has always responded very well to chiropractic care. She does have numerous complicating factors which cause periodic exacerbations of her neuromusculoskeletal condition. These complicating factors include advanced age, degenerative disk disease, and positive MRI findings, however chiropractic has been very effective and beneficial for her.

On August 23, 2018, Independent Medical Expert Consulting Services, Inc. (IMEDECS) reviewed Ms. P's claims for chiropractic services between August 21, 2017 and February 5, 2018.[45] The reviewer did not, however, have chart notes for the dates of service during the period of review.[46] Citing Aetna's Clinical Policy Bulletin for Chiropractic Services, the reviewer identified March 16, 2014 as the start of Ms. P's chiropractic treatment and concluded that the chiropractic records provided failed to document improvement in Ms. P's condition within the initial two weeks of care; they failed to document that treatment had been modified in the four years of treatment; and they failed to show that Ms. P had made continuous, sustained

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40 AR at 50.
41 AR at 50.
42 AR at 45 – 47.
43 AR at 47.
44 AR at 47.
45 AR at 19 – 26.
46 AR at 22.

improvement towards measurable goals in a reasonable amount of time for her condition.[47] The reviewer opined that Ms. P had reached maximum therapeutic benefit from chiropractic care for her chronic condition with no further improvement reasonably expected.[48] The reviewer thus recommended upholding the decision to deny coverage because the chiropractic care was not medically necessary.[49] Aetna notified Ms. P of the decision and her appeal rights on August 24, 2018.[50]

Ms. P filed her notice of appeal to the OAH on September 18, 2018.[51] In a letter she included with her notice, she referenced her February 18, 2018 appeal letter. She argued that she has not been given any other options to maintain her spine in its arthritic condition and stated, "At one point, our insurance coverage allowed 20 visits per year. That should be enough to meet my needs as regular adjustments keep me functioning without pharmaceutical intervention."[52]

After Ms. P filed her appeal, she provided records for dates of service from March 13, 2017 through October 1, 2018 from Ireland Clinic of Chiropractic, LLC.[53] The Division received those records on October 31, 2018.[54]

While Ms. P's appeal was pending, the Division forwarded the claims to CoreVisory for a second independent medical review.[55] The report summarizes records from July 2015 and references services for the period between March 2014 and September 2015.[56] The report does not, however, reference or identify any records for the dates at issue in this case.[57] Based on the records reviewed, the reviewer concluded:[58]

> [T]he documentation submitted does not support subsequent chiropractic services based on the policy criteria. In general chiropractic charting shows very little if any objective findings including lack of orthopedic findings and actual range of motion. There is also repetition of the modalities.
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> It is generally accepted practice that there should be objective progression with treatment. Medical necessity for treatment is not clearly documented; and clear objective improvement is not documented.

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47 AR at 23.
48 AR at 24.
49 AR at 24.
50 AR at 16 – 17.
51 AR at 2.
52 AR at 2.
53 AR at 193.
54 AR at 193.
55 AR at 195 – 203.
56 AR at 197, 200.
57 AR at 197, 200.
58 AR at 197, 200.

The reviewer recommended upholding the decision to deny coverage for chiropractic services.

An evidentiary hearing was held before the OAH on February 25, 2018. Assistant Attorney General Kevin Higgins represented the Division. The Division did not present any witness testimony, and instead, relied on the agency record, consisting of 164 pages. Ms. P represented herself and testified on her own behalf. She also presented testimony from Dr. Egeland. The agency record and all exhibits were admitted with no objections.

III. Discussion

As the party who is challenging the Division's decision, Ms. P has the burden of proof as to all factual matters in her appeal.[59] This means that Ms. P must present evidence or point to evidence already in the record showing more likely than not her chiropractic treatment was medically necessary under the terms of the Plan. Ms. P argues that chiropractic treatment is the only treatment recommended by her orthopedic surgeon that is effective in alleviating flare-ups and exacerbations of her degenerative disc disease. The Division argues that Ms. P's chiropractic treatment was not medically necessary under the terms of the Plan because although Ms. P has been receiving extensive chiropractic services for over four years, including services for multiple exacerbations of her condition throughout that time, there is no documentation of sustained improvement. At hearing, the Division explained that in its view, the Plan does not cover chiropractic services for flare-ups or exacerbations of a chronic condition. So, the issue here is whether given the facts as found in the record and at the hearing, the chiropractic services provided to alleviate flare-ups or exacerbations of Ms. P's chronic, degenerative condition were "medically necessary" within the meaning of the Plan.

The 2003 Plan booklet, as amended, explains that the Plan will cover only expenses for medical services and supplies that are medically necessary.[60] A treatment that may benefit a member or beneficiary is not always covered as medically necessary under the Plan.[61] The Plan provides two different ways to determine whether a medical service or procedure is "medically necessary." First, the Plan will consider the service or procedure medically necessary if a current *Medical and Pharmacy Clinical Policy Bulletin* published by Aetna designates the service or procedure as medically necessary.[62] This method was added to the Plan by the 2014

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[59] 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 . . .").

[60] Plan Booklet at xlii, AlaskaCare Retiree Health Plan Amendment, Number 2014-1, effective January 1, 2014, *available at* http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf.

[61] Plan Booklet at xliv.

[62] Plan Booklet at xlii.

amendments. Second, if no Aetna Bulletin addresses the specific service, the Plan provides a checklist of criteria that it will use to determine medical necessity.[63]

Here, the checklist approach is not needed because Aetna Medical Clinical Policy Bulletin 0107: Chiropractic Services addresses when chiropractic treatment is medically necessary under the Plan. The bulletin states that chiropractic services are medically necessary when:[64]

A. The member has a neuromusculoskeletal disorder; *and*
B. The medical necessity for treatment is clearly documented; *and*
C. Improvement is documented within the initial 2 weeks of chiropractic care.

The bulletin further explains:[65]

> If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified.
>
> If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered *not* medically necessary.
>
> Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.
>
> Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.
>
> Chiropractic care in persons, whose condition is neither regressing nor improving, is considered not medically necessary.
> . . .

The dispute between Ms. P and the Division is a question of contract interpretation. The Plan is interpreted in the same manner as any other insurance contract.[66] "When interpreting contracts, the goal is to 'give effect to the reasonable expectations of the parties.'"[67] Insurance contracts "are considered contracts of adhesion that must be construed to provide the coverage 'a layperson would have reasonably expected from a lay interpretation of the policy terms.'"[68]

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63 Plan Booklet at xlii – xliv.

64 Aetna Bulletin 0107 at 1, AR 112 (emphasis in original).

65 *Id.* at 1 – 2; AR 112 – 113.

66 *In re D.M.*, OAH No. 08-0153-PER at 8 (OAH 2008) (citing *Arbuckle v. State*, 941 P.2d 181, 184 (Alaska 1997)). The 2003 booklet and all amendments to the booklet adopted since 2003 can be found on the Division's website. http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf

67 *Stepanov v. Homer Elec. Ass'n, Inc.,* 814 P.2d 731, 734 (Alaska 1991).

68 *In re D.T.*, OAH No. 10-0577-PER at 2 (OAH 2011) (*quoting Whispering Creek Condominium Owner Association v. Alaska National Insurance Company*¸ 774 P.2d 176, 177–178 (Alaska 1989)); *see also Makarka v. Great American Insurance Co.*, 14 P.3d 964, 966 (Alaska 2000); *Starry v. Horace Mann Insurance Co.*, 649 P.2d 937, 939 (Alaska 1982).

When determining the expectations of the parties to an insurance contract, some special rules apply. Insurance "coverage provisions are interpreted broadly, while exclusions are viewed narrowly."[69] The doctrine of interpretation in favor of an insured's reasonable expectations "is not dependent on there being any ambiguity in the contract language."[70] But any ambiguities are interpreted in favor of the insured.[71]

There is no dispute that Ms. P meets the first requirement of medical necessity for chiropractic services. Ms. P has been diagnosed with arthritis, spondylosis, and degenerative disc disease.[72] According to the Clinical Policy Bulletin, degenerative conditions of the joints, osteoarthritis (intervertebral disc disorders of the spine such as disc protrusion, bulging, degeneration, and displacement), and spondylosis are all neuromusculoskeletal conditions commonly treated by chiropractic physicians.[73]

Likewise, the medical necessity of Ms. P's chiropractic treatment is clearly documented. Ms. P's degenerative disc disease is chronic and degenerative.[74] She is prone to relapses.[75] When she suffers a relapse, Ms. P experiences increased pain, tenderness, decreased range of motion, spinal restrictions and subluxations (i.e. points on the spine that feel stuck when Dr. Egeland touches, moves, or palpates), and muscle spasms (tightness in the muscles on touch).[76] Recognizing that Ms. P would experience relapses and exacerbations, her orthopedic surgeon, Dr. Peterson, recommended that Ms. P continue with the chiropractic traction with Dr. Egeland.[77] Because there is no way to predict when or how often she will experience a flare-up, Dr. Egeland has Ms. P on an "as-needed" treatment plan.[78]

The last requirement for medical necessity (i.e. documented improvement within the initial 2 weeks of chiropractic care) is a closer call. The requirement is ambiguous in that there is room for more than one interpretation of what constitutes "improvement." The Division argues that although Ms. P has been receiving extensive chiropractic services for over four years,

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69 *Arbuckle,* 941 P.2d at 184 n. 3; *C.P. ex rel M.L. v. Allstate Ins. Co.,* 996 P.2d 1216, 1226 (Alaska 2000).
70 *In re D.T.*, OAH No. 10-0577-PER at 2 (*citing Bering Strait School District v. RLI Insurance Company*, 373 P.2d 1292, 1295 (Alaska 1994)).
71 *In re T.O.T,* OAH No. 15-1204-PER at 5 (OAH 2016) (citing *Bering Strait School District*, 373 P.2d at 1295); *State Farm Fire and Cas. Co. v. Bongen,* 925 P.2d 1042, 1045 (Alaska 1996).
72 AR at 47, 96; Egeland Testimony.
73 Aetna Bulletin 0107 at 3, AR 114.
74 Egeland Testimony; P Testimony.
75 AR at 98.
76 *See for example* AR at 172; Egeland Testimony.
77 AR at 97; Egeland Testimony; P Testimony.
78 Egeland Testimony.

including services for multiple exacerbations of her condition throughout that time, there is no documentation of *continuous, sustained improvement*. In other words, regardless of whether chiropractic treatment *improves* or alleviates a patient's flare-up symptoms or exacerbations, the Division's position appears to be that chiropractic services are not medically necessary unless the patient's condition or symptoms are *resolved* or *continuously* improved within 30 days (or some other unidentified timeframe) of the patient's first visit to the chiropractor.[79]

The Division's interpretation is not in line with what a layperson would have reasonably expected from a lay interpretation of the policy terms.[80] There is nothing in the language of the Plan that would advise Ms. P or any other member that chiropractic services are only covered under the Plan if they will cure a condition or result in *continuous, sustained* improvement. Instead, the Division adds those qualifiers to the provision. Moreover, coverage provisions are interpreted broadly, while exclusions are viewed narrowly, and the Division's interpretation effectively carves out an exception to chiropractic services for chronic conditions.[81] It is true that chiropractic treatment will not cure degenerative disc disease, and it may not prevent all flare-ups, but the treatments do limit or reduce flare-ups for Ms. P.[82] Ms. P goes to Dr. Egeland only sporadically when she exacerbates her condition or experiences a relapse or a "flare-up."[83] The "as needed" treatment has been successful for Ms. P.[84] When she has flare-ups, she goes to Dr. Egeland for an adjustment; the adjustment relieves her symptoms; and Dr. Egeland does not see Ms. P again until she has another flare-up.[85] The records show about one to three months between Ms. P's visits to Dr. Egeland.[86] The lack of follow-up chart notes within two weeks of the initial treatment after each flare-up or exacerbation combined with an "as-needed" treatment plan are adequate information from which to infer improvement within two weeks.

In sum, the Plan does not have an exception to chiropractic services for chronic conditions. Ms. P has an identifiable neuromusculoskeletal disorder. Her doctors have

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79 "If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified. If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered *not* medically necessary."

80 *In re D.T.*, OAH No. 10-0577-PER at 2 (OAH 2011) (*quoting Whispering Creek Condominium Owner Association*¸ 774 P.2d at 177–178; *see also Makarka*, 14 P.3d at 966; *Starry*, 649 P.2d at 939.

81 *Arbuckle,* 941 P.2d at 184 n. 3; *C.P. ex rel M.L.,* 996 P.2d at 1226.

82 Egeland Testimony.

83 Egeland Testimony; P Testimony.

84 Egeland Testimony; P Testimony.

85 Egeland Testimony.

86 AR at 166 – 188; Egeland Testimony.

recommended chiropractic services in response to flare-ups or exacerbations of her chronic neuromusculoskeletal disorder. And those chiropractic services have successfully alleviated or improved her flare-up symptoms or exacerbations. Given these facts, the chiropractic services provided to alleviate flare-ups or exacerbations of Ms. P's chronic, degenerative condition were "medically necessary" within the meaning of the Plan.

IV. Conclusion

The Division's denial of claims for chiropractic services on August 21, 2017 and February 5, 2018 is REVERSED.

DATED: March 28, 2019.

By: *Signed*
Jessica Leeah
Administrative Law Judge

Certificate of Service: I certify that on March 28, 2019, a true and correct copy of this order was distributed as follows: Q P (by mail); Kevin Higgins (by email).

By: *Signed*
Office of Administrative Hearings

Adoption

This Decision is issued under the authority of AS 39.35.006. The undersigned, in accordance with AS 44.64.060, adopts this Decision 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 23rd day of April, 2019.

By: *Signed*
Signature
Jessica Leeah
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.]