DIAGNOSIS AND TREATMENT OF IMPOTENCE (NCD 230.4)

Guideline Number: MPG075.04
Approval Date: July 11, 2018

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POLICY SUMMARY

Overview
Impotence is the failure of a body part for which the diagnosis, and frequently the treatment, requires medical expertise. Depending on the cause of the condition, treatment may be surgical; e.g., implantation of a penile prosthesis, or nonsurgical; e.g., medical or psychotherapeutic treatment.

Indications and Limitations of Coverage
A duplex scan (also known as duplex ultrasonography) is a simple, painless, non-invasive examination that uses sound waves to take images of the blood vessels and blood flow. It allows detailed assessment of the major veins and arteries.

Duplex scan is used to evaluate blood flow, venous leak, signs of atherosclerosis and scarring or calcification of erectile tissue. Erection is induced by injecting prostaglandin, a hormone-like stimulator produced in the body. Ultrasound is then used to visualize vascular dilation and measure penile blood pressure (which may also be measured with a special cuff). Measurements are compared to those taken when the penis is flaccid. Duplex scan of the penile vessels is a diagnostic study. It should not be used for routine monitoring in a rehabilitation protocol or post-operative follow-up protocol.

Indications
Duplex scan of the penile vessels will be considered medically reasonable and necessary for:
• the treatment failure of erectile dysfunction in patients who have sustained a documented groin, pelvic or vascular injury where a vascular etiology for impotence is suspected;
• the differentiation of ischemic priapism from non-ischemic priapism for determining appropriate medical management;
• patients with a lifetime history erectile dysfunction;
• for assisting in determining whether the cause of erectile dysfunction is psychogenic or vascular in origin;
• Peyronie’s Disease

Limitations
Duplex scan of the penile vessels will be considered not medically reasonable and necessary:
• when not preceded by pharmacological/medicinal treatment;
• when performed as a routine procedure;
• when the outcome is not contributory to a plan of treatment.

APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws.

Related Medicare Advantage Policy Guidelines
• Cavernous Nerves by Electrical Stimulation with Penile Plethysmography (NCD 160.26)
• Testosterone Replacement Therapy

Related Medicare Advantage Coverage Summary
• Impotence Treatment
that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
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<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>93980</td>
<td>Duplex scan of arterial inflow and venous outflow of penile vessels; complete study</td>
</tr>
<tr>
<td>93981</td>
<td>Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study</td>
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**ICD-10 Diagnosis Codes**

See related Local Coverage Determinations

**PURPOSE**

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

**REFERENCES**

- CMS National Coverage Determinations (NCDs)
  - NCD 230.4 Diagnosis and Treatment of Impotence
- CMS Local Coverage Determinations (LCDs)
  - LCD Medicare Part A Medicare Part B
    - L33816 (Duplex Scan for Erectile Dysfunction) First Coast FL, PR, VI FL, PR, VI
    - L35755 (Non-Invasive Abdominal / Visceral Vascular Studies) WPS AK, AL, AR, AZ, CT, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, OH, OR, RI, SC, SD, TN, UT, VA, VI, VT, WA, WI, WV, WY IA, IN, KS, MI, MO, NE
    - L34268 (Medicine: Noninvasive Vascular Studies of Abdominal, Pelvic, Scrotal Contents and/or Retroperitoneal Organs) Cahaba Retired 06/01/2017 AL, GA, TN AL, GA, TN
- CMS Benefit Policy Manual
  - Chapter 15, § 70 Sleep Disorder Clinics (B)(3) Impotence
- UnitedHealthcare Commercial Policies
  - Nerve Graft to Restore Erectile Function During Radical Prostatectomy

**GUIDELINE HISTORY/REVISION INFORMATION**

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<tr>
<td>04/01/2019</td>
<td>• Reorganized policy template; relocated Terms and Conditions and Purpose section</td>
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<tr>
<td>07/11/2018</td>
<td>• Annual review; no changes</td>
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