TAX DOLLAR FUNDING OF MEDICALLY UNNECESSARY CIRCUMCISIONS THROUGH MEDICAID

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May 8, 2001

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OVERVIEW

United States taxpayers currently fund more than 25% of all routine non-therapeutic infant circumcisions performed in this country.[1] The American Medical Association,[2] the American Academy of Pediatrics,[3] and the American College of Obstetrics and Gynecology[4] consider routine circumcision of male infants to be a medically unnecessary procedure performed for cosmetic, social, or religious reasons, and these organizations do not recommend it as a routine medical procedure.

Worldwide circumcision of the male or female genitals is rare. Routine circumcision is not performed in Europe, Australia, most of Asia, or Latin America. Eighty-five percent of the world's male population and ninety-eight percent of the world's female population are not circumcised.[5] The United States is the only country in the world that circumcises a majority of male infants for non-religious reasons. Non-religious infant circumcision in the United States persists because of medical misinformation, physician ignorance, cultural tradition, personal

motive and/or financial incentive. Although circumcision is the most commonly performed surgery on male infants in the United States, this medical procedure is rarely performed for actual medical reasons.

The International Coalition for Genital Integrity (ICGI), along with two of its member organizations, Attorneys for the Rights of the Child (ARC) and Doctors Opposing Circumcision (DOC), commenced in 1999 a survey of each state's Medicaid programs to determine if tax dollars were used to support elective, non-therapeutic circumcision (the removal of healthy, normal tissue from the penis of newborn males) for clients enrolled in their program. **The state Medicaid programs in California, Oregon, North Dakota, Nevada, Mississippi, and Washington have policies against funding circumcision unless there is a demonstrated medical need**. Consequently, no routine non-therapeutic circumcisions are funded with tax dollars in these states, saving taxpayers millions of dollars. Many taxpayers oppose the use of public tax dollars to fund a non-medical procedure, especially when numerous health needs of Medicaid children go unmet because of limited public health care funds.

A BRIEF HISTORY OF CIRCUMCISION AND MEDICINE IN THE UNITED STATES

The history of circumcision in medical practice is an intriguing study of Victorian medicine and the impact of the anti-sexuality mores of that time.[6] American circumcision began in 1870 when New York physician, Lewis A. Sayre, treated a boy for paralysis with circumcision.[7] The operation appeared to be successful. This "miraculous" response immediately instigated the circumcision procedure as treatment for all sorts of illnesses, including masturbation, epilepsy, mental illness, elephantiasis, insanity, asthma, alcoholism, hernia, premature ejaculation, penile cancer, cervical cancer, and also as a necessity for hygiene.[8] Although all of these justifications were eventually proven false, advocates of circumcision continued to promote a seemingly limitless number of pretexts for this needless genital surgery. Circumcision became firmly established in the medical community and in the American psyche as a beneficial and desirable procedure during the early to mid-twentieth century.

This relentless promotion of circumcision by the medical community led to over 50% of all newborn boys being circumcised by the 1930s; by 1970, 85% or more of newborn boys were circumcised during the neonatal period.

Current Purported Benefits of Circumcision

The potential and often disputed benefits offered for circumcision by proponents today are: a slight decrease in UTIs for babies under one year, a potential decreased risk in contracting sexually transmitted viruses, and the prevention of penile cancer. The American Medical Association in their 1999 position paper stated the following regarding these potential benefits:[9]

AMA Risk-Benefit Analysis of Circumcision

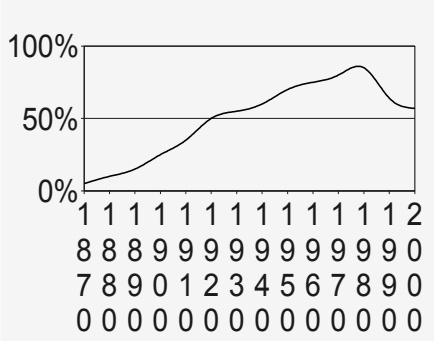
> **Urinary Tract Infection:** Despite the increased relative risk in uncircumcised infants, the absolute incidence of UTI is small in this population (0.4%-1%). Approximately 100 to 200 circumcisions would need to be performed to prevent 1 UTI. The incidence of UTI would have to be substantially higher in uncircumcised males to justify circumcision as a preventive measure against this condition.
>
> **Human Immunodeficiency Virus Infection and Sexually Transmissible Diseases:** Behavioral factors are far more important risk factors for acquisition of HIV and other sexually transmissible diseases than circumcision status, and circumcision cannot be responsibly viewed as "protecting" against such infections.
>
> **Penile Cancer:** Penile cancer is a rare disease in the United States (0.9 to 1 per 100,000). Among uncircumcised men the incidence is estimated to be 2.2/100,000. Nevertheless, because this disease is rare and occurs later in life, the use of circumcision as a preventive practice is not justified.

In 1999, the American Academy of Pediatrics (AAP), after an exhaustive review of more than 40 years of research data on the potential benefits of circumcision, issued a policy statement concluding, "these data are not sufficient to recommend routine neonatal circumcision."[10] The AAP first adopted this policy in 1971 with their

first position statement on circumcision declaring, "There are no valid medical indications for circumcision in the neonatal period."[11]

Current Circumcision Practice in the United States

While circumcision proponents continue to offer new excuses to justify genital cutting, the incidence of neonatal circumcision in the US has continued to decrease over the last two decades as national medical societies independently confirm that there is no medical justification for routine circumcision. This decline has accelerated



in recent years and continues to the present day.[12] Currently, 57% of newborn males are circumcised in the United States.[13] Circumcision rates vary widely by region: In 1997 the Midwest had the highest rates of neonatal circumcision at 81.6 %, while the Western States had the lowest rate at 38.0%.[14]

U.S. Circumcision Rate from Wallerstein & Bollinger[15]

Summary of Pertinent Medical Society Position Statements

1999 *American Medical Association*[16]

"Virtually all current policy statements from specialty societies and medical organizations do not recommend routine neonatal circumcision, and support the provision of accurate and unbiased information to parents to inform their choice."

"The AMA supports the general principles of the 1999 Circumcision Policy Statement of the American Academy of Pediatrics."

1999 *American Academy of Pediatrics*[17]

"Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision."

1996 *Canadian Paediatric Society, Fetus and Newborn Committee*[18]

"(The Committee) does not support recommending circumcision as a routine procedure for newborns."

1996 *Australian College of Paediatrics*[19]

"The Australasian Association of Paediatric Surgeons has informed the College that 'neonatal male circumcision has no medical indication. It is a traumatic procedure performed without anesthesia to remove a normal functional and protective prepuce (foreskin).' "

1996 *British Medical Association Guidelines*[20]

"To circumcise for therapeutic reasons where medical research has shown other techniques to be at least as effective and less invasive would be unethical and inappropriate."

DATA COLLECTION

Method/Type of Data Collected

During the spring of 2000, Medicaid directors whose programs fund routine infant circumcision were sent a letter from ICGI requesting the following information:

- How many males were born in 1999?
- How many circumcisions did your Medicaid program pay for in 1999 under each of the following codes: 54150 [Newborn Circumcision (age 0-1), using clamp], 54152 [Non-Newborn Circumcision (age 1+), using clamp], 54160 [Newborn Circumcision (age 0-1), surgical excision], 54161 [Non-Newborn Circumcision (age 1+), surgical excision]?
- Of those infants circumcised, how many received anesthesia in the form of a penile nerve block? What was the cost per infant?
- How much does your program reimburse per infant circumcision for each of the following codes: 54150, 54152, 54160, 54161?

In the fall of 2000, ICGI sent follow-up letters to the states, requesting information on how much each Medicaid program spent on facility fees (payments to hospitals, free-standing ambulatory centers, and clinics). The results of these data collections can be seen in appendix "B" below.

Roadblocks to Data Collection

While some states such as **Colorado, Florida,** and **Wisconsin** promptly and efficiently responded with the information entitled under the Freedom of Information Act, other states refused to respond, requested prohibitive fees, or failed to provide complete data.

South Carolina: Charles M. Black, Jr., Assistant General Counsel, replied that South Carolina required a $250 payment before providing the requested data. South Carolina Medicaid promptly responded to the Attorneys for the Rights of the Child (ARC) response to this cost-prohibitive request, and mailed the requested data, accompanied with a note stating that the actual cost of gathering this data was $6.03.

South Dakota: South Dakota refused to release any information and responded that, “The State of South Dakota does not have a statutory mandate comparable to the federal Freedom of Information Act (FOIA). The release of our public records and files is governed by South Dakota Codified Laws (SDCL), chapter 1-27, particularly SDCL 1-27-1.” Anthony M. Sanchez, Assistant Attorney General, added, “Moreover, the state is not required to create records which do not already exist, such as summaries.” Mr. Sanchez did confirm that their non-confidential public records were “open to inspection by any person during normal business hours.” Two ARC representatives traveled to the South Dakota Medicaid office to obtain the Medicaid data in person. Mr. Larry Iverson orally dictated responses to the original Medicaid survey questions submitted by ICGI to the ARC representatives. No written information was provided to ARC or to ICGI.

Arkansas: After numerous letters, phone calls, and faxes from ICGI and ARC, Arkansas refused to provide the data requested. In a letter from Dr. McGhee to ARC, she states, “The Freedom of Information Act applies only to requests from within the state of Arkansas.” ARC wrote a letter disputing this, to which ARC received the following reply from Judy Besancon, Office of Chief Council, dated March 9, 2001, “The information you request must be generated by a 'special' report. The cost for using a programmer will be $90 per hour. The estimated programmer time spent on this project is six to eight hours. After this is completed, the actual document would then cost 25 cents per page for copying. The number of pages is unknown until the report is run.”

Considering that 36 states easily provided the requested data on a one-page report submitted to either ICGI or ARC, and three states ran a one-page report for a nominal fee, the estimated fee of $540 to $720 was determined to be an excessive and prohibitive cost that was out of line with all other state Medicaid agencies. Arkansas was

originally sent the survey questions on March 14, 2000 and a year later they requested exorbitant fees for public information. Unfortunately, due to time constraints for the completion of this report, ARC was unable to pursue this last-minute roadblock erected by Arkansas.

Non-Compliant States

The following states failed to comply with the requests for Medicaid data by the survey-ending deadline of March 16, 2001: **Arkansas, Hawaii, Maryland,** and **Tennessee**. A minimum of one letter from ICGI, one certified letter, return receipt requested, from Attorneys for the Rights of the Child (ARC), and several follow-up phone calls from ARC, were sent or made to each of these states. All states were given between 6 and 12 months to comply with the Freedom of Information Act that allows public access to this type of public health data.

Observations and Notes about Directors' Responses

Response from States that Fund Routine Infant Circumcisions

Surprisingly, a large number of directors reported that they fund routine circumcision specifically for cosmetic, social, and cultural reasons. Government funding of any other medically unnecessary cosmetic procedure is virtually non-existent. Infant male circumcision is unique in this regard. According to the Medical Director of **Maine** Medicaid, Dr. Timothy S. Clifford, Jr., "Although we are in agreement that routine circumcision is not medically indicated this is one area where there is a very strong interaction between cultural expectations existing [sic] influence upon community medical practices. In this case, [we] prefer to allow the medical community and the parents to gradually move towards the apparent new standard of care, which is routine non-circumcision." Michael Deily, Director of **Utah** Division of Health Care Financing, replied, "The American Academy of Pediatricians has recently released a new position statement against routine circumcision, we will expect to see a significant and gradual decline in expenditures for this procedure as individual physicians and families become aware of this information. In light of the Medical Care Advisory Committee's position, we prefer this natural decline rather than abrupt cessation of payment for a common and accepted medical practice." **Hawaii** justified its use of tax dollars to fund medically unnecessary circumcisions by stating, "The Hawaii Medicaid program believes that the decision of whether a newborn circumcision is performed should take into account cultural, social, as well as medical issues." **New Mexico** also noted the importance of cultural factors in covering this service. Ross Becker, Acting Division Director, stated, "The New Mexico Medical Assistance Division (MAD) appreciates the AAP noting cultural, religious, and ethnic traditions as factors to consider when parents are making their decision. New Mexico is a culturally diverse state where this issue may have significant importance, either pro or con, for some families." **Wisconsin** also justified coverage for cultural reasons: "Poverty should not be the determining factor in determining whether or not children can be reared in an environment that respects their cultural heritage. " **Texas** in acknowledgment that coverage for infant circumcision is performed mostly for non-medical reasons reported, "Circumcision is a benefit of the Medicaid Program only for clients under one (1) year of age. Routine circumcision for clients more than one (1) year of age is not a benefit of the program. If the client is more than one (1) year of age, Medicaid will cover the procedure only for medical reasons." Many other states justified coverage simply because circumcision has been a common practice for years. According to the Commonwealth of **Virginia**, "The procedure to which you refer is routinely done at birth and has been a standard of practice for decades. "Most noteworthy was **Oklahoma's** inconsistent circumcision coverage policy. While Oklahoma spent $650,000 in 1999 for circumcisions for non-HMO Medicaid clients in 1999, Lynn Rambo-Jones, Deputy General Counsel of the Oklahoma Health Care Authority, advised that regarding Medicaid recipients served by HMOs, "Several of the HMOs have determined that circumcision is not medically necessary and do not cover it as a routine service."

Response from States that Do Not Fund Routine Infant Circumcisions

Responses from states that do not fund routine infant circumcisions gave medical observations that were in stark contrast to the responses received from states that do fund routine circumcisions. **North Dakota** Director David Zentner explained his state's decision to not fund non-therapeutic circumcisions, "The North Dakota Medicaid Program has not reimbursed for routine circumcisions since 1991. Payment will be made only if it can be demonstrated to our medical consultant that the procedure was medically necessary for a specific medical condition. Payment for medically necessary circumcisions is rare." (See Appendix A.)

The Double Standard for Allowance of Cultural or Religious Considerations

There is a double standard regarding cultural or religious considerations for Medicaid funding of the removal of healthy genital tissue in children. No Medicaid program in the United States funds the removal of healthy genital tissue from female infants, regardless of the parents' cultural beliefs, which may include religious preferences for female circumcision. However, many Medicaid programs justify spending taxpayer dollars allotted for the needed health care of disadvantaged children to fund the cultural and sometimes religious procedure of male circumcision. The United States government in effect funds a religious cultural practice of some groups. Government funding of non-therapeutic circumcision represents a clear discrepancy between the fundamental principles of separation of church and state.

DATA COLLECTION SUMMARY

Data from Reporting States

The states of **Alaska, Arizona, Colorado, Florida, Idaho, Illinois, Iowa, Louisiana, Maine, Michigan, Minnesota, Missouri, New Hampshire, North Carolina, Texas, Utah, West Virginia, Wisconsin**, and the **District of Columbia** all promptly provided the Medicaid survey information upon request. The states of **Alabama, Connecticut, Indiana, New Jersey, New Mexico, New York, Ohio, Pennsylvania, South Carolina, Vermont**, and **Virginia** did not initially respond to one to two letter requests from ICGI, but promptly provided information when requested by the attorney's group, ARC. **Georgia** provided the requested information after an ARC payment of $45, and **Kansas** provided data after an ARC payment of $55. After several letters and numerous follow-up phone calls, the states of **Delaware, Kentucky, Massachusetts, Montana, Nebraska, Oklahoma, Rhode Island,** and **Wyoming** provided the data to ARC. **South Dakota** never provided the data in writing, but did orally dictate their responses to ARC representatives that traveled to their Medicaid office.

State Medicaid spending varies widely. Some states spend as little as a few thousand dollars while other states spend well over a million dollars per year. The actual Medicaid population of the state does not seem to be a significant factor in amount of spending. The average spending per state was over half a million dollars. The data clearly indicate that the circumcision rate is higher in states that reimburse a higher physician fee. Of the 36 states for which the annual Medicaid circumcision percentage rate could be determined, the circumcision rate in states that paid doctors less than $50 was 21.56%. In states that paid doctors more than $60, the circumcision rate nearly

STATES	FEE	# of Births	# of Circumcisions	Circumcision %
CT, IA, MO, NJ, NY, VT, CO, DC, NE	< $50	106,080	22,876	21.56
KS, ME, MN, MI, SD, TX, WI, WY	> $50 < $60	143,336	39,597	27.62
AL, AK, DE, FL, GA, ID, IL, IN, KY, LA, MA, MT, NH, NM, NC, OH, OK, PA, SC	> $60	304,425	115,805	38.04

doubled to 38.04%. These figures only represent circumcisions the Medicaid offices reported to have paid for in 1999.

The data collected from reporting states shows the total minimum expenditures for circumcision in these states to be $20,361,154. This figure is just the tip of the iceberg, as it was calculated almost exclusively from the fees paid to the physician, and does not account for related expenses (see "Additional Cost Factors" below).

Lack of Data from Non-Reporting States

Arkansas, Tennessee, Maryland, and **Hawaii** failed to provide the requested information. Each of these states received between 6 to 12 months to respond to the Medicaid information request, which consisted of several written requests and numerous phone calls to the state's Medicaid director.

ADDITIONAL COST FACTORS

In addition to the fees paid directly to physicians to perform the circumcision procedure, the following items significantly increase the annual cost of circumcision to Medicaid—and ultimately, to the American taxpayers:

Facility Fees

With the exception of **Florida, Louisiana,** and **Illinois**, the calculated state spending did not take into account the state's Medicaid program total expenditure on facility fees. This cost was difficult to determine for most states. There is no separate fee billed to Medicaid for circumcisions performed immediately following birth in the hospital because circumcision is included in the hospital's DRG (Diagnostically Related Group) fee. Medicaid pays a separate hospital or facility fee if the circumcision is performed after the newborn is initially released from the hospital.

It is impossible to accurately determine which circumcisions include a separate facility fee billing. Circumcisions performed after the immediate hospital stay following birth significantly add to the total expenditure. **South Carolina** pays an additional $570 facility fee per outpatient circumcision, while **Minnesota** pays a facility fee varying from $288.32 to $803.23. **Illinois** spent $475,255 in circumcision-related hospital fees for fiscal year 1999, and **Louisiana** reported spending $4,108,521 on facility fees for inpatient circumcisions and $272,301 on fees for outpatient circumcisions between July 1, 1999 and June 30, 2000. **Louisiana** spent a four times greater amount on facility fees than on physician fees for circumcisions performed under Medicaid.

Anesthesia

Following the AAP and the AMA's strong mandate in 1999 that analgesia for routine circumcision is "essential," analgesia use is increasing substantially. In some states, like **Indiana**, the doctor bills analgesia/anesthesia separately. Other states include analgesia/ anesthesia in their DRG (Diagnostically Related Group) payments. **Louisiana** spent $121,695.29 on anesthesia in 1999. Very few states could provide specific figures for the amount they spent on anesthesia. The growing increase in anesthesia use will continue to increase the overall circumcision reimbursement fees requested from Medicaid.

Supplies

Circumcisions require standard surgical supplies: sterilized tools, Circumstraint boards, clamps and/or Plastibells, antiseptics, syringes, gauze pads, etc.

Non-Physician Staff Salary

The cost of nursing assistance or technician assistance is paid by salary. Therefore non-physician staff does not increase the overall circumcision procedure costs. Nonetheless, the time nurses and technicians spend prepping

the patient, cleaning up after the surgery, caring for the patient, and treating the wound could be spent more cost effectively on other tasks.

Managed Care Enrollment

Data on the amount HMOs and managed care plans that serve Medicaid patients spend on circumcision was unavailable for most states responding to the survey. (**Iowa** did provide HMO data.) Many states have enrolled some or all of their Medicaid recipients into managed care plans, while other states do not have any recipients enrolled privately. Circumcision costs were unable to be calculated for **Arizona** because almost all of their Medicaid recipients are enrolled in an HMO. **Pennsylvania** noted, "About 55% of Medicaid recipients are enrolled in managed care." **Utah** reported "45% of all births being in HMOs." Too little data was received to determine the true percentage of Medicaid recipients enrolled; however, it appears that in many states half or more recipients are enrolled privately. A two-fold enrollment factor, which seems to be indicated by several states' HMO enrollment numbers, would double the figures calculated for what Medicaid currently pays for circumcisions.

Treatment of Complications

Medicaid programs that fund routine non-therapeutic circumcision automatically incur additional medical expenses for the treatment of complications that often result from neonatal circumcisions. While the incidence of complications is controversial and dependent upon the definition of a complication, complications do commonly occur. Gracely-Kilgore (1984) reported a 15 percent complication rate from adhesions alone. Williams & Kapila (1993) in a survey of medical literature more-conservatively estimated a significant complication rate of 2-10%.[21] None of the complication studies considers psychological complications or later sexual impairment.

The most common complications are bleeding or hemorrhage. The prepuce is highly vascularized[22,23,24] to support its neurological sensory and erogenous functions and hemorrhage can easily occur in this area.

Infections of the open wound, ranging from trivial to life threatening, are also common. Case reports include tuberculosis,[25] meningitis,[26] staphylococcus scalded skin syndrome,[27] Fournier's gangrene,[28] and other forms of sepsis.

Surgical mishaps are also common. Case reports include amputation of the glans penis,[29] urethral fistula,[30] and total loss of the penis.[31] It is estimated that more than 200 infants per year die from circumcision related complications.[32,33] The actual mortality rate from circumcision complications is unknown since deaths are usually classified under the actual complication that causes the death, such as anesthesia reaction or widespread sepsis caused by infection at the circumcision wound site.

MEDICALLY UNNECESSARY CIRCUMCISIONS AFTER THE NEWBORN PERIOD

While the scope of this report is primarily focused on routine "non-therapeutic" circumcisions in the neonatal period, state spending on all circumcisions performed is included in this report's total of Medicaid expenditures for male circumcisions. A majority of the post-neonatal circumcisions performed during childhood and adolescence under the Medicaid program are for improper diagnosis of foreskin "problems" that do not exist. In the rare instances of true pathological conditions of the foreskin, circumcision is often erroneously and aggressively utilized as a first course of treatment when highly effective and less expensive non-surgical treatments are more appropriate and readily available.

Criteria for Medically Indicated Surgery

According to the Heath Care Financing Administration (HCFA), a medically indicated circumcision requires a patient complaint, a diagnosis of a pathology or of a physical abnormality, and the most conservative effective treatment for the diagnosed condition must be utilized.[34]

Routine circumcision does not meet the criteria for a medically necessary surgery because there is no documented pathology, physical abnormality, or complaint on the part of the patient. Therefore, routine circumcision is non-therapeutic. In their latest statement, the American Medical Association says, "The term 'non-therapeutic' is synonymous with elective circumcisions that are still commonly performed on newborn males in the United States."

Fraud and Abuse

The amputation of the prepuce and its subsequent disposal makes verification of disease impossible. Medicaid must rely solely on the doctor's report and evaluation. Circumcision is uniquely prone to fraud and abuse and rigorous controls are needed to prevent fraudulent claims.

Male circumcision is traumatic, destructive, removes erogenous protective tissue, and therefore is not in the best interest of the patient. Male post-neonatal circumcision should not be covered by Medicaid except in strictly medically necessary circumstances.

Common Reasons Inappropriately Used to Justify Circumcision after the Neonatal Period

Circumcision is inappropriately used after the neonatal period to treat several conditions that either do not constitute a physical problem or can be easily and effectively treated with less invasive means. Circumcision is not necessary or desirable for the following conditions listed:

Social Factors

Parents report that some medical professionals recommend circumcisions without medical indication so that their intact children will resemble their peers. Immigrant families who do not typically circumcise in their culture most often experience this recommendation for social reasons.

Phimosis

Medical doctors in the United States receive little or no education about the structure, functions, development, and care of the normal intact penis. Consequently, some American physicians may diagnose a problem that simply does not exist. The non-retractile foreskin is normal in childhood, and becomes retractable with increasing maturity, usually requiring no treatment other than reassurance to the parents that normal development is in process.[35] The American Academy of Pediatrics guidelines state the foreskin may not retract until age 18.[36]

Unfortunately, some American physicians, relying on inaccurate data, recommend a circumcision for a preschool or elementary age child with a non-retractile foreskin. The early retraction figures provided by Gairdner[37] in 1949, which Wright (1994)[38] says are inaccurate, were taught to many currently practicing doctors in medical school. Consequently, many of today's medical professionals confuse normal penile development conditions with pathological conditions.

Øster (1968)[39] and Kayaba (1996)[40] provide more accurate data. According to Øster, 23% of boys in the 6-7-year-old age group have fully retractable foreskins. By age 10-11, this increases to 44%; in the 14-15-year-old group, 75% are retractable, and in the 16-17-year-old group, 95% are retractable. Kayaba's figures are similar. Kayaba found that 16.7% of 3-4-year-old boys had fully retractable foreskins. In the 11-15 age group, this figure had increased to 62.9%.

Balanitis Xerotica Obliterans (BXO)

Phimosis caused by balanitis xerotica obliterans (BXO) is recognizable by a whitish ring of indurated tissue near the tip of the foreskin, and the resulting constriction prevents foreskin retraction. This diagnosis is confirmed by pathological examination. Phimosis caused by BXO is often treatable without surgery, but there may be an

indication for post-neonatal circumcision.[41] BXO, however, is an uncommon condition affecting only 0.6 of 1% of boys by their 15th birthday.[42]

Non-Surgical Standard of Treatment of Foreskin Pathologies

Adult Phimosis

If a healthy non-retractile foreskin (without a diagnosis of BXO) causes problems, retraction usually is achieved by topical treatment with steroid ointment (betamethasone valerate 0.05% or clobetasol proprionate 0.05%) for 30 to 60 days.[43,44,45] This treatment is 85% effective.[46] [47]

The remaining 15% can be treated by preputioplasty.[48] The dorsal slit with transverse closure has been demonstrated to be safe and effective.[49,50] The newer lateral preputioplasty offers the same benefits, and claims better cosmetic results.[51] Preputioplasty offers less morbidity, trauma, and discomfort, with easier recovery, and significant cost reduction than circumcision.[52] The preservation of the foreskin prevents meatal stenosis.[53] A circumcision for phimosis is only medically indicated after all other less invasive treatments have been tried.

Recurrent Balanitis

Physical trauma, irritants, excessive washing, soap, or infection with pathogenic organisms cause balanitis (inflammation), which may be protozoal, fungal, viral, bacterial, or amoebic in nature.[54] The causative factor may be difficult to diagnose. Escala & Rickwood[55] recommend taking a swab; Birley[56] and Edwards[57] recommend a biopsy.

The correct diagnosis of the causative factor determines the appropriate treatment. If balanitis is caused by trauma such as "foreskin fiddling" or by premature forcible retraction, the traumatic action should be stopped. If the use of soap or other irritants causes balanitis, washing with soap should be stopped and the irritant avoided.[58] If balanitis is caused by infection, the appropriate drug should be selected to fight the specific infectious organism.[59] The proper treatment is medical, not surgical.[60] The foreskin should be left in place so that its protective effect may aid in the treatment.

Escala & Rickwood advise circumcision of boys *only* "after recurrent attacks of balanitis which cause *appreciable* discomfort" [emphasis added].[61] Birley and colleagues hesitate to recommend circumcision except in cases of plasma cell (Zoon's balanitis) and lichen sclerosis, but state that it may be helpful if the balanitis is recurrent.[62] They note, however, that several of their balanitis patients were circumcised men, demonstrating that circumcision did not prevent balanitis. Edwards recommends circumcision only when the balanitis is Zoon's balanitis or the balanitis of Queyrat.[63] Circumcision may not reduce the incidence of balanitis in boys. Preston states, "[b]alanitis is uncommon in childhood when the prepuce is performing its protective function."[64] Van Howe found *increased* balanitis in circumcised boys rather than in intact non-circumcised boys.[65]

There is absolutely no proof that circumcision for balanitis is an efficacious treatment. The proper treatment is accurate diagnosis of the cause of the inflammation with the aid of cultures and biopsies. After the etiology of the balanitis is determined, irritants can be eliminated and/or the proper treatment can be provided.

Medicaid should pay for a circumcision for recurrent balanitis only after the conditions outlined above have been met.

Valid Indications for Post-Neonatal Circumcision

The following rare conditions may indicate treatment with circumcision:

Yeast infections with diabetes mellitus

Non-circumcised males with diabetes mellitus tend to have yeast infections under the foreskin caused by high sugar content in the urine. Careful control of blood sugar can help to reduce these infections, as will ingestion and the application of

Acidophilus culture.[66] "Circumcision may be medically indicated in some very rare instances for individuals suffering from chronic, frequent yeast infections, when all other less invasive treatments have failed."

Frostbite

If the foreskin is frostbitten to the point of necrosis, partial or full amputation may be required.

Gangrene

Individuals with diabetes or chronic alcoholism have been known to have circulatory problems that result in gangrene of the foreskin. Circumcision is indicated in this rare condition.

Malignancy

Should malignancy develop on the foreskin, circumcision would be indicated. Such malignancies are extremely rare.

MEDICAID'S PROMOTION OF MEDICALLY UNNECESSARY TREATMENT FOR MEDICAID CLIENTELE

A recent study in *Pediatrics* concluded that physicians significantly underinformed parents regarding the risks and benefits of routine non-therapeutic circumcision.[67] This study found that nine out of ten parents were not given adequate information, and some male infants are being circumcised without parental consent or knowledge. This is especially true for economically or educationally disadvantaged parents. The American Academy of Pediatrics stresses in their current 1999 policy statement that "Physicians counseling families concerning this decision should assist parents by explaining potential benefits and risks, and by ensuring that they understand circumcision is an elective procedure."

Circumcision is perpetuated by the lack of accurate information offered to parents by medical professionals, as well as by the "tacit" approval Medicaid (and some private insurance companies) inadvertently give towards routine infant circumcision by unquestioningly funding this elective, medically non-indicated procedure. Subtle or unintended "endorsement" for this procedure is strongly opposed by the AAP in its policy statement, "Parents should not be coerced by medical professionals to make this choice."

Unfortunately, many Medicaid recipients may interpret Medicaid payment of circumcision as a Medicaid and government endorsement of circumcision. Just as Medicaid mothers believe that routine vaccinations and regular pre-natal care (covered Medicaid services) are necessary and important for their child's health, it would be natural for them to conclude that, if Medicaid covers circumcision, it must be medically beneficial and necessary for the health and well-being of their child.

The geographical region in which the child is born has little to do with the circumcision decision. The Medicaid data presented in this report show, however, that reimbursement allowances are a significant factor in whether or not a child born under the Medicaid program will be circumcised. A Medicaid child born in a state that pays a physician a higher fee to circumcise is almost twice as likely to have his foreskin removed than a Medicaid child that lives in a state where the Medicaid reimbursement for circumcision is low.

REMOVING SERVICES AND CHOICE FOR THE POOR

Some advocates for the poor have argued that eliminating Medicaid coverage for routine circumcision will take away choice options for poor parents. The removal of Medicaid funding will not take away a parent's choice to circumcise. The AAP and the AMA maintain a parent's proxy right to elective circumcision of male children for "cultural, religious, or ethnic traditions." Medicaid tax dollars should not be used to fund a cultural, religious, or ethnic tradition, especially when those same funds are so desperately needed for the actual medical

requirements of children in the United States. Parental option is not removed with the elimination of Medicaid funding since infant circumcision costs are not prohibitive (the average Medicaid payment is $81). However, many children in need of medical care lose the option to receive proper care when Medicaid cuts funding for important services, while maintaining coverage for medically unnecessary services. Unless there is a diagnosed medical need, Medicaid funds should not be used to cover cosmetic preferences or religious choices of parents, regardless of their economic circumstance.

Contrary to some fears, Medicaid parents would not lose needed benefits in the removal of circumcision coverage because more Medicaid funding would become available for the actual medical needs of their children. For example, **North Carolina** currently spends $1.3 million per year funding medically unnecessary circumcisions, yet legislators are currently considering dropping other "optional" services such as coverage for eyeglasses, dental care, and prescription drugs for Medicaid recipients.[68] Furthermore, **North Carolina** is in need of an additional $8 million to provide health insurance for the 10,000 poor children estimated to be on their waiting list by June, 2001.[69] Many needy children go without any health insurance while parents are provided government funding for a cosmetic procedure performed for cultural and sometimes religious reasons. Budget shortfalls in many states are forcing Medicaid programs to consider the elimination of coverage for important, medically beneficial services.

Many Medicaid parents currently are uneducated about the inherent risks of circumcision and the protective and sensory functions of the foreskin. Medicaid parents are often reluctant to ask questions or to question the authority of medical professionals, and many are inclined to sign a consent form because they assume circumcision is medically necessary.

One strong factor affecting Medicaid circumcision rates has nothing whatsoever to do with the parents wishes: the amount of government money the doctor is paid to perform the surgery. States that pay doctors over $60 report almost twice as high a circumcision rate as states that pay less than $50. (The circumcision rates in these states do not reflect the regional trends in circumcision rates.) By discontinuing Medicaid coverage of medically unnecessary circumcisions, Medicaid parents will be afforded the opportunity to understand that circumcision is not recommended by any national or international medical organization in the world, and they will not feel institutional pressure to have their sons circumcised.

SUMMARY OF MEDICAID SPENDING

According to data supplied by HCIA-Sachs for 1999, Medicaid paid for 310,403 circumcisions in the United States.[70] The current 1999 AAP Circumcision Policy Statement states, "It is estimated that 1.2 million newborn males are circumcised in the United States annually at a cost of between $150 and $270 million."[71] These figures are conservative, not taking into account facility fees, fees used to correct complications, etc. The United States taxpayers are currently funding more than 25% of all medically unnecessary newborn circumcisions through the Medicaid program at an estimated cost to US taxpayers of $39 to $70 million a year. In the southern region of the United States, the Medicaid program funds more than 40% of all newborn circumcisions.

The AAP also states that circumcision is extremely painful and therefore it is "essential" that pain relief be provided, and this new mandate will increase circumcision costs. Considering that the US government funds more than 25% of all circumcisions, the current level of expenditure in the United States for circumcision is alarming, especially when routine infant circumcision is not recommended by any medical organization in the United States. In their position statements, both the AAP and the AMA highlight the fact that "a number of medical societies in the developed world have published statements that do not recommend routine circumcision of male newborns."

This survey accounted for 183,817 Medicaid covered circumcisions, costing taxpayers a minimum of $20,361,500 in 1999. According to HCIA-Sachs there were a total of 310,403 Medicaid paid circumcisions in

1999 performed in hospitals. From this, we can extrapolate minimum nationwide Medicaid payments of $34,680,406 for 1999.

CONCLUSION

The United States Medicaid program currently funds more than 25% of all routine infant circumcisions performed in the United States (1999) despite recent policy statements by the American Academy of Pediatrics and the American Medical Association that do not recommend this procedure. Many American taxpayers are increasingly concerned that the US Federal and State governments continue to fund this non-therapeutic elective procedure when currently many economically deprived children's health-care needs go unmet. Many states provide inadequate coverage in health-care services to poor children, and currently seek additional health care cuts in Medicaid, while the promotion and performance of non-therapeutic circumcision continue unabated.

Some states (**California, Mississippi, Nevada, North Dakota, Oregon,** and **Washington**) have already discontinued circumcision funding, saving their state taxpayers millions of dollars. HMO plans in other states (such as **Oklahoma**) have discontinued coverage for circumcision for Medicaid recipients, and many state Medicaid agencies and legislatures are currently looking into whether or not they will continue to provide coverage for routine "non-therapeutic" circumcisions. There is currently a bill under consideration in the **Michigan** legislature to cease Medicaid funding for circumcisions.

In 1999, 43% of parents chose not to have their male infant circumcised.[72] Many Americans are now opposed to routine infant circumcision, as is evident in the proliferation of organizations in America devoted to ending this practice. Their concerns are supported by numerous national medical organizations in the United States and worldwide who deem this traumatic and diminishing genital surgery on male infants to be unwarranted.

Tax paying US citizens who are morally, ethically, and culturally opposed to the non-therapeutic routine circumcision of male children should not have to pay for medically unnecessary circumcisions. Medicaid pays for 25.9% of these circumcisions annually, at a cost to US taxpayers of a minimum of $35 million a year. Medicaid should not utilize taxpayer dollars to fund procedures that are not recognized by the overall medical community as offering a significant health benefit, regardless of the current standard of practice in medicine, or of the cultural or religious preference of the parent requesting this non-therapeutic, elective procedure. Tax dollars that fund Medicaid programs should be directed solely to necessary medical services desperately needed by all children in the United States and not wasted on medically unnecessary circumcisions of male children.

APPENDIX A: LETTER FROM NORTH DAKOTA

North Dakota Department of Human Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505-0250

May 3, 2000

Rio Cruz, PhD, and John W. Travis, MD, MPH
Executive Co-Directors International Coalition for Genital Integrity
PO Box 8462
Santa Cruz, CA 95060

Gentlemen:

I am responding to your letter of April 3, 2000, in which you requested information regarding payment of routine infant circumcisions through the North Dakota Medicaid Program.

The North Dakota Medicaid Program has not reimbursed for routine circumcisions since 1991. Payment will be made only if it can be demonstrated to our medical consultant that the procedure was medically necessary for a specific medical condition. Payment for medically necessary circumcisions are rare.

If you have any additional questions regarding our policy, please contact me at any time.

Sincerely,

David J. Zentner

Director, Medical Service

APPENDIX B: TABLE OF CIRCUMCISIONS COVERED BY STATE MEDICAID PROGRAMS—1999

CIRCUMCISIONS COVERED BY STATE MEDICAID PROGRAMS–1999

	Male Live Births	Circumcised Number	Circumcised Percent	Circumcisions by Code 54150	54152	54160	54161	Medicaid Reimbursement to Physician 54150	54152	54160	54161	Annual Est. Expense
Alabama**	15,000	9,065	60.4%	7263	197	1802	773	$114.00	$101.00	$147.00	$161.00	$1,237,226
Alaska**(1)	1,947	1,010	51.9%	1,002	18	8	54	$278.45	$237.61	$357.03	$311.49	$302,961
Arkansas	Arkansas failed to comply with requests for data – see Non-Compliance Report for details.											
Arizona (2)	16,762	Majority of circumcisions covered under private health plans: rates determined plans.										$17,529
California	California Medicaid does not cover routine non-therapeutic circumcision.											
Colorado**	9,909	1,567	15.8%	1,374	14	149	30	$38.11	$33.43	$38.11	$167.15	$63,524
Connecticut** (3)	5,728	2,101	36.7%	200	0	13	11	$43.86	$94.19	$40.86	$124.88	$10,677
Delaware**	2,385	982	41.2%	975	25	7	60	$290.94	$156.13	$274.21	$204.46	$301,757
District of Columbia (4)	2,431	254	10.4%	167	0	48	39	$43	$80	$80	$105	$15,116
Florida (5)	48,327	7,024	14.5%	6,991	592	353	667	$66.41	$83.55	$98.18	$109.53	$967,167
Georgia**	43,434	14,314	33.0%	13,395	48	919	103	$70.76	$269.27	$140.44	$527.18	$1,144,119
Hawaii	Hawaii failed to comply with requests for data – see Non-Compliance Report for details.											
Idaho** (6)	3,000	2,323	77.0%	2,058	9	151	105	$93.65	$125.15	$57.74	$163.54	$219,748
Illinois (7)	30,436	9,665	31.8%	7,892	250	1,773	2,224	$60	$148.25	$75	$155.25	$1,191,127
Indiana** (8)	17,070	11,973	70.1%	11,196	98	777	539	$65.45	$114.80	$115.57	$151.50	$915,485
Iowa (9)	6,748	3,834	56.8%	3,769	17	65	143	$47.53	$62.02	$43.28	$216.42	$228,801
Kansas (10)	8458	3,167	37.4%					$55.80	$137.50	$92.92	$177.21	$176,719

Code 54150 = Newborn (age 0-1) Circumcision, using clamp
Code 54152 = Non-Newborn (age 1+) Circumcision, using clamp
Code 54160 = Newborn (age 0-1) Circumcision, Surgical Excision
Code 54161 = Non-Newborn (age 1+) Circumcision, Surgical Excision

** The state provided total number of circumcisions re-imbursed under each code, and their payment to physicians for fiscal year 1999. Total annual estimate was calculated by multiplying number of circumcisions performed by the physician fee. This estimate does not take into account extra costs of hospital charges, anesthesia, supplies, etc...

1 Calculated total based on fee schedule of 1/1/01, however, if 5/5/99 fee schedule is used to calculate expenditure, Alaska expenditure would be $219,136.

2 Almost all Arizona recipients are in managed care plans, and no data were provided for these plans. The estimated annual expense was calculated using only the 80 circumcisions Arizona reported paying for. The estimated annual expense would be significantly higher if data for HMOs had been provided.

3 Connecticut reported a total of 2,101 circumcisions. The final estimated total only accounts for 224 circumcisions reported under the FFS program. The significant discrepancy between total circumcisions and the number paid for in FFS may represent the number paid for by HMOs. HMO data was not reported. Estimated expense was calculated using only FFS payments, and would be substantially higher if HMO data had been provided.

4 Total expense provided by District of Columbia.

5 Florida provided total expenditure, which included $859,823 in professional service fees and $107,374 for facility fees.

6 Idaho did not provide total of male births, but did provide number of total births. Number of male births determined by the M/F birth ratio 1049/1000. 7/1/00 fee schedule used.

7 Illinois provided their total expenditure for 1999: $709,905.29 for physician payments and $481,222 in outpatient facility fees for circumcisions after newborn hospital stay.

8 Circumcision during newborn period is covered under DRG. Indiana pays $337.08 facility fee for codes 54150 and 54152, $469.08 facility fee for codes 54160 and 54161.

9 Iowa reported expenditures of $72,990 for HMO and $155,811.09 for FFS recipients.

10 Kansas reported 3,167 total circumcision claims, but did not break them down by code. Annual total was estimated by using most common and lowest paid fee, $55.80. Percent of newborns circumcised is a gross estimate.

CIRCUMCISIONS COVERED BY STATE MEDICAID PROGRAMS–1999

	Male Live Births	Circumcised Number	Circumcised Percent	Circumcisions by Code 54150	54152	54160	54161	Medicaid Reimbursement to Physician 54150	54152	54160	54161	Annual Est. Expense
Kentucky**	15,214	5,022	33.0%	4,737	38	285	347	$67.93	$119.99	$120.95	$158.28	$415,738
Louisiana (11)	21,116	10,763	51.0%	10,140	24	623	1,310	$81.00	$135.00	$72.00	$262.80	$4,698,331
Maine**	2,481	1,036	41.8%	970	11	66	17	$58.43	$55.85	$47.07	$125.39	$62,215
Maryland	Maryland failed to comply with requests for data – see Non-Compliance Report for details.											
Massachusetts (12)	4,766	2,848	59.8%	2,798	136	50	444	$75.47	$141.89	$142.20	$184.61	$323,385
Michigan** (13)	12,968	6,842	52.8%	6,583	17	259	161	$50.44	$91.76	$92.34	$120.09	$376,857
Minnesota** (14)	12,400	5,423	43.7%	5,386	73	37	347	$54.84	$69.13	$53.30	$193.12	$369,399
Mississippi	Mississippi Medicaid does not cover routine non-therapeutic circumcision.											
Missouri** (15)	17,789	5,125	28.8%	4745	11	380	227	$42.00	$55.00	$66.00	$86.00	$250,172
Montana** (16)	4,084	1,422	34.8%	1,396	4	26	7	$99.28	$131.78	$127.71	$174.13	$143,661
Nebraska	4,382	2,519	57.5%	2,482	18	37	77	$37.43	$46.79	$37.43	$140.37	$105,937
Nevada	Nevada Medicaid does not cover routine non-therapeutic circumcision.											
New Hampshire (17)	2,055	709	34.5%	708		1	3	$80.00		$80.00	$82.50	$57,176
New Jersey (18)	16,000	837	5.2%	780	58	57	172	$16.00	$61.00	$16.00	$97.00	$33,614
New Mexico**	7,904	2,802	35.5%	2,706		96	270	$157.94	$137.94	$203.06	$182.19	$496,071
New York (19)	41,316	6,365	15.4%	5,817	259	548	1,360	$11.98	$33.97	$39.45	$54.91	$174,794
North Carolina (20)	21,969	15,758	71.7%	15,384	25	374	684	$72.87	$124.96	$159.18	$233.90	$1,343,685
North Dakota	North Dakota Medicaid does not cover routine non-therapeutic circumcision.											

11 Louisiana provided conflicting data, based on number of circumcisions and physician reimbursement rates. Louisiana expenditure for professional fees is calculated to be $1,213,704 plus the $121,695.29 Louisiana reported to reimburse for anesthesia. However, they reported their professional fees, including anesthesia, expenditure were $317,509, and reported paying $4,108,521 in hospital fees and $272,301 in outpatient facility fees for a total of $4,698,331.

12 Massachusetts did not provide total of male births, but did provide number of total births. Number of male births was determined by the M/F birth ratio 1049/1000. Massachusetts data was for circumcisions reimbursed in 1998. They reimbursed for six inpatient facility fees in 1999, for a total of $3,845.76.

13 Michigan did not provide total number of male births, but did provide the number of total births. Number of male births was determined by the M/F birth ratio 1049/1000

14 Minnesota provided total number of procedures covered by FFS and managed care plans in 1999. FFS pays a facility fee of $288.32 for code 54150, $317.00 for code 54152, $803.23 for code 54160, and $425.00 for code 54161, but Minnesota did not provide number of facility fees reimbursed, so total does not include facility fees.

15 Missouri provided specific data for which circumcisions were performed in an office and which were performed elsewhere. Slightly higher rates were paid for all codes performed in an office – they paid $42 for code 54150 (total $4,447) and $58 for code 54150 in office (total $298).

16 Total amount for Montana calculated using the 7/1/00 fee schedule. Data does not include information from 2 HMO-managed care plans that serve some Medicaid recipients. No information was available on facility fees.

17 New Hampshire reported a total of $56,989 for circumcision fees, and 14 billings for anesthesia, costing $13.50 per unit, for a total of $186.90 for anesthesia.

18 New Jersey data was difficult to interpret, and the numbers do not accurately reflect circumcision payment. NJ informed us that the majority of their children were in HMOs. However, they only provided data for FFS. They determine fee accordingly: paying $14 for codes 54150 and 54160 for a non-specialist, and $16 for 54150 and 54160 for a specialist. However, they also pay for anesthesia using Anesthesia Basic Units (ABU) and Time Units (TU). Each unit is payable at $6.30. Therefore, annual expense is strictly a gross estimate of the FFS expenditure. The total would be substantially higher with HMO data and additional information on exact number of units billed.

19 The New York figures "do not completely represent the number of circumcisions performed. Many circumcisions are performed on an inpatient basis, and the cost of circumcision is included in the DRG." Physician fee was estimated by dividing total expense provided by NY for each code, by the number of circumcisions performed. For example, for code 54150 New York reported there were 5,817 circumcisions performed, and their total expenditure was$69,695 for this code.

20 Physician fee was estimated by dividing total expense provided by North Carolina for each code by the number of circumcisions performed. For example, North Carolina reported 15,384 circumcisions were performed under code 54150, and their total expenditure was $1,121,041.29 for this code. Physician fee calculated by dividing total expense by number of procedures.

CIRCUMCISIONS COVERED BY STATE MEDICAID PROGRAMS–1999

	Male Live Births	Circumcised Number	Circumcised Percent	Circumcisions by Code 54150	54152	54160	54161	Medicaid Reimbursement to Physician 54150	54152	54160	54161	Annual Est. Expense
Ohio** (21)	24,392	507	2.1%	2	161	505	456	$70.39	$109.85	$126.88	$144.15	$147,633
Oklahoma (22)	17,819	5,208	29.2%	5,198	46	101	223	$114.87	$100.53	$147.69	$132.98	$649,570
Oregon	Oregon Medicaid does not cover routine non-therapeutic circumcision.											
Pennsylvania (23)	8,890	4,305	48.4%	4,126	23	179	369	$79.00	$89.00	$128.00	$128.00	$453,630
Rhode Island (24)		2300 est.										
South Carolina** (25)	14,617	10,105	69.1%	9,539	26	566	610	$65.16	$109.54	$114.50	$150.38	$780,948
South Dakota** (26)	1,700	1,156	68.0%	1,131	2	25	22	$50.40	$129.53	$60.00	$181.40	$62,752
Tennessee	Tennessee failed to comply with requests for data – see Non-Compliance Report for details.											
Texas**	91,540	19,562	21.4%	17,201	102	2,361	1,773	$50.75	$86.28	$101.50	$152.25	$1,391,332
Utah (27)	5,727	2,279	39.8%	2,270	28	9						$140,610
Vermont**	1,777	274	15.4%	258	2	16	2	$26.30	$32.13	$32.13	$96.51	$7,557
Virginia (28)	11,621	4,420	38.0%					$127.33	$110.15	$163.53	$145.04	$562,879
Washington	Washington Medicaid does not cover routine non-therapeutic circumcision.											
West Virginia**(29)		2,234		1,674	49	339	172	$201.50	$111.41	$224.94	$147.24	$335,611
Wisconsin (30)	12,683	1,342	10.6%	1,282	1	11	48	$56.48	$43.93		$62.76	$125,880
Wyoming** (31)	1,206	1,069	88.6%	1,042	1	27	29	$50.40	$63.00	$63.00	$189.00	$59,761
TOTAL	**573,051**	**178,146**		**157,374**	**2,186**	**11,241**	**13,105**					**$20,361,154**
AVERAGES	**15,080**	**4,688**	**39.80%**	**4,372**	**64**	**312**	**374**	**$79.79**	**$103.68**	**$107.55**	**$153.31**	**$509,029**

21 Low number of circumcisions reimbursed, contributing factors (ex. HMOs) unknown. Ohio provided figures for facility fee reimbursement - code 54150 = $222; 54152 = $389; 54160 = $222; 54161 = $682, but they did not provide data for the number of procedures billed for facility fee. Ohio provided fiscal year 1998 data.

22 Oklahoma reported facility fee reimbursement of $204.10 for codes 54150, 54152, and 54160, and $274.30 for code 54161. They did not provide data for the number of procedures billed for facility fee. Many areas of the state are covered under HMOs and "Several of the HMOs have determined that circumcision is not medically necessary and do not cover it as a routine service."

23 According to a calculation multiplying number of procedures by physician fee, Pennsylvania spent $821,451.58 on circumcisions, but they listed total circumcision reimbursement as $453,629.65. Their data represents only the FFS recipients, and 55% of their recipients are in HMOs. The annual estimated expense would substantially increase with additional data from HMOs.

24 According to RI, 95% of all children born on Medicaid in 1999 were enrolled in a managed care program. Billing for circumcision varies greatly with HMOs--some bundle the procedure in with the mother's charges, others bill separately. Facility fees vary for each hospital.

25 South Carolina reimburses $570.00 for outpatient circumcision facility fees, but did not provide number of facility fee claims reimbursed.

26 Despite numerous written requests and phone calls, Anthony Sanchez, Assistant Attorney General, refused to provide data in writing. ARC representatives, Duane Voskuil and Jody McLaughlin traveled to the South Dakota Medicaid office to obtain the data. They met with Mr. Larry Iverson who orally dictated the requested data to the ARC representatives from a prepared sheet. No written documentation was provided.

27 Utah data does not include estimated 45% of recipients in HMOs. Total annual expense provided by Utah. They did not provide amount reimbursed to physicians for each procedure code.

28 Virginia failed to provide any data on number of circumcisions performed. The annual total is strictly a gross estimate, assuming the circumcision rate in VA was 38.04%, the average circumcision rate in states that paid over $60 to physicians for circumcision code 54150. Their total number of male births was multiplied by 38.04%, and that number was multiplied by physician fee for code 54150, the lowest and most common reimbursement rate.

29 West Virginia's estimated annual expense was calculated using 2000 data; their 1999 circumcision expense was $294,985.12.

30 Total expenses provided by Wisconsin include $124,447 in physician fees and $1,433 for anesthesia.

31 Wyoming provided hospital outpatient reimbursement amounts of $75.18 for code 54150, $756.29 for 54152, $174.08 for 54160, and $806.18 for code 54161. They did not provide number of facility fees paid, so this expense was not calculated.

APPENDIX C: NON-COMPLIANCE REPORT—STATES THAT FAILED TO COMPLY WITH THE FREEDOM OF INFORMATION ACT

At the time of the first publication of the report in March, 2001, forty-four states and the District of Columbia had provided the requested information to either the International Coalition for Genital Integrity (ICGI) or Attorneys for the Rights of the Child (ARC). Two other states, **Rhode Island** and **Nebraska** provided the data shortly thereafter. Two months after the initial publication, despite numerous letters, phone calls, and faxes, six states had still not provided the requested data: **Arkansas, Hawaii, Maryland,** and **Tennessee**. ICGI does not have the resources to continue this pursuit.

Arkansas: ICGI sent questions *3/14/00*, and received no response. ARC sent the questions again, certified mail, *10/4/00*. *11/3/00*—Voicemail message left with ARC by Dr. McGhee, Medical Director, stating AR was looking into our request. *2/12/01*—J. Steven Svoboda, Executive Director of ARC, left two voice messages requesting data. *2/19/01*—Mr. Svoboda spoke with Dr. McGhee's assistant about data needed. *2/20/01*—Dr. McGhee left voicemail for ARC stating she was unaware of our request (despite her previous message of 11/3/00). *2/22/01*—ARC faxed request to Dr. McGhee. *3/7/01*—Dr. McGhee sent ARC a letter stating that ***"the Freedom of Information Act applies only to requests from within the state of Arkansas."*** *3/8/01*—ARC wrote a letter disputing this, to which ARC received the following reply from Judy Besancon, Office of Chief Council, dated March 9, 2001, "The information you request must be generated by a "special" report. The cost for using a programmer will be $90 per hour. The estimated programmer time spent on this project is six to eight hours. After this is completed, the actual document would then cost 25 cents per page for copying. The number of pages is unknown until the report is run." Considering that 36 states easily provided the requested data on a one page report submitted to either ICGI or ARC, and three states ran a one page report for a nominal fee, the estimated fee of $540 to $720 was determined to be an excessive and prohibitive cost that was out of line with other state Medicaid agencies. Arkansas was originally sent the survey questions on March 14, 2000 and a year later they requested exorbitant fees for public information. Due to time constraints, ARC was unable to pursue the latest roadblock erected by Arkansas.

Hawaii: ICGI sent questions *5/17/00*. HI replied *5/25/00* that gathering data would cost an unspecified amount of money. ARC sent questions again, certified mail, *10/18/00*, with a request to waive any fee. *2/12/01*—Mr. Svoboda left message for Charles Duarte requesting status of fee waiver request. *2/19/01*—Mr. Svoboda spoke with Henrietta Gueso about data needed, and left messages on voice mails for Eileen Hiramatsu and Diane Tachera. Faxed letter of 10/18/00 to Ms. Hiramatsu. *2/23/01*—Diane Tachera left a message on ARC's voicemail that fee waiver was denied, did not specify amount of money ARC needed to send. *3/7/01*—Individual from HI left ARC a voicemail message indicating they did not know what data ARC was requesting. ARC faxed letter of 10/18/00 again. *3/12/01*—Mr. Svoboda made follow-up called and was informed by HI that they were generating data. *3/13/01*—Svoboda left message for HI requesting status of data gathering. *3/14/01*—HI left message on ARC's voicemail stating they would not be able to gather data by 3/15/01 deadline. *4/23/01*—ARC received a voicemail message from Diane Tachera stating that consultant time is $100 an hour and machine time is $500 an hour, costing ARC approximately $2100 to receive requested data. This estimate was determined to be an excessive and prohibitive cost that was out of line with other state Medicaid agencies.

Maryland: ICGI sent questions *9/2/00*, and received no response. ARC sent questions again, certified mail, *12/1/00. 2/19/01*—Mr. Svoboda called MD Department of Health, was transferred to several departments and finally spoke with Eileen Cohen, Office for Children with Special Health Care Needs. Mr. Svoboda faxed Ms. Cohen 12/1/00 letter. Ms. Cohen stated she would forward it to the appropriate person. *2/20/01*—Ms. Cohen called ARC to confirm she received the fax and passed it on. Sandy Malone also called to inform ARC that Andy Udom of the Hospital Cost Review Commission would be handling the request. *3/7/01*—MD faxed ARC a form to fill out. ARC filled out form and faxed it back with another copy of 12/1/00 letter. *3/12/01*- Mr. Svoboda left another voicemail message explaining urgency of information needed, and the 3/15/01 deadline for data. *3/14/01*

—Mr. Svoboda called Andy Udom, who informed Mr. Svoboda that he had no record of receiving previous faxes. ARC faxed Mr. Udom all letters and forms previously faxed. *3/14/01*—Mr. Udom called ARC to inform ARC that his office could only provide part of the data needed (however, nothing was received), and that the rest of the data needed to be obtained directly from MD Medicaid. Since ICGI had started the whole process with MD Medicaid, who subsequently deferred to the Department of Health, no further action was taken.

Tennessee: ICGI sent questions *3/6/00*, and received no response. ARC sent questions again, certified mail, *10/4/00. 10/30/00*—TennCare left message on ARC's voicemail stating they were looking into the request but were not required to send any information. *2/12/01*—Svoboda spoke with Dorothy Appleton about request. *2/20/01*—Svoboda left voicemail message for Dr. Karen Oldham. *3/7/01*—Svoboda left another voicemail message. *3/12/01*—Mr. Svoboda spoke with Ms. Appleton again. She stated they would try to provide data by deadline. ARC faxed her another copy of questions. No response.

REFERENCES

HCIA-Sachs, Inc. Baltimore, Maryland, (800) 568-3282, <info@hcia.com>.

Council on Scientific Affairs, American Medical Association, *Neonatal circumcision.* Chicago: AMA, 2000.

American Academy of Pediatrics Task Force on Circumcision. Circumcision Policy Statement, *Pediatrics* 1999;103(3):686-693.

The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. In: *Guidelines for Perinatal Care*, 4th ed. American Academy of Pediatrics; 1997.

Wallerstein E. Circumcision: the uniquely American medical enigma. *Urologic Clinics of North America* 1985;12(1):123-132.

O. Moscucci, "Clitoridectomy, Circumcision, and the Politics of Sexual Pleasure." In: *Sexualities in Victorian Britain.* Eds: Andrew H. Miller and James Eli Adams. Indiana University Press, Bloomington and Indianapolis. 63-65 (1996).

David L. Gollaher. *A History of the World's Most Controversial Surgery*, New York: Basic Books, 2000, pp 73-75.

Ibid.

American Medical Association (AMA) Report 10 of the Council on Scientific Affairs (I-99).

The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

American Academy of Pediatrics, Committee on Fetus and Newborn. *Standards and Recommendations for Hospital Care of Newborn infants*. 5th ed. Evanston, IL: American Academy of Pediatrics: 1971.

HCIA-Sachs, Inc.

Bollinger D. (2000) Normal Versus Circumcised: Male Neonatal Genital Ratio in the United States. Circumcision Reference Library (an original online publication), 13 November 2000. updating and expanding on data in: Wallerstein E, *Circumcision: An American Health Fallacy*, Springer Publ., New York, 1980, Appendix B <www.cirp.org/library/statistics/bollinger3> .

National Center for Health Statistics, Room 922, Department of Health and Human Services, Beltsville Road, Hyattsville, MD 20782

Bollinger D.

American Medical Association (AMA)

American Academy of Pediatrics Task Force on Circumcision.

Neonatal circumcision revisited (1996) Fetus and Newborn Committee, Canadian Paediatric Society (CPS) *Canadian Medical Association Journal* 1996; 154(6): 769-780/

Australian College of Paediatrics. *Position Statement: Routine Circumcision of Normal Male Infants and Boys*. Parkville, Victoria: 1996.

British Medical Association. *Circumcision of Male Infants: Guidance for Doctors.* London: British Medical Association, 1996.

Williams N, Kapila L. Complications of circumcision. *Brit J Surg* 1993;80:1231-1236.

Taylor JR, Lockwood AP, Taylor AJ. The prepuce: specialized mucosa of the penis and its loss to circumcision. *Br J Urol* 1996;77:291-295.

Fleiss P, Hodges F, Van Howe RS. Immunological functions of the human prepuce. *Sex Trans Inf* 1998;74:364-367

Cold CJ, Taylor JR. The prepuce. *BJU Int* 1999;83Suppl.1:34-44.

Mahlberg FA, Rodermund OE, Muller RW. Ein Fall von Zirkumzision-stuberkulose. [A case of circumcision tuberculosis] *Hautarzt* 1977;28:424-425.

Scurlock JM, Pemberton PJ. Neonatal meningitis and circumcision. *Med J Aust* 1977;1(10):332-334.

Annunziato D, Goldblum LM. Staphylococcal scalded skin syndrome. A complication of circumcision. *Am J Dis Child* 1978;132(12):1187-1188.

Sussman SJ, Schiller RP, Shashikumar VL. Fournier's syndrome. Report of three cases and review of the literature. *Am J Dis Child* 1978;132(12):1189-1191.

Neulander, S, Walfisch SJ. Kaneti X. Amputation of distal penile glans during neonatal ritual circumcision—a rare complication. *Br J Urol* 1996;77:924-925.

Lackey JT, Mannion RA, & Kerr JE. Urethral fistula following circumcision. *JAMA* 1968;206:2318.

[31] Money J, Ablatio Penis: Normal male infant sex-reassigned as a girl *Archives of Sexual Behavior* 1975;4:65-71.

[32] Baker RL. Newborn male circumcision: needless and dangerous. *Sexual Medicine Today* 1979;3(11):35-36. <www.cirp.org/library/general/baker1>

[33] Gellis, SS. Circumcision. *American Journal of Diseases of Childhood* 1978;132:1168.

[34] Wayne EM. Focus on the foreskin, not its destruction. *Clin Pediatr* 2000;39(1):65.

[35] Griffiths D, Frank JD, Inappropriate circumcision referrals by GPs. *J R Soc Med* 1992;85:324-325.

[36] American Academy of Pediatrics. *Care of the Uncircumcised Penis.* 1999.

[37] Gairdner D. The fate of the foreskin. *Br Med J* 1949;2:1433-1437.

[38] Wright JE. Further to the "Further fate of the foreskin" *Med J Aust* 1994;160:134-135.

[39] Øster J. Further fate of the foreskin. *Arch Dis Child* 1968;43:200-203.

[40] 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):1813-1815.

[41] Shankar KR, Rickwood AM. The incidence of phimosis in boys. *BJU Int* 1999;84(1):101-102.

[42] Ibid.

[43] Dewan PA, Tieu HC, and Chieng BS. Phimosis: Is circumcision necessary? *J Paediatr Child Health* 1996;32:285-289.

[44] Van Howe RS. Cost-effective treatment of phimosis. *Pediatrics* 1998; 102(4):e43.

[45] Berdeu D, Sauze L, Ha-Vinh P, Blum-Boisgard C. Cost-effectiveness analysis of treatments for phimosis: a comparison of surgical and medicinal approaches and their economic effect. *BJU Int* 2001;87(3):239-244.

[46] Ibid.

[47] Van Howe RS.

[48] Ibid.

[49] de Castella H. Prepuceplasty: An alternative to circumcision. *Ann R Coll Surg Engl* 1994; 76:257-258

[50] Cuckow PM, Rix G, Mouriquand PD. Preputial plasty: a good alternative to circumcision. *J Pediatr Surg* 1994; 29:561-563.

[51] Lane TM, South LM. Lateral preputioplasty for phimosis. *J R Coll Surg Edinb* 1999;44(5):310-312.

[52] Van Howe RS.

[53] Ibid.

[54] Edwards S. Balanitis and balanoposthitis: A review. *Genitourin Med* 1996;72;155-159. <www.cirp.org/library/disease/balanitis/edwards1>.

[55] Escala JM, & Rickwood AMK. Balanitis*, Brit J Urol* 1989;63:196-197 <www.cirp.org/library/disease/balanitis/escala1>.

[56] Birley HDL, Walker MM, Luzzi GA. Clinical features and management of recurrent balanitis: association with recurrent washing. *Genitourin Med* 1993;69:400-403 <www.cirp.org/library/disease/balanitis/birley/>.

[57] Edwards S.

[58] Øster J.

[59] Ibid.

[60] Birley HDL, Walker MM, Luzzi GA.

[61] Escala JM, & Rickwood AMK

[62] Birley HDL, Walker MM, Luzzi GA.

[63] Edwards S.

[64] Preston EN. Whither the foreskin. *JAMA* 1970; 213(11):1853-1858 <www.cirp.org/library/general/preston/>.

[65] Robert S, Van Howe RS. Variability in penile appearance and penile findings: a prospective study. *Brit J Urol* 1997;80:776-782 <www.cirp.org/library/complications/vanhowe/>.

[66] NOCIRC Educational Pamphlet 4, *Answers to Your Questions About Your Young Son's Intact Penis.* 2001.

[67] Adler R, Ottaway S, & Gould S. Circumcision: We have heard from the experts; Now let's hear from the parents. *Pediatrics* 2001;107, e20.

[68] Mooneyham, Scott. "Rising Medicaid Costs Get Scrutiny: Legislators Pondering Options in Budget Crisis." *Raleigh News and Observer*, March 15, 2001.

[69] Wilson, Trish. "Kids' Insurance Needs CPR." *Raleigh News and Observer,* March 9, 2001.

[70] HCIA-Sachs, Inc.

[71] American Academy of Pediatrics Task Force on Circumcision.

[72] Bollinger D.