

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909  
(877) 833-0870; Fax: (517) 373-4147

**IN THE MATTER OF:**

██████████,

Appellant

\_\_\_\_\_ /

**Docket No.** 2014-888 QHP

██████████

██████████

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon a request for hearing filed on behalf of the minor Appellant/Petitioner.

After due notice, a hearing was held on ██████████, Appellant's mother, appeared and testified on Appellant's behalf. ██████████, Paralegal, represented UnitedHealthcare Community Plan, the Medicaid Health Plan (MHP). ██████████, Medical Director, appeared as a witness for the MHP.

**ISSUE**

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

**FINDINGS OF FACT**

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. On or about ██████████, the MHP received a prior authorization request from Appellant's doctor on Appellant's behalf for a circumcision. (Respondent's Exhibit C, pages 1-6).
2. The doctor's letter dated ██████████ accompanying the prior authorization request noted that Appellant, who was born on ██████████, was circumcised at birth, but "continues to have a redundant prepuce and his parents are unhappy with the appearance." (Respondent's Exhibit C, page 3).
3. That letter also noted that the "genitalia exam showed a very redundant prepuce giving the phallus an uncircumcised appearance. There were also circumferential penile adhesions but the phallus was otherwise normal." (Respondent's Exhibit C, page 3).

4. The letter further noted that the doctor was prescribing a topical steroid ointment for █████ weeks and that, if that treatment was unsuccessful, Appellant would be reevaluated for a possible circumcision revision. (Respondent's Exhibit C, pages 3-4).
5. According to Appellant's representative, the steroid ointment was ineffective and, consequently, the doctor made the prior authorization request for Appellant. (Testimony of Appellant's representative).
6. The MHP utilizes the Milliman Care Guidelines for determining the medical necessity of circumcision. (Respondent's Exhibit B; Testimony of █████).
7. On █████, the MHP sent Appellant's parents written notice that the request to repair an incomplete circumcision was denied. (Respondent's Exhibit A, page 1).
8. Specifically, the denial stated:

Based on review of the information provided the following determination has been made:

You asked for surgery for your child. You want a circumcision. We looked at the information that was sent to us. He did not meet the health plan rules for this surgery. Your request is denied. We did not see that there was a medical problem or that treatment for a medical problem had failed.

*Respondent's Exhibit A, page 1*

9. On █████, the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing. (Petitioner's Exhibit 1, page 1).
10. The MHP's Medical Director testified that, in reviewing this case, he believes that the penile adhesions may resolve without surgery as Appellant develops, as is common, and that there is no medical reason justifying the requested procedure. (Testimony of █████).
11. Appellant's representative also testified that there are no medical concerns behind the request and that Appellant's family wants to ensure that the circumcision is complete for reasons based on religion and appearance. (Testimony of Appellant's representative).

## **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 Michigan Department of Community Health received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified MHPs.

The Respondent is one of those MHPs and, as provided in the Medicaid Provider Manual (MPM) is responsible for providing covered services pursuant to its contract with the Department:

The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.) MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The

following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

*MPM, July 1, 2013 version  
Medicaid Health Plan Chapter, page 1  
(Underline added by ALJ)*

The DCH-MHP contract provisions also provide that the MHP may limit services to those that are medically necessary pursuant to its own prior authorization requirements, utilization management or review criteria:

#### E. Services

##### (1) Covered Services

The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee. In general, the Contractor is responsible for covered services related to the following:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity

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.

\* \* \*

AA. Utilization Management

- (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.
  
- (2) Prior Approval Policy and Procedure

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 . . .

*Contract No. 071B02000, Print Version 1/23/2013  
Article 1.020 Scope of [Services], pages 22-23, 55  
(Underline added by ALJ)*

Additionally, as stated above in both the MPM and the Department-MHP contract, whatever the prior approval procedure, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." Here, the pertinent sections of the Michigan Medicaid Provider Manual (MPM) state as follows:

### **1.9 PRIOR AUTHORIZATION [RE-NUMBERED 4/1/13]**

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 . . .

\* \* \*

### **SECTION 12 – SURGERY - GENERAL**

Medicaid covers medically necessary surgical procedures.

*MPM, July 1, 2013 version  
Practitioner Chapter, pages 4, 60  
(Underline added by ALJ)*

Pursuant to the above guidelines and contractual language, the MHP utilizes the Milliman Care Guidelines in reviewing Appellant's request and determined that the requested surgery must be denied as it was not medically necessary.

Appellant bears the burden of proving by a preponderance of the evidence that the MHP erred in denying the prior authorization request. In this case, given the above policy and the evidence found in the record, Appellant has failed to meet that burden of proof and the MHP's decision must be sustained.

The MHP's Medical Director testified that, in reviewing this case, he believes that Appellant's penile adhesions may resolve without surgery as Appellant develops, as is common, and that there is no medical reason justifying the requested procedure. (Testimony of ██████████). He also testified that it is too early to determine if Appellant's earlier circumcision is actually incomplete, but that, even if it was incomplete, the submitted documentation did not show a medical complication or problem arising from that procedure that needed to be corrected or reversed. (Testimony of ██████████).

The doctor's letter accompanying the prior authorization request briefly mentioned the penile adhesions, but also expressly stated that the surgery was to be performed because Appellant's parents were unhappy with the appearance. (Respondent's Exhibit C, page 3). Appellant's representative also confirmed that there are no medical concerns behind the request and that Appellant's family wants to ensure that the circumcision is completed for reasons based on religion and appearance. (Testimony of Appellant's representative).

[REDACTED]  
Docket No. 2014-888 QHP  
Decision and Order

As discussed above, the MHP's coverage and limitations must be consistent with Medicaid policy. Here, the criteria used by the MHP in considering request for circumcision is consistent with Medicaid policy and, pursuant to that criteria, the request was denied. While it may be desirable or preferred for Appellant to have the requested procedure, Medicaid beneficiaries are only entitled to medically necessary, Medicaid-covered services. Appellant's representative has failed to show such medical necessity in this case or meet her burden of proving that the MHP erred.

**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 prior authorization request for a circumcision.

**IT IS THEREFORE ORDERED** that:

The Medicaid Health Plan's decision is **AFFIRMED**.

*Steven Kibit*

\_\_\_\_\_  
Steven Kibit  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/db

cc: [REDACTED]

**\*\*\* NOTICE \*\*\***

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.