MetroPlus Health

Policy and Procedure

Title: Sexual Dysfunction / Erectile Dysfunction (SD/ED) Treatment	Division: Medical Management Department: Utilization Management
Approval Date: 10/26/2018	LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP
Effective Date: 10/26/2018	Policy Number: UM-MP238
Review Date: 4/23/2024	Cross Reference Number:
Retired Date:	Page 1 of 10

1. **POLICY DESCRIPTION:**
   Treatment of Sexual Dysfunction / Erectile Dysfunction (SD/ED) , including medication and devices. This policy does not address the use of medication or devices which could be used for SD/ED but are being prescribed for other purposes (e.g. pulmonary hypertension)

2. **RESPONSIBLE PARTIES:**
   Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting, Benefit Coding, Regulatory
   On at least a quarterly basis the Utilization Management Subcommittee (UMS) is responsible for monitoring the appropriate utilization of SD/ED services and providing oversight. The UMS will identify opportunities for improvement and make recommendations for policy changes.

3. **DEFINITIONS:**
   Sexual Dysfunction / Erectile Dysfunction (SD/ED) is defined as the inability to attain and/or maintain penile erection sufficient for satisfactory sexual performance. For example, including peyronie's disease.

4. **POLICY:**
   i. **Medication**: Medicaid does not cover any medication for treatment of SD/ED. For all other lines of business, secondary review is required. Currently, medication used for SD/ED are phosphodiesterase inhibitors (PDE5) taken orally or alprostadil injected directly into the penile carvenosa.
   ii. **Devices**:
      1. **Vacuum erection system (L7900)**
         a. Requires documentation of ED by a urologist or neurologist
         b. Normal prolactin, testosterone and thyroid levels (addressing hormone abnormality might address the ED).
         c. Medicaid covers twice/lifetime
      2. **Penile Prosthesis Implantation**: Penile Prosthesis Implantation Secondary to Erectile Dysfunction (ED) will be considered medically necessary for beneficiaries with documented physiologic ED when all of the following criteria are met.
         a. Absence of:
            i. active alcohol or substance abuse;
            ii. Drug induced impotence related to: anabolic steroids, anticholinergics, antidepressants, antipsychotics or central nervous system

depressants;
iii. Untreated depression or psychiatric illness.

b. Nonsurgical methods have proven ineffective or are contraindicated.
c. Normal prolactin, testosterone, cortisol and thyroid levels (addressing hormone abnormality might address the ED)
    i. The Cortisol level can be a 24 hour urine collection, or two blood tests: one drawn near the time of awakening in the morning and the other drawn at mid afternoon (around 16:00, 4PM)
d. History of **any** of the following:
    i. Documented injury to perineum/genitalia; or
    ii. Major pelvic trauma affecting bladder and/or anal and/or erection control; or
    iii. Major vascular surgery involving aorta or femoral blood vessels; or
    iv. Neurological disease (e.g., diabetic neuropathy); or
    v. Peyronie's disease; or
    vi. Renal failure
    vii. Secondary to spinal cord injury or
    viii. ED following prostate, bladder, bowel or spinal surgery
    ix. Vascular insufficiency or venous incompetence documented by dynamic infusion cavernosometry and cavernosography (DICC)
    x. Venous leak of the penis.

Additional Considerations:

1. Patients with sickle cell anemia who have stuttering priapism and/or cavernosal scarring are also potential candidates for inflatable penile prosthesis, which offers not only a cure for their priapism but also a close approximation to normal appearance and function.

2. Further considerations for optimizing outcome include selecting patients whose etiology is previous pelvic trauma and patients who are young, do not have diabetes, do not smoke, and have no underlying neurologic disease.

3. Removal of a penile implant is considered medically necessary if the prosthesis, is infected, causing intractable pain, is exhibiting mechanical failure, or has been identified as the etiology of urinary obstruction.

4. Reimplantation of a penile prosthesis is considered medically necessary for persons who meet medical necessity criteria above for a penile prosthesis and whose prior prosthesis was removed for medically necessary indications.

5. Implantable penile prostheses are considered experimental and investigational for other indications because their effectiveness for indications other than the criteria listed above has not been established.

5. LIMITATIONS/ EXCLUSIONS:

i. In accordance with Chapter 645 of the Laws of 2005, NYS Medicaid does not pay for Sexual Dysfunction (SD) or Erectile Dysfunction (ED) related drugs, this includes prescriptions or physician administered drugs.
ii. NYS Medicaid will not pay for medical supplies and procedures related to SE/ED for registered sex offenders.
iii. Preservice review requirement: NYS requires that all requests for SD/ED services (procedures and medical supplies) must undergo verification through the NYS department of health Erectile Dysfunction Verification System (EDVS) before services are rendered. This requirement for preservice verification includes requests for any drugs that may be used for SD/ED services (including FDA labeled and off-label indications). Therefore, ALL requests for the codes listed below and in Section 6 requires prior authorization.
iv. Should a member receive drugs for reasons other than SD/ED as approved by the FDA, providers can appeal the claim denial and provide records for review. Records received will be reviewed for medical necessity.

Hospital Setting

In the inpatient setting, alprostadil and papaverine may be covered for the treatment of a condition other than sexual or erectile dysfunction for which the drugs have been approved by the Food and Drug Administration (FDA). Additionally, physician-administered collagenase, clostridium histolyticum and phentolamine mesylate may be covered for the treatment of a condition, other than sexual or erectile dysfunction, for which the drug has

been approved by the FDA and prior approval has been received

(ICD-10) Inpatient Procedures	Descriptions
"0VHS03Z"	Insertion of Infusion Device into Penis, Open Approach
"0VHS0YZ"	Insertion of Other Device into Penis, Open Approach
"0VHS33Z"	Insertion of Infusion Device into Penis, Percutaneous Approach
"0VHS3YZ"	Insertion of Other Device into Penis, Percutaneous Approach
"0VHS4YZ"	Insertion of Other Device into Penis, Percutaneous Endoscopic Approach
"0VHS7YZ"	Insertion of Other Device into Penis, Via Natural or Artificial Opening
"0VHS8YZ"	Insertion of Other Device into Penis, Via Natural or Artificial Opening Endoscopic
"0VHSX3Z"	Insertion of Infusion Device into Penis, External Approach
"0VUS07Z"	Supplement Penis with Autologous Tissue Substitute, Open Approach
"0VUS0JZ"	Supplement Penis with Synthetic Substitute, Open Approach
"0VUS0KZ"	Supplement Penis with Nonautologous Tissue Substitute, Open Approach
"0VUS47Z"	Supplement Penis with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
"0VUS4JZ"	Supplement Penis with Synthetic Substitute, Percutaneous Endoscopic Approach
"0VUS4KZ"	Supplement Penis with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
"0VUSX7Z"	Supplement Penis with Autologous Tissue Substitute, External Approach
"0VUSXJZ"	Supplement Penis with Synthetic Substitute, External Approach
"0VUSXKZ"	Supplement Penis with Nonautologous Tissue Substitute, External Approach
"0VWS07Z"	Revision of Autologous Tissue Substitute in Penis, Open Approach
"0VWS0JZ"	Revision of Synthetic Substitute in Penis, Open Approach
"0VWS0KZ"	Revision of Nonautologous Tissue Substitute in Penis, Open Approach
"0VWS47Z"	Revision of Autologous Tissue Substitute in Penis, Percutaneous Endoscopic Approach
"0VWS4JZ"	Revision of Synthetic Substitute in Penis, Percutaneous Endoscopic Approach
"0VWS4KZ"	Revision of Nonautologous Tissue Substitute in Penis, Percutaneous Endoscopic Approach
"0VWSX7Z"	Revision of Autologous Tissue Substitute in Penis, External Approach
"0VWSXJZ"	Revision of Synthetic Substitute in Penis, External Approach
"0VWSXKZ"	Revision of Nonautologous Tissue Substitute in Penis, External Approach
"0VY50Z0"	Transplantation of Scrotum, Allogeneic, Open Approach
"0VY50Z1"	Transplantation of Scrotum, Syngeneic, Open Approach
"0VY50Z2"	Transplantation of Scrotum, Zooplastic, Open Approach
"0VYS0Z0"	Transplantation of Penis, Allogeneic, Open Approach
"0VYS0Z1"	Transplantation of Penis, Syngeneic, Open Approach
"0VYS0Z2"	Transplantation of Penis, Zooplastic, Open Approach

Please note: This list provides all known procedures at the time of publication but may not be all-inclusive. Providers are encouraged to use their clinical knowledge to apply

this policy to similar drugs, procedures, and supplies.

6. APPLICABLE PROCEDURE CODES:

CPT	Description
37788	Penile revascularization, artery, with or without vein graft
37790	Penile venous occlusive procedure
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis, inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component, inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
55870	Electroejaculation
J0270	Injection, alprostadil, 1.25 mcg (aka Caverject)
J0275	Alprostadil urethral suppository (aka MUSE)
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg
J2440	Injection, papaverine hcl, up to 60 mg
J2760	Injection, phentolamine mesylate, up to 5 mg
L7900	Vacuum erection system
L7902	Tension ring, for vacuum erection device, any type, replacement only, each
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, noninflatable
*96372	Injection of drug/substance under skin or into muscle.

* Code will be denied if associated with applicable denied J-code

Effective date: 05/08/2024: The following drugs require prior authorization.

Code	Description	Drug that requires EDVS verification
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg	Xiaflex
J2440	Injection, papaverine hydrochloride injection (HCl), up to 60 mg	papaverine
J2760	Injection, phentolamine mesylate, up to 5 mg	phentolamine
J1071	Injection, testosterone cypionate, 1 mg	testosterone Cypionate
J2371	Injection, phenylephrine hydrochloride, 20 micrograms	phenylephrine
J3121	Injection, testosterone enanthate, 1 mg	testosterone enanthate
S0106	Bupropion HCL sustained release tablet	bupropion SR
J3490	Unclassified Drugs	prostin VR
		testosterone undecanoate
		testosterone (gel)
		testosterone (topical solution)
		testosterone cypionate powder (bulk)
		testosterone enanthate
		verapamil
J8499	Prescription drug, oral, non-chemotherapeutic, nos	tadalafil tablets
		bupropion XL
		testosterone undecanoate
J7999	Compounded drug, not otherwise classified	testosterone
		testosterone cypionate (compound)
C9399	Unclassified drugs or biologicals	testosterone enanthate subcutaneous

*Miscellaneous billing codes should not be used if a drug has as an assigned code.

7. APPLICABLE DIAGNOSIS CODES:

CODE	Description
F52.0	Hypoactive sexual desire disorder

CODE	Description
F52.21	Male erectile disorder
F52.32	Male orgasmic disorder
N52.01	Erectile dysfunction due to arterial insufficiency
N52.02	Corporo-venous occlusive erectile dysfunction
N52.03	Combined arterial insufficiency and corporo-venous occlusive erectile dysfunction
N52.1	Erectile dysfunction due to diseases classified elsewhere
N52.2	Drug-induced erectile dysfunction
N52.31	Erectile dysfunction following radical prostatectomy
N52.32	Erectile dysfunction following radical cystectomy
N52.33	Erectile dysfunction following urethral surgery
N52.34	Erectile dysfunction following simple prostatectomy
N52.35	Erectile dysfunction following radiation therapy
N52.36	Erectile dysfunction following interstitial seed therapy
N52.37	Erectile dysfunction following prostate ablative therapy
N52.39	Other and unspecified postprocedural erectile dysfunction
N52.8	Other male erectile dysfunction
N52.9	Male erectile dysfunction, unspecified
0VUSX7Z-	Supplement Penis with Autologous Tissue Substitute, External Approach
0VUSXJZ-	Supplement Penis with Synthetic Substitute, External Approach
0VUSXKZ	Supplement Penis with Nonautologous Tissue Substitute, External Approach
0VUS0JZ	Supplement Penis with Synthetic Substitute, Open Approach
0VUS4JZ	Supplement Penis with Synthetic Substitute, Percutaneous Endoscopic Approach

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10251093/#:~:text=Conclusions,in%20the%20manifestation%20of%20ED.

REVISION LOG:

REVISIONS	DATE
Creation date	
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Annual Review	10/2/2020
Annual Review, code list updated, policy name change	12/17/2021
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Sanjiv Shah MD Digitally signed by Sanjiv Shah MD Date: 2024.05.01 17:15:54 -04'00'	**Date:**
Approved: **Sanjiv Shah, MD** **Chief Medical Officer**	

Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, MetroPlus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical

literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government, or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.