STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2010-45601 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], the Appellant's mother, appeared on his behalf. [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 [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] male Medicaid beneficiary.

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

3. On [redacted], the Appellant's primary care physician, [redacted], and his mother requested the MHP cover a circumcision procedure for the Appellant. (Exhibit 1, page 2; Exhibit 2, page 2)

4. On [redacted], the request was denied because medical necessity for the procedure was not established by the documentation submitted. (Exhibit 1, page 3)

5. The State Office of Administrative Hearings and Rules received Appellant's request for hearing on [redacted]

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 he reviewed the documentation submitted with the request—a history and physical report from the Appellant's physician—and he did not find any medical necessity for the circumcision. The only abnormality noted in the report was that the Appellant's testicles had not come down. However, the Medical Director opined that circumcision would not remedy that medical condition.

The Appellant's mother testified that she believes that all boys should be circumcised so that they do not contract diseases. Further, the Appellant's mother conceded that there was no medical reason for the procedure.

As stated in the contract language above, MHP coverages and limitations must be consistent with Medicaid policy. The MHP criteria used for considering circumcision is consistent with Medicaid policy. There was no evidence that the procedure requested is medically necessary. While it may be desirable or preferred for the Appellant to have the requested procedure, there is no evidence that he is currently suffering from a medical condition that must be treated with the requested procedure.

Medicaid beneficiaries are only entitled to medically necessary Medicaid-covered services. *See 42 CFR 440.230.* Because there is no medical condition warranting a need for the procedure, the MHP was proper to deny the request.

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.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/17/2010

***** 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.