Clinical Policy: Medically Necessary Circumcision

Reference Number: WNC.CP.256 Coding Implications
Last Review Date: Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Male circumcision is the surgical removal of the foreskin (prepuce), which is the layer of skin covering the head (glans) of the penis. The foreskin provides sensation and lubrication for the penis. After the foreskin is removed, it cannot be put back on.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover a circumcision for a healthy infant (**180 days or less**) while the baby is in the hospital or in an office setting for:
- **A.** Congenital obstructive urinary tract anomalies;
- **B.** Neurogenic bladder;
- **C.** Spina bifida;
- **D.** Urinary tract infections; **or**
- **E.** Prophylaxis for Human Immunodeficiency Virus (HIV).

II. WellCare of North Carolina® shall cover a circumcision for a member beyond the infant period (**greater than 180 days**) only when the procedure is **medically necessary,**.
Conditions that meet medical necessity for non-infant circumcision are:
- **A.** A documented prior history of recurrent urinary tract infections;
- **B.** Documented vesicoureteral reflux of at least a Grade III;
- **C.** Paraphimosis;
- **D.** Recurrent balanoposthitis;
- **E.** Recurrent balanitis or balanitis xerotica obliterans;
- **F.** Congenital Chordee;
- **G.** True phimosis causing urinary obstruction, hematuria, or preputial pain for a member aged **six and older**;
- **H.** Secondary or acquired phimosis causing urinary obstruction, hematuria, or preputial pain unresponsive to medical therapy;
- **I.** Condyloma acuminatum;
- **J.** Malignant neoplasm of the prepuce; **or**
- **K.** Prophylaxis for Human Immunodeficiency Virus (HIV).

III. WellCare of North Carolina® shall cover lysis or excision of penile post-circumcision adhesions when medically necessary.

IV. WellCare of North Carolina® shall cover the repair of incomplete circumcision when excessive residual prepuce remains after a previous medically necessary circumcision.

V. According to Session Law 2011-0145 Section 10.37(a) (11)(g)(2), WellCare of North Carolina® shall "**Restrict circumcision coverage to medically necessary procedures**."

Background[1]

I. Circumcision can provide the following health benefits:
- **A.** Relief from problems of irritation with the penis which can happen with or without circumcision.
- **B.** Decreased risk of sexually transmitted infections (STIs) later in life including HIV.
- **C.** Decreased risk of urinary tract infections.
- **D.** Decreased risk of penile cancer later in life.

II. The following procedures, when medically necessary, are covered only **once per lifetime**.
- **A.** Circumcision; and
- **B.** Repair of incomplete circumcision.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block
54160	Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)

CPT®* Codes	Description
54161	Circumcision, surgical excision other than clamp, device, or dorsal slit; older than 28 days of age
54162	Lysis or excision of penile post-circumcision adhesions
54163	Repair incomplete circumcision
54450	Foreskin manipulation including lysis of preputial adhesions and stretching

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original Approval date.	05/21	05/21
Changed wording from “and” to “or” in Section I. Removed periods from and added semicolons after each criteria and added the word “or” in Section II.	07/21	08/21
Reviewed CPT codes.	06/22	08/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage.	05/23	05/23
Annual Review. Removed VAB verbiage "This policy is in addition to WellCare of NC Value Added Benefit" and "WellCare of NC offers circumcision as a value-added benefit to infants up to age 6 months without regard to medical necessity or diagnosis code." Criteria I and II. Changed "newborn to infant" and "28 to 180 days." Criteria II removed "in addition to the value-added benefit above" Removed HCPCS and ICD-10 tables.	05/24	05/24
Annual Review. Removed “Medicaid and health choice” text from References. CPT codes reviewed. Under NC Guidance/Claims related information, updated state web address.		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 1A-22 Medically Necessary Circumcision. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published May 1, 2023. Accessed February 12, 2025.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary’s eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s)

shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.