DIAGNOSIS AND TREATMENT OF IMPOTENCE (NCD 230.4)

Guideline Number: MPG075.03
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TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®)**, Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

**CPT® is a registered trademark of the American Medical Association.

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.

**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 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>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>93980</td>
<td>Duplex scan of arterial inflow and venous outflow of penile vessels; complete study</td>
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<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

**REFERENCES**

**CMS National Coverage Determinations (NCDs)**
- NCD 230.4 Diagnosis and Treatment of Impotence

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### CMS Local Coverage Determinations (LCDs)

<table>
<thead>
<tr>
<th>LCD</th>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
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<tr>
<td>L33816 (Duplex Scan for Erectile Dysfunction) First Coast</td>
<td>FL, PR, VI</td>
<td>FL, PR, VI</td>
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<tr>
<td>L35755 (Non-Invasive Abdominal / Visceral Vascular Studies) WPS</td>
<td>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</td>
<td>IA, KS, MI, MO, NE, IN</td>
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<tr>
<td>L34268 (Medicine: Noninvasive Vascular Studies of Abdominal, Pelvic, Scrotal Contents and/or Retroperitoneal Organs) Cahaba Retired 06/01/2017</td>
<td>AL, GA, TN</td>
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### 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>
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<tr>
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| 08/01/2017 | • Updated policy template:  
  o Removed and replaced Instructions for Use; added Terms and Conditions and  
    Purpose language  
  o Updated Guideline History/Revision Information; added disclaimer language to  
    indicate 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 |
| 07/12/2017 | • Annual review                                                                     |