Texas Children's	Circumcision Guidelines	
Guideline # 6177	***Categories*** Clinical →Care Management CM, TCHP Guidelines, Utilization Management UM	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Andrea Canady

GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs authorization of all circumcisions on patients over the age of 12 months.

DEFINITIONS:

- **Balanitis xerotica obliterans** is defined as chronic sclerosis and atrophic process of the glans penis and prepuce of unknown etiology. Genetic factors have been implicated. Associated phimosis, if present, is characterized by white scarring and induration.
- **Paraphimosis** is defined as painful swelling of the glans that results when a tight foreskin is retracted behind the head of the penis. This may be a medical emergency that requires a dorsal slit procedure.
- **Phimosis** is defined as narrowing of the preputial orifice leading to non-retractability of the prepuce that in rare instances may be a congenital condition, but which is more commonly associated with balanitis xerotica obliterans or balanoposthitis.
- **Preputial adhesions** are a normal developmental process whereby the prepuce gradually separates from the glans as epithelial cell layers become keratinized and smegma is produced.
- **Posthitis** is defined as inflammation of the foreskin.

PRIOR AUTHORIZATION GUIDELINES

1. Prior Authorization is not required for circumcisions in children under the age of 1 year old.

2. All requests for prior authorization for circumcisions in children who are 1 year of age or older are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.

3. To request prior authorization for circumcision in a member over the age of 12 months, documentation supporting the medical necessity of the procedure must be provided.

4. Utilization Management professionals will reference the most recent available version of InterQual criteria to establish medical necessity for the circumcision.

5. In cases where the clinical reason for the circumcision is not clearly stated in the InterQual criteria, TCHP considers the following as indications for medically necessary circumcision:

   5.1. Phimosis:
      5.1.1. True phimosis causing urinary obstruction, hematuria or preputial pain, that has not responded to conservative treatment (e.g., trial of topical steroids)
      5.1.2. Phimosis secondary to balanitis xerotica obliterans
      5.1.3. Phimosis associated with urologic anomalies (e.g., pyelonephritis, and renal failure)

   5.2. Paraphimosis that cannot be returned to the unretracted position

   5.3. Urinary tract infection with an urological abnormality (e.g. vesicoureteral reflux)

   5.4. Balanitis and balanoposthitis (inflammation of the prepuce) unresponsive to:
      5.4.1. Use of topical antibiotics/topical steroids
         5.4.1.1. Teaching and practice of proper penile hygiene
         5.4.1.2. Improved blood sugar control if diabetic

   5.5. Gangrene, frostbite, and/or irreparable physical trauma of the foreskin

   5.6. Non-retractile foreskin due to preputial adhesions when complicated by:
      5.6.1. Posthitis
      5.6.2. Penile cellulitis
      5.6.3. Obstruction of urination (e.g., the foreskin balloons during voiding).
      5.6.4. Painful or incomplete erection

   5.7. Non-retractile foreskin due to preputial adhesions that persist beyond the 3rd birthday despite:
      5.7.1. Implementation of an appropriate regimen of penile hygiene.
      5.7.2. Trial of appropriate potency topical steroid (e.g. betamethasone)

   5.8. Revision of a prior circumcision due to inadequate removal of foreskin or correction of operative complication.

   5.9. Condyloma acuminate (HPV) confirmed by Physical Exam/testing of foreskin (prepuce).

   5.10. Radiation therapy for penile cancer

   5.11. Recurrent UTI in adolescent/adult male without any other anatomic urinary tract abnormalities identified

6. All requests for Circumcision that do not meet the guidelines referenced here will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Policy will be followed.

7. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and

exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

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Government Agency, Medical Society, and Other Publications:

- Texas Medicaid Provider Procedures Manual Accessed May 1, 2019 http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/TMPPM/2019/May_2019%20TMPPM.pdf
- American Academy of Pediatrics. Circumcision Policy Statement. Task Force on Circumcision, 2012. Available at: http://pediatrics.aappublications.org/content/early/2012/08/22/peds. Assessed September 3, 2014.
- American Urological Association. Urological Services: Circumcision. May 1989; February 2012. Available at: http://www.auanet.org/about/policy-statements/circumcision.cfm. Assessed September 3, 2014.