Male Erectile Dysfunction

Policy Number: MM.12.011
Original Effective Date: 03/11/2008
Line(s) of Business: PPO; HMO; Fed 87
Current Effective Date: 03/01/2013
Lines of Business Excluded
QUEST
Section: Other/Miscellaneous
Place(s) of Service: Outpatient

I. Description

Erectile dysfunction (ED), also called impotence, is the persistent inability to attain and maintain an erection sufficient for sexual intercourse. Causes of ED are divided into two types, psychogenic and organic. Psychogenic ED is often secondary to anxiety, stress or depression. It usually has sudden onset and can be intermittent; frequently, nocturnal erections occur in men who have psychogenic ED. Organic disease is defined as anatomic or pathophysiologic changes occurring in some bodily tissue or organ. Organic ED may be secondary to specific vascular, systemic, respiratory, endocrine or nervous system conditions. A good medical and sexual history as well as a physical exam are important in the diagnosis of ED.

Several treatments are available for organic and psychogenic causes of ED. With the exception of the Fed87 plan, HMSA does not cover oral pharmaceuticals for the treatment of ED whether it is of organic or psychogenic origin.

II. Criteria/Guidelines

A. The evaluation of ED is covered (subject to Limitations/ Exclusions and Administrative Guidelines) when all of the following criteria are met:

1. ED has lasted more than six months
2. A comprehensive history and physical exam (including medical and sexual) and, if appropriate, psychosocial evaluation has been performed
3. Patient has a history of conditions that may be associated with organic causes ED including but not limited to, cardiovascular disease, diabetes, obesity, epilepsy, stroke, multiple sclerosis, hypogonadism, surgical causes including radical prostatectomy, aortoiliac bypass, Parkinson’s disease, Alzheimer’s disease, thyroid disease Peyronie’s disease, Guillain-Barre syndrome, and leukemia.
B. The following are the possible covered diagnostic tests for the evaluation of ED when all of the criteria in II.A.1, 2, and 3 are met (subject to Limitations/Exclusions and Administrative Guidelines):
   1. Duplex scan (Doppler and ultrasound) in conjunction with extracorporeal papaverine
   2. Dynamic infusion cavernosometry and cavernosography
   3. Pharmacological response test for ED (using vasoactive drugs, e.g., papaverine HCl, phentolamine mesylate, prostaglandin E1)
   4. Pudendal arteriography

C. Laboratory testing is covered (subject to Limitations/Exclusions and Administrative Guidelines) when all of the criteria in II.A.1, 2, and 3 are met:
   1. Blood glucose
   2. Complete blood count
   3. Creatinine
   4. Hepatic panel
   5. Lipid profile
   6. Prostate specific antigen
   7. Serum testosterone (if serum testosterone is below normal, testing for pituitary dysfunction is covered)
   8. Thyroid function
   9. Urinalysis

D. The following treatments are covered (subject to Limitations/Exclusions and Administrative Guidelines) when the etiology of ED is determined to be organic:
   1. Injectable medications
      a. Papaverine, alporostadil, phentolamine self-injected into the corpus cavernosa
      b. Medical Urethral System for Erection method (i.e., intraurethral insertion of prostaglandin alprostadil)
   2. External devices - Penile vacuum pump when prescribed by physician
   3. Implantable devices - Semi-rigid penile prostheses or inflatable penile prostheses for patients with documented physiologic ED who have failed medical therapy or for whom medical therapy is contraindicated

III. Limitations/Exclusions

A. The following procedures are not covered for the diagnosis of ED:
   1. Dorsal nerve conduction latencies
   2. Evoked potential measurements
   3. Corpora cavernosal electromyography

B. The following are benefit exclusions:
   1. Drug therapies related to ED except for certain injectables or suppositories as listed above (for Federal Plan 87 members, phosphodiesterase (PDE5) inhibitors are covered, see plan benefits)
   2. Treatment of ED due to nonorganic etiology
   3. The treatment of ED is not a covered service under the HMSA QUEST plan
C. The following services are not covered for the treatment of ED:
   1. Application of topical cream or gel containing vasodilators (minoxidil, nitroglycerin, papaverine and PGE1).
   2. Venous ligation in the treatment of venous leak impotency
   3. Vascular surgery (revascularization of the corpora, CPT 37788 or penile venous occlusive procedure, CPT 37790) is not covered except in a young patient without identifiable risk factors for impotency or who has suffered perineal or pelvic trauma (higher success rates in younger men with congenital or traumatic abnormalities).

D. Penile prosthesis implantation precludes subsequent use of vasoactive injection therapy and vacuum/constriction devices.

IV. Administrative Guidelines

Precertification is not required. Documentation supporting the medical necessity should be legible, maintained in the patient’s medical record and must be made available to HMSA upon request. HMSA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54200</td>
<td>Injection procedure for Peyronie’s disease</td>
</tr>
<tr>
<td>54205</td>
<td>with surgical exposure of plaque</td>
</tr>
<tr>
<td>54230</td>
<td>Injection procedure for corpora cavernosography</td>
</tr>
<tr>
<td>54231</td>
<td>Dynamic cavernosometry, including intracavernosal injection of vasoactive drugs (e.g., papaverine, phentolamine)</td>
</tr>
<tr>
<td>54235</td>
<td>Injection of corpora cavernosa with pharmacologic agent(s) (e.g., papaverine, phentolamine)</td>
</tr>
<tr>
<td>54250</td>
<td>Nocturnal penile tumescence (NPT) and/or rigidity test</td>
</tr>
<tr>
<td>54400</td>
<td>Insertion of penile prosthesis; non-inflatable (semi-rigid)</td>
</tr>
<tr>
<td>54401</td>
<td>inflatable (self-contained)</td>
</tr>
<tr>
<td>54405</td>
<td>Insertion of multi-component inflatable penile prosthesis, including placement of pump, cylinders, and/or reservoir</td>
</tr>
</tbody>
</table>

V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.
Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA's determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References