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The Medical Director's Guide to Male Circumcision

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Medical expenses are rising faster than available resources. Consequently, there is great interest in reducing unnecessary expenses. We offer this information regarding male circumcision so that medical directors may have full information about the advisability of discontinuing coverage of male circumcision, especially that of the newborn.

There are no medical indications for circumcision of newborn infants.[1] [2] The Council on Scientific Affairs of the American Medical Association classifies neonatal male circumcision as a *non-therapeutic* procedure.[3] No disease is present in newborn male infants, so no therapeutic action is required. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, in a joint publication, *Guidelines for Perinatal Care*, have re-classified neonatal circumcision as an "*elective procedure to be performed at the discretion of the parents*."[4] [5] This re-classification removes any suggestion that newborn circumcision is a normal part of hospital routine or a medically recommended procedure. Non-therapeutic infant circumcision, therefore, is not presently the American standard of care.

A few doctors have expressed the *opinion* that there are medical or prophylactic benefits from circumcision. The medical *evidence*, however, does not support these claims. Recent evidence-based statements from the American Academy of Pediatrics,[6] the American Medical Association,[7] the American Academy of Family Physicians,[8] and the American College of Obstetricians and Gynecologists[9] firmly establish that circumcision is *not* medically necessary. All decline to recommend the procedure. All emphasize that circumcision is an *elective* procedure.

Medical societies worldwide find that the *alleged* benefits do *not* exceed the *known* risks.[10] [11] They counsel that circumcision should *not* be routinely performed, meaning that circumcision should *not* be performed without a specific medical indication.

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[1] Foetus and Newborn Committee. FN 75-01 Circumcision in the Newborn Period. *Canadian Paediatric Society News Bulletin Supplement* 1975;8(2):1-2.

[2] Committee on Fetus and Newborn: *Standards and Recommendations for Hospital Care of Newborn Infants*. Sixth Edition. American Academy of Pediatrics; Evanston, IL, 1977: 66-7.

[3] Council on Scientific Affairs, American Medical Association. Report 10: Neonatal circumcision. Chicago: American Medical Association, 1999. Available at URL: http://www.ama-assn.org/ama/pub/article/2036-2511.html

[4] American Academy of Pediatrics & American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*, Fourth Edition, 1997.

[5] American Academy of Pediatrics & American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*, Fifth Edition, 2002.

[6] American Academy of Pediatrics Task Force on Circumcision. Circumcision Policy Statement. *Pediatrics* 1999;103(3):686-93. URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;103/3/686

[7] Council on Scientific Affairs, American Medical Association. Report 10: Neonatal circumcision. Chicago: American Medical Association, 1999. Available at URL: http://www.ama-assn.org/ama/pub/article/2036-2511.html

[8] Commission on Clinical Policies and Research. *Position Paper on Neonatal Circumcision*. Leawood, KS. American Academy of Family Physicians, 2002. URL: http://www.aafp.org/policy/camp/4.html

[9] ACOG Committee Opinion Number 260: Circumcision. *Obstetrics & Gynecology* 2001; 98(4):707-8.

[10] Fetus and Newborn Committee, Canadian Paediatric Society. Neonatal circumcision revisited. (CPS) *Can Med Assoc J* 1996; 154(6): 769-780. URL: http://www.cps.ca/english/statements/FN/fn96-01.htm

[11] Beasley S, Darlow B, Craig J, *et al.* Position statement on circumcision. Sydney: Royal Australasian College of Physicians, 2002. URL: http://www.racp.edu.au/hpu/paed/circumcision/

Medical studies support removal of non-therapeutic neonatal circumcision from the schedule of covered procedures. Cadman *et al.* studied the economics of elective neonatal non-therapeutic circumcision. They found it to be uneconomic and recommend that public health care dollars not be expended on neonatal circumcision.[12] They argue that funds spent on this wasteful procedure should be spent on medically useful services. They recommend that parents bear the cost of this unnecessary elective surgery. Spilsbury *et al.* have studied the effects of insurance coverage of elective non-therapeutic circumcision.[13] They find that coverage of non-therapeutic circumcision should be discontinued to encourage parents to elect the medically preferred option of non-circumcision.

The British National Health Service stopped payment for circumcision in 1950. Canada has 13 provincial and territorial health insurance plans, eleven of which (84.6%) have dropped coverage of circumcision. New Zealand's health plan discontinued coverage over 40 years ago.

A growing number of private insurers decline to reimburse for medically unnecessary procedures such as non-therapeutic circumcision.

Congress designates federal dollars for medically necessary services.[14] The Medicaid programs of thirteen states (26%) — Arizona, California, Florida, Maine, Mississippi, Missouri, Montana, Nevada, North Carolina, North Dakota, Oregon, Utah, and Washington — have discontinued covering unnecessary non-therapeutic circumcision. California, the first, delisted circumcision in 1982; Maine, the most recent, delisted circumcision in February 2004. Other states actively are considering this move.

Based on the above, we believe that deleting coverage of non-therapeutic circumcision is a responsible and reasonable action to reduce costs. It is appropriate to shift the cost of this *elective* medically unnecessary non-therapeutic surgery and its complications to those who *elect* to have a circumcision performed.

Additional Costs

The total cost for circumcision is likely to be much higher than one would expect because, if circumcision is performed, both mother and baby tend to remain in hospital longer and consume more services.[15]

When circumcisions are performed, complications frequently occur and must be treated at additional expense. The most common complications of circumcision are bleeding and infection. Infection may be minor or major. Major infections include meningitis,[16] tuberculosis,[17] and necrotizing fasciitis requiring extensive surgical debridement of infected tissue.[18] Van Howe reported a case in which the baby was unable to nurse after circumcision, resulting in a four-day hospital stay.[19] Connelly *et al*. reported a case of gastric rupture secondary to neonatal circumcision, which resulted in a 25-day hospital stay.[20] Botched circumcisions sometimes result in cases of inconspicuous penis that require surgical attention.[21] Penile ablation is a complication of circumcision, usually treated by costly surgical reconstruction of a phallus[22] or a sex change operation with psychosexual follow-up.[23] Unfortunately, there are no data to indicate the total cost of treatment for complications of circumcision.

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[12] Cadman D, Gafni A, McNamee J. Newborn circumcision: an economic perspective. *Can Med Assoc J* 1984;131:1353-5.
[13] Spilsbury K, Semmons JB, Wisniewski ZS, Holman CD. Routine circumcision practice in Western Australia 1981–1999. *ANZ J Surg* 2003;73(8):610-4.
[14] 42 U.S.C. 1396.
[15] Mansfield CJ, Hueston WJ, Rudy M. Neonatal circumcision: associated factors and length of hospital stay. *J Fam Pract* 1995;41(4):370-6.
[16] Scurlock JM, Pemberton PJ. Neonatal meningitis and circumcision. *Med J Aust* 1977;1(10):332-4.
[17] Holt LE. Tuberculosis acquired through ritual circumcision. *JAMA* 1913;LXI(2):99-102.
[18] Bliss Jr DP. Healey PJ, Waldhausen JHT. Necrotizing fasciitis after Plastibell circumcision. *J Pediatr* 1997;31:459-62.
[19] Van Howe RS. Neonatal circumcision: associated factors and length of hospital stay (letter). *J Fam Pract* 1996;43(5):431.
[20] Connelly KC, Shropshire LC, Salzberg A. Gastric rupture associated with circumcision. *Clinical Pediatrics* 1992;31(9):560-1.
[21] Bergeson PS, Hopkin RJ, Bailey RB, *et al.* The inconspicious penis. *Pediatrics* 1993; 92:794-7.
[22] Pearlman CK. Reconstruction following iatrogenic burn of the penis. *J Pediatr Surg* 1976; 11: 121-2.

Meatitis, meatal ulceration, and meatal stenosis occur only in circumcised boys who lack the protection of the foreskin. Meatal stenosis usually requires a meatotomy. Circumcised boys also tend to be troubled with adhesions – caused by the raw residual foreskin healing to the raw glans penis – which may require a lysing.[24]

When circumcisions are avoided, these additional costs, which fall on the health insurance provider, also are avoided.

The Normal Foreskin in the Child

Many doctors see only circumcised boys and may not be familiar with the normal intact foreskin.

The prepuce of infants and children is quite different from that of adults because the penis is developmentally immature at birth. The inner surface of the prepuce is attached to the underlying glans penis.[25] The foreskin often extends well beyond the tip of the glans penis of the infant.[26] [27] The opening of the foreskin usually is narrower than the glans penis, so the foreskin cannot be retracted. The long narrow non-retractile foreskin provides certain health benefits.[28] It protects the glans penis from contact with ammonia, which is formed in wet diapers and prevents meatitis, meatal ulceration, and meatal stenosis—conditions seen only in circumcised boys. Furthermore, the narrow sphincter-like foreskin opening prevents admission of fecal material with bacteria to the vicinity of the urethra and helps to prevent urinary tract infection. A long, narrow non-retractile foreskin, therefore, is completely normal, healthy, and advantageous in infants and children.

The penis matures during the childhood and pubertal years. The inner surface of the foreskin gradually separates from the glans penis; the shaft of the penis lengthens, and the apparently excessive foreskin ceases to exist; the opening of the foreskin widens; and the foreskin becomes retractable.[29] The rule of thumb is that 50 percent of boys have a retractile foreskin by puberty, and the hormones of puberty complete the process for the majority of others. After puberty, the penis assumes its adult appearance without the need for surgery.

Redundant prepuce refers to a prepuce that someone thinks is too long. However, there is no objective standard to determine how much is too long, just as there is no objective standard to determine whether someone's nose is too long. So-called "redundant prepuce" is not a medical problem.[30]

Code Information

The medical industry provides guides for doctors to assist them in obtaining payments from health insurance providers. One such guide[31] recommends using ICD-9-CM code V.50.2 to obtain payment for circumcision. Code V50.2 is for circumcision at parental request, which denotes a circumcision in the *absence* of any medical indication. This guide also recommends the use of ICD-9-CM Code 605, which, as we indicate in the discussion above, denotes a *normal* condition in the newborn, child, and youth. ICD-9-CM Code 605 denotes phimosis, adherent prepuce, or redundant prepuce, conditions that are normal physiology in a male infant, and *do not* indicate pathology or disease.

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[23] Bradley SJ, Oliver GD, Chernick AB. Experiment of Nurture: Ablatio Penis at 2 Months, Sex Reassignment at 7 Months, and a Psychosexual Follow-up in Young Adulthood. *Pediatrics* 1998;102(1):e9.
[24] Gracely-Kilgore KA. Penile adhesion: the hidden complication of circumcision. *Nurse Pract* 1984; 9: 22-4.
[25] Deibert, GA. The separation of the prepuce in the human penis. *Anat Rec* 1933;57:387-99.
[26] Davenport M. ABC of General Surgery in Children: Problems with the penis and prepuce *BMJ* 1996;312:299-301.
[27]Camille CJ, Kuo RL, Wiener JS. Caring for the uncircumcised penis: What parents (and you) need to know. *Contemp Pediatr* 2002;11:61.
[28] Fleiss P, Hodges F, Van Howe RS. Immunological functions of the human prepuce. *Sex Trans Inf* 1998;74:364-7.
[29] Kayaba H, Tamura H, Kitajima S, *et al.* Analysis of shape and retractability of the prepuce in 603 Japanese boys. *J Urol* 1996;156(5):1813-5.
[30] Fleiss PM, Hodges FM. *What your doctors may not tell you about circumcision*. New York: Warner, 2002: 171, 199.
[31] Reimbursement adviser: how to get paid for circumcision. *OBG Management* 1993; October:25.

Current Procedure Terminology (CPT) codes also are used to obtain payment for non-therapeutic circumcision of the newborn. Codes are available for non-therapeutic procedures. The existence of these codes does not imply that the procedure is beneficial or necessary.

Code	Description
54150	circumcision, using clamp or other device: newborn
54160	circumcision, surgical excision other than clamp, device or dorsal slit: newborn
54163	repair incomplete circumcision.

The American College of Obstetricians and Gynecologists now is advising its members to use anesthetic codes to obtain payments for non-therapeutic circumcisions.[32] They specifically recommend code 00920 (anesthesia for procedures on male genitals not other wise specified) and code 64450 (injection, anesthetic agent; other peripheral nerve or branch). These codes should raise a red flag when submitted by an obstetrician.

There is no medical purpose for these procedures, which, when performed, create an abnormal physical appearance. The American Academy of Family Physicians now classifies neonatal circumcision as a "cosmetic" procedure.[33]

Recommendations

Doctors Opposing Circumcision makes the following recommendations:

1. No payment should be allowed under any circumstances for CPT Codes 54150, 54160, and 54163 because 54150 and 54160 are for non-therapeutic neonatal circumcision for which there is never a medical indication. CPT Code 54163 is a non-therapeutic cosmetic procedure to excise more tissue. (The American Medical Association describes neonatal circumcision as a 'non-therapeutic' procedure.[34])

2. ICD-9-CM code V50.2 should not be recognized as a valid diagnostic code because this is for non-therapeutic circumcision at parental request.

3. ICD-9-CM diagnostic code 605 should not be recognized as a valid diagnostic code in children because this code describes conditions that are normal prior to the completion of puberty.

4. Conservative treatment should be required prior to approval of a request for therapeutic circumcision.[35]

5. Prior approval for coverage of a therapeutic circumcision should be required. Evidence of need must be submitted with the application. Such evidence should include diagnosis of a disease and a pathologist's report on the actual existence of preputial disease (usually balanitis xerotica obliterans or BXO[36 37]). In the absence of documented evidence of disease, requests for circumcision payments should be refused.

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[32] James Scroggs. Practice Management and Coding Update. Washington: American College of Obstetricians and Gynecologists, April 2004.

[33] Commission on Clinical Policies and Research. *Position Paper on Neonatal Circumcision*. Leawood, KS. American Academy of Family Physicians, 2002. Available at URL: http://www.aafp.org/policy/camp/4.html

[34] Council on Scientific Affairs, American Medical Association. Report 10: Neonatal circumcision. Chicago: American Medical Association, 1999. Available at URL: http://www.ama-assn.org/ama/pub/article/2036-2511.htm

[35] Committee on Medical Ethics. *The law & ethics of male circumcision - guidance for doctors*. London: British Medical Association, 2003. URL: http://www.bma.org.uk/ap.nsf/Content/malecircumcision2003

[36] Rickwood AMK, Kenny SE, Donnell SC. Towards evidence based circumcision of English boys: survey of trends in practice. *BMJ* 2000;321:792-3. URL: http://bmj.bmjjournals.com/cgi/content/full/321/7264/792

[37] Spilsbury K, Semmens JB, Wisniewski ZS. *et al*. Circumcision for phimosis and other medical indications in Western Australian boys. *Med J Aust* 2003 178 (4): 155-158. URL: http://www.mja.com.au/public/issues/178_04_170203/spi10278_fm.html

6. In the alternative, claims for payment for a therapeutic circumcision must be accompanied by a pathologist's report showing disease for which circumcision is the treatment of choice, or payment should be refused in the absence of the pathologist's report of disease (BXO).

Implementation of these measures should greatly reduce the number of payments for circumcision procedures, the vast majority of which are medically unnecessary.

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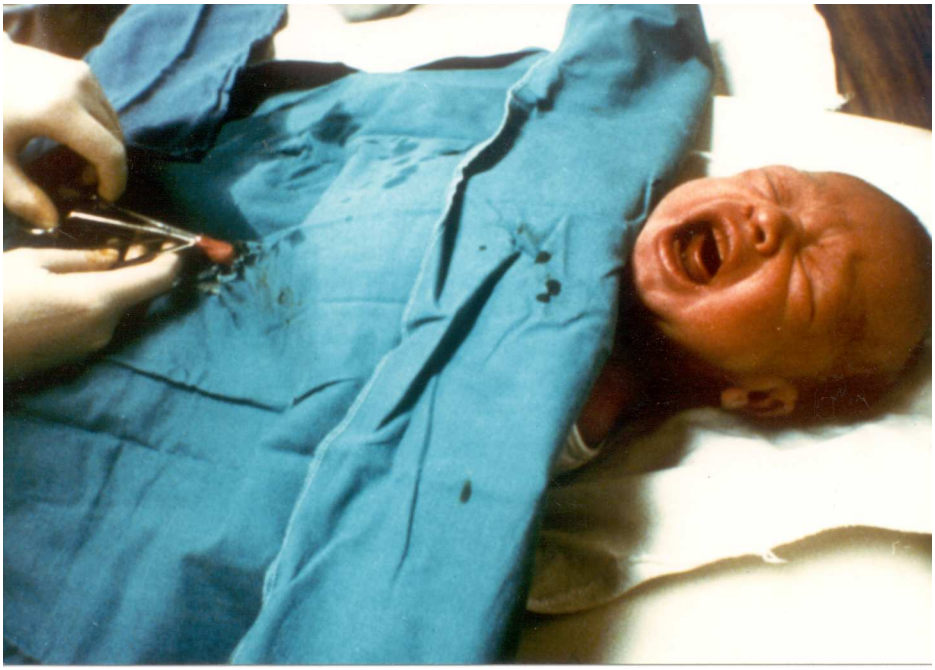

Infant boy screams in agony as doctor uses blunt probe to tear foreskin from underlying glans penis, with which the foreskin is fused at birth, prior to starting the actual circumcision.