STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

Docket No. 2010-42523 QHP
[redacted]

[redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on the Appellant's behalf. [redacted]il, mother, appeared and testified as a witness for the Appellant. [redacted], Paralegal for [redacted], appeared on behalf of the Department of Community Health contracted Medicaid Health Plan (MHP). [redacted], R.N. Case Manager/Hearings Coordinator, and Dr. [redacted], Medical Director, were present as witnesses for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for circumcision?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a [redacted] Medicaid beneficiary.

2. Appellant was enrolled in the Respondent MHP on [redacted], and he is still enrolled as of the hearing date. (Hearing Summary)

3. On [redacted] requested the MHP cover a circumcision procedure for the Appellant. (Exhibit C, pages 15-18)

4. The MHP utilizes the Milliman Care Guidelines for determining the medical necessity of circumcision. (Exhibit A and Medical Director Testimony)

5. On [redacted], the MHP issued a denial letter indicating the request was denied because the Milliman criteria for circumcision were not met, such as recurrent balanitis and/or failure of medical therapy, including a six week course of steroid therapy. (Exhibit B)

6. On [redacted], the State Office of Administrative Hearings and Rules received Appellant's request for hearing.

7. The MHP subsequently requested additional medical records from the Appellant's primary care physician, [redacted] Hospital. (Hearing Summary and Exhibit C, page 2)

8. Additional records were only received from [redacted] hospital, but did not change the MHP's determination that a circumcision was not medically necessary. (Hearing Summary, Exhibit C pages 3-14, Medical Director Testimony)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

On May 30, 1997, the Department received approval from the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If

new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 2.024.

Section 1.022(E)(1), Covered Services.
MDCH contract (Contract) with the Medicaid Health Plans,
October 1, 2009.

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
(e) The Um activities of the Contractor must be integrated with the Contractor's QAPI program.

(3) The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a

> health care professional who has appropriate clinical expertise regarding the service under review.
>
> *Section 1.022(AA)(1) and (2), Utilization Management, Contract, October 1, 2009.*

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent sections of the Michigan Medicaid Provider Manual (MPM) state as follows:

> **1.10 PRIOR AUTHORIZATION**
>
> Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:
>
> - Procedures identified as requiring PA on the procedure code databases on the MDCH website;
> - Procedures/items that are normally noncovered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery, off-label use drugs, etc.); and
> - Referrals for elective services by out-of-state nonenrolled providers.
>
> *Department of Community Health, Medicaid Provider Manual, Practitioner Version Date: July 1, 2010, Page 4*
> (Underline added by ALJ).

SECTION 12 – SURGERY - GENERAL

Medicaid covers medically necessary surgical procedures.

Department of Community Health,
Medicaid Provider Manual, Practicioner
Version Date: July 1, 2010, Page 60
(Underline added by ALJ).

The MHP's Medical Director testified that circumcisions are not covered if requested for personal preference. He explained that the MHP must determine medical necessity for the surgery, for which they utilize the Milliman Care Guidelines. (Exhibit A) The Medical Director testified that he has reviewed all of the documentation submitted, Dr. [redacted] office visit report and the [redacted] records, and he did not find medical necessity for the circumcision in the Appellant's case. He explained that while phimosis is noted in [redacted] office visit report, there is no documentation that conservative measures have been tried to remedy this condition. The Medical Director described conservative treatment as including cleaning, gentle retraction and application of steroid ointment. The Milliman criterion for circumcision also includes failure of a six-week course of topical steroid therapy. (Exhibit A) The Medical Director opined that surgery is not generally necessary to remedy this condition. (Medical Director Testimony)

The Appellant's mother testified that a circumcision could not be performed at birth due to swelling, which the doctors indicated would go away in about 6 months. She stated that the swelling did not go away in the expected six months. Regarding the Appellant's current condition, she indicated that the redness began not too long ago and that she steroid medication has been tried. (Mother Testimony) Unfortunately, no records of a trial of a steroid medication were provided when the MHP requested additional records from the Appellant's primary care doctor, or from [redacted]

As stated in the contract language above, MHP coverages and limitations must be consistent with Medicaid policy. The criteria used by the MHP for considering circumcision is consistent with Medicaid policy. While it may be desirable or preferred for the Appellant to have the requested procedure, Medicaid beneficiaries are only entitled to medically necessary Medicaid-covered services. See 42 CFR 440.230. The submitted medical records do not document a medical necessity for circumcision. Records documenting a trial and failure of conservative treatment can always be submitted to the MHP with a new request for this procedure.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for circumcision.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/27/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.