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1.0 Description of the Procedure, Product, or Service

Circumcision is the surgical removal of all or part of the prepuce of the penis. Excision of penile post-circumcision adhesions is the surgical release of adhesions resulting from a previous circumcision procedure. Lysis of adhesions can also be accomplished through foreskin manipulation and stretching. Repair of an incomplete circumcision is the surgical removal of excessive residual prepuce after a previous circumcision procedure.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC 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.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term "Specific" found throughout this policy only applies to this policy)

- a. **Medicaid**
None Apply.
- b. **NCHC**
None Apply.

2.2 Special Provisions

2.2.1 [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.

b. 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: <http://www.ncdhhs.gov/dma/epsdt/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

a. Medically Necessary Circumcision for Non-Newborns

Medicaid and NCHC cover circumcision for beneficiaries beyond the newborn period only when the procedure is medically necessary. Examples of medical necessity for non-newborn circumcision include, but are not limited to, the following conditions:

1. Young males with a documented prior history of recurrent urinary tract infections.
2. Males with documented vesicoureteral reflux of at least a Grade III.
3. Paraphimosis.
4. Recurrent balanoposthitis.
5. True phimosis causing urinary obstruction, hematuria or preputial pain for beneficiaries ages 6 and older. True phimosis is defined as pathological scarring of the tip of the prepuce preventing sufficient retraction of the prepuce to visualize the meatus and does not include congenital or acquired preputial adhesions to the glans proximal to the meatus.
6. Secondary or acquired phimosis causing urinary obstruction, hematuria or preputial pain unresponsive to medical therapy.
7. Condyloma acuminatum.
8. Malignant neoplasm of the prepuce.

b. Lysis or Excision of Penile Post-Circumcision Adhesions

Medicaid and NCHC cover lysis or excision of penile post-circumcision adhesions when medically necessary.

1. Refer to **Attachment A, Section C** for the specific CPT code when adhesions are severe enough to require anesthesia or analgesia stronger than topical analgesia and an instrumented release under sterile conditions.
2. Refer to **Attachment A, Section C** for the specific CPT code if adhesions require only foreskin manipulation, including lysis of preputial adhesions and stretching.

c. Repair of Incomplete Circumcision

Medicaid and NCHC cover the repair of incomplete circumcision when excessive residual prepuce remains after a previous medically necessary circumcision.

3.2.2 Medicaid Additional Criteria Covered

a. Medically Necessary Circumcision for Newborns

Medicaid covers medically necessary circumcision for newborns. The conditions justifying medical necessity are extremely rare (i.e., certain congenital obstructive urinary tract anomalies, neurogenic bladder, spina bifida, or urinary tract infections) and are subject to individual review.

Note: “Newborn” is interpreted as the first 28 days of life.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid program does not cover routine or elective newborn circumcision. N.C. state law prohibits the Medicaid program from reimbursing for ritualistic, religious, and routine newborn circumcision.

Specific diagnosis codes do not indicate medical necessity for newborn circumcision and are, therefore, not covered under Medicaid. Refer to **Attachment A, Section B** for specific newborn non-covered diagnosis codes.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid and NCHC shall not require prior approval for medically necessary circumcision; however

- a. circumcision procedures billed to Medicaid for newborn circumcisions are subject to post-payment review.
- b. circumcision procedures billed to Medicaid for Medicaid and NCHC beneficiaries for any circumcision procedure are subject to post-payment review.

5.2 Limitations

The following procedures, when medically necessary, are covered only once per lifetime.

- a. Circumcision.
- b. Repair of incomplete circumcision.

5.3 Documentation

Medical documentation supporting medical necessity must be available to DMA or its contractual agents upon request.

When providing a medically necessary post-circumcision procedure (refer to **Subsections 3.3 and 3.4**), the date of the original circumcision must be noted in the medical record.

6.0 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 or NCHC 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.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 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 DMA'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).

7.2 Use of Anesthesia or Analgesics for the Procedure

Anesthesia or analgesia stronger than topical analgesia must be provided during the procedure when it is determined that a beneficiary meets medical necessity criteria for any of the following:

- a. Circumcision.
- b. Lysis or excision of penile post-circumcision adhesions.
- c. Repair of incomplete circumcision.

Anesthesia or analgesia stronger than topical analgesia may not be necessary for foreskin manipulation including lysis of preputial adhesions and stretching.

8.0 Policy Implementation/Revision Information

Original Effective Date: November 1, 2001

Revision Information:

Date	Section Revised	Change
07/01/2007	Throughout	Initial promulgation of Medicaid policy.
7/1/2010	Throughout	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
3/12/2012	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1A-22 under Session Law 2011-145 § 10.41.(b)
3/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Providers 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.

The following diagnosis codes do not indicate medical necessity for newborn circumcision and are, therefore, not covered.

ICD-10-CM Code(s)		
N47.0	Z37.53	Z38.61
N47.1	Z37.54	Z38.62
N47.2	Z37.59	Z38.63
N47.3	Z37.7	Z38.64
N47.4	Z38.00	Z38.65
N47.5	Z38.01	Z38.66
N47.6	Z38.1	Z38.68
Z00.121	Z38.2	Z38.69
Z00.129	Z38.30	Z38.7
Z37.0	Z38.31	Z38.8
Z37.2	Z38.4	Z41.2
Z37.51	Z38.5	Z76.2
Z37.52		

Note: This list is not all inclusive.

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.

CPT Code(s)	
54150	54162
54160	54163
54161	54450

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

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient Hospital, Outpatient Hospital, Ambulatory Surgery Center, Physician's Office.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

H. Reimbursement

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>