Claims Edit Guideline: Circumcision (Florida Medicaid)

Policy Number: HS-151

Original Effective Date: 2/4/2010


BACKGROUND

An estimated 1 million circumcisions are performed each year in the United States. The rate of circumcision began rapidly to increase prior to World War II. The percent of men circumcised increased from 34% in 1932 to 60% in 1935. In 1960, over 80% of men in the United States were circumcised. However, the percentage is now decreasing, and in 1992 the prevalence of circumcised men was estimated to be 77%. One study found that between 1987 and 1996, 37% of newborn males were circumcised during newborn hospitalization. Circumcision rates are shown to differ among racial and ethnic groups. Circumcision, in the preterm or term infant, is an elective routine procedure which this guideline does not address. However, in some males, a circumcision is performed alone or as part of a procedure to correct urethrogenital problems.\(^1\)\(^2\)

This document is based on state Medicaid guidelines and the Circumcision Policy Statement of the American Academy of Pediatrics (AAP). Both resources discuss suggested medical indications for circumcision. The most frequent indications are phimosis and paraphimosis. Phimosis is a tightness of the foreskin or prepuce that prevents the retraction of the foreskin over the glans and may cause pain with erection or during intercourse. Conversely, paraphimosis occurs when a narrow foreskin is retracted and becomes trapped behind the groove of the coronal sulcus between the shaft and the glans. This causes blood to pool in the veins behind the entrapment, leading to swelling and severe pain. Acute paraphimosis is a urologic emergency requiring reduction of the foreskin through surgical or nonsurgical methods. Recurrent balanitis and posthitis (inflammation of the foreskin), neoplasms, redundant foreskin tissue and tears in the frenulum are also medical indications for circumcision.\(^1\)

A circumcision may be performed as part of a surgical repair of congenital urethrogenital defects, most common of which is hypospadias. Hypospadias is a congenital anomaly resulting in the abnormal location of the urethral opening on the underside of the penis. Surgical repair of this condition places the urethra at the end of the penis and removes the foreskin if necessary. The foreskin tissue is sometimes used for grafting if the repair is extensive.\(^2\)

The AAP recommend that the benefits and risks of circumcision should be explained to the patient or parents of the patient and informed consent obtained.\(^1\)
POSITION STATEMENT

NOTE: This is a claims based policy and not for use by the UM team.

Applicable To:
☑ Medicaid - Florida

Circumcision, excision of post-circumcision adhesions (foreskin manipulation including lysis of preputial adhesions and stretching), and repair of incomplete circumcision are considered medically necessary when the following criteria are met:

General Criteria

- The procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member’s needs; AND,
- The procedure can be safely furnished, and no equally effective and more conservative or less costly treatment is available; AND,
- The procedure is furnished in a manner not primarily intended for the convenience or non-medically indicated desire of the member, the member’s caretaker, or the provider.

In addition, the Member must meet one of the following:

1. **Newborn (Age 0 to 3 months)**

   Circumcision in newborns (first 28 days of life) is considered medically necessary if the newborn presents with ONE of the following conditions:

   - Congenital obstructive urinary tract anomalies; OR,
   - Neurogenic bladder; OR,
   - Spina bifida; OR,
   - Recurrent urinary tract infections with the first 28 days of life.

   NOTE: Conditions justifying medical necessity in newborns are rare and are subject to individual review.

   NOTE: V50.2 - Routine or elective newborn circumcisions are NOT medically necessary.

   OR,

2. **Non-Newborn**

   Circumcision in non-newborns is considered medically necessary if one of the following conditions is present:

   - Documented vesicoureteral reflux of at least a Grade III;
     - **Grade III**: Urine backs up into the ureter and collecting system. The ureter and pelvis appear mildly dilated, and the calyces are mildly blunted.
     - **Grade IV**: Urine backs up into the ureter and collecting system. The ureter and pelvis appear moderately dilated, and the calyces are moderately blunted.
     - **Grade V**: Urine backs up into the ureter and collecting system. The pelvis is severely dilated, the ureter appears tortuous, and the calyces are severely blunted.

   Other medically necessary procedures include:
   - Lysis or excision of penile post-circumcision adhesions
   - Repair of incomplete circumcision

CODING

**Covered CPT® Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>54150</td>
<td>Circumcision, using clamp or other device with regional dorsal penile or ring block</td>
</tr>
<tr>
<td>54160</td>
<td>Circumcision, neonate - 28 days of age or less; surgical excision other than clamp, device, or dorsal slit.</td>
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CIRCUMCISION
(FLORIDA MEDICAID)
HS-151

54161 Circumcision, older than 28 days of age; surgical excision other than clamp, device, or dorsal slit.
54162 Lysis or excision of penile post-circumcision adhesions
54163 Repair incomplete circumcision

Covered ICD-10-CM Diagnosis Codes
B97.7 Papillomavirus as the cause of diseases classified elsewhere
C60.0 Malignant neoplasm of prepuce
C79.82 Secondary malignant neoplasm of genital organs
D29.0 Benign neoplasm of penis
D07.4 Carcinoma in situ of penis
N13.70 Vesicoureteral-reflux, unspecified
N13.71 Vesicoureteral-reflux without reflux nephropathy
N13.721 Vesicoureteral-reflux with reflux nephropathy without hydroureter, unilateral
N13.731 Vesicoureteral-reflux with reflux nephropathy with hydroureter, unilateral
N13.722 Vesicoureteral-reflux with reflux nephropathy without hydroureter, bilateral
N13.732 Vesicoureteral-reflux with reflux nephropathy with hydroureter, bilateral
N13.729 Vesicoureteral-reflux with reflux nephropathy without hydroureter, unspecified
N13.739 Vesicoureteral-reflux with reflux nephropathy with hydroureter, unspecified
N13.9 Obstructive and reflux uropathy, unspecified
N39.0 Urinary tract infection, site not specified
N47.0 Adherent prepuce, newborn
N47.1 Phimosis
N47.2 Paraphimosis
N47.3 Deficient foreskin
N47.4 Benign cyst of prepuce
N47.5 Adhesions of prepuce and glans penis
N47.7 Other inflammatory diseases of prepuce
N47.8 Other disorders of prepuce
N47.6 Balanoposthitis
N48.1 Balanitis
P39.3 Neonatal urinary tract infection
S30.201A Contusion of unspecified external genital organ, male, initial encounter
S30.21xA Contusion of penis, initial encounter
S30.22xA Contusion of scrotum and testes, initial encounter

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES
   Accessed March 6, 2018.

DISCLAIMER
The Claims Edit Guideline (CEG) is intended to supplement certain standard WellCare benefit plans. The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CEG. When a conflict exists between the two documents, the Member’s Benefit Plan always supersedes the information contained in the CEG. Additionally, CEGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the CEG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. All links are current at time of approval by the Medical Policy Committee (MPC). Lines of business (LOB) are subject to change without notice; current LOBs can be found at www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

Care1st Health Plan Arizona, Inc. – Easy Choice Health Plan – Harmony Health Plan of Illinois – Missouri Care – ‘Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care1st Health Plan Arizona, Inc.) – Staywell of Florida – WellCare Prescription Insurance
WellCare (Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

### MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tr>
<td>5/4/2015</td>
<td>- Approved by MPC. Clarification of age of newborn (from age 0 to 1; now reads 0 to 3 months).</td>
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<tr>
<td>9/4/2014</td>
<td>- Approved by MPC. No changes.</td>
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<tr>
<td>9/13/2013</td>
<td>- Approved by MPC. Added age criteria (item A, p. 2) per Florida Managed Medical Assistance benefits.</td>
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<tr>
<td>2/7/2013</td>
<td>- Approved by MPC. No changes.</td>
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<tr>
<td>2/2/2012</td>
<td>- Approved by MPC. No changes.</td>
</tr>
<tr>
<td>12/1/2011</td>
<td>- New template design approved by MPC.</td>
</tr>
<tr>
<td>2/4/2011</td>
<td>- Approved by MPC.</td>
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