

**STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

Docket No. 2010-25704 QHP
Case No. [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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held [REDACTED]. [REDACTED], the Appellant's mother, appeared on his behalf. [REDACTED], appeared on behalf of the Department of Community Health contracted Medicaid Health Plan (MHP). [REDACTED], was present as a witness on behalf of the Department. [REDACTED], was present on behalf of the Department. [REDACTED], was also present.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for circumcision?

FINDINGS OF FACT

The Administrative Law Judge, based upon 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 health plan on [REDACTED] and is still enrolled as of the hearing date.
3. The Appellant's [REDACTED] and his mother requested the MHP cover a circumcision procedure for the Appellant.

4. On ██████████, the two (2) MHP physicians reviewed the request for circumcision and the accompanying medical documentation. The request was denied as a result of determining no medical necessity for the procedure was established by the documentation submitted.
5. The State Office of Administrative Hearings and Rules received Appellant's appeal on ██████████

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.*

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.

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1.5 MEDICAL NECESSITY

Services are covered if they are the most cost-effective treatment available and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.

A service is determined to be medically necessary if prescribed by a physician and it is:

- Within applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
- Medically appropriate and necessary to treat a specific medical diagnosis or medical condition, or functional need.
- Within accepted medical standards; practice guidelines related to type, frequency, and duration of treatment; and within scope of current medical practice.
- Inappropriate to use a nonmedical item.
- The most cost effective treatment available.

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During the hearing, the Appellant's representative/mother testified that her son does not have a medical problem, but his doctor said he needs to have it to avoid diseases. She had not been given steroid cream to try on her the Appellant as of the hearing date. She did testify she can pull back her son's foreskin to clean the area but it is with some difficulty and he does not like it.

The MHP witness, [REDACTED] testified he reviewed the documentation sent. He did not find records of pathologic phimosis (obstruction). Furthermore, there was no evidence of a failed trial of steroidal cream. The MHP asserts medical necessity had not been established by the documentation submitted.

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 the procedure requested meets the criteria as medically necessary. It may be desirable for the Appellant to have the requested procedure or a preference, however, no functional limitation results by not having the procedure, nor is there medical evidence supporting a finding that he is currently suffering a disease process that must be treated with the requested procedure.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. See 42 CFR 440.230. Without medical documentation from the Appellant's physician to support the request, 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 Medicaid Health Plan properly denied Appellant's request for circumcision.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

[REDACTED]

Date Mailed: 06/04/2010

***** 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.