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. The Council on Scientific Affairs of the American Medical Association classifies neonatal male circumcision as a non-therapeutic procedure. 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.” 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, the American Medical Association, the American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists 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. They counsel that circumcision should not be routinely performed, meaning that circumcision should not be performed without a specific medical indication.

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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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,\textsuperscript{16} tuberculosis,\textsuperscript{17} and necrotizing fasciitis requiring extensive surgical debridement of infected tissue.\textsuperscript{18} Van Howe reported a case in which the baby was unable to nurse after circumcision, resulting in a four-day hospital stay.\textsuperscript{19} Connelly et al. reported a case of gastric rupture secondary to neonatal circumcision, which resulted in a 25-day hospital stay.\textsuperscript{20} Botched circumcisions sometimes result in cases of inconspicuous penis that require surgical attention.\textsuperscript{21} Penile ablation is a complication of circumcision, usually treated by costly surgical reconstruction of a phallus\textsuperscript{22} or a sex change operation with psychosexual follow-up.\textsuperscript{23} Unfortunately, there are no data to indicate the total cost of treatment for complications of circumcision.

\textsuperscript{14} 42 U.S.C. 1396.
\textsuperscript{17} Holt LE. Tuberculosis acquired through ritual circumcision. \textit{JAMA} 1971;211:299-102.
\textsuperscript{20} Connelly KC, Shropshire LC, Salzberg A. Gastric rupture associated with circumcision. \textit{Clinical Pediatrics} 1992;31(9):560-1.
Meatitis, meatal ulceration, and meatal stenosis occur only in circumcised boys who lack the protection of the foreskin. Meatal stenosis usually requires a meatomomy. 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 guide31 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.

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.

<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: newborn</td>
</tr>
<tr>
<td>54160</td>
<td>circumcision, surgical excision other than clamp, device or dorsal slit: newborn</td>
</tr>
<tr>
<td>54163</td>
<td>repair incomplete circumcision.</td>
</tr>
</tbody>
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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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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.

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