

## Diagnosis and Treatment of Male Sexual Dysfunction

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<b>Approved By:</b>	Highmark Health Options – Market Leadership
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<b>Application:</b>	All participating hospitals and providers
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### Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

### POLICY STATEMENT

Highmark Health Options may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary benefits.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

### DEFINITIONS

**Highmark Health Options (HHO)** – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently serves Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan and Health Plan Plus members.

### POLICY POSITION

Prior Authorization is required.

Erectile dysfunction is defined as the inability to achieve a sufficient erection for satisfactory sexual performance. Erectile function requires competent arterial blood inflow as well as a reduction of venous blood outflow. Disease and other risk factors may affect the arterial and venous systems in a manner that impedes erectile function and may lead to erectile dysfunction.

Oral and topical pharmacological treatments are not addressed in this policy.

## Diagnosis of Male Sexual Dysfunction

The following procedures and tests for the diagnosis of erectile dysfunction may be considered medically necessary:

- Comprehensive history and physical examination
- Lab tests for testosterone levels
  - Abnormal testosterone levels may necessitate further endocrine testing for hypothalamus, pituitary, thyroid, and adrenal dysfunction
- Nocturnal Penile Tumescence (NPT) testing
  - NPT testing may be considered medically necessary when the following criteria are met:
    - Clinical evaluation, including history and physical examination, is unable to distinguish psychogenic from organic erectile dysfunction; and
    - Any identified medical disorders have been corrected.
  - Types of NPT testing that may be considered medically necessary:
    - Snap-Gauge Device; or
    - RigiScan
      - NPT testing using the RigiScan may be considered medically necessary only:
        - When NPT testing is indicated; and
        - The results of Snap-Gauge testing are equivocal or inconclusive.
  - All other indications for NPT are considered not medically necessary.

The following diagnostic procedures are considered not medically necessary, as these tests do not have any therapeutic value because spinal cord injury and other neurological deficits that may cause erectile dysfunction are typically identified during a comprehensive history and examination:

- Corpora cavernosal electromyography
- Dorsal nerve conduction latencies
- Evoked potential measurements

Procedures and testing for erectile dysfunction not meeting the criteria as indicated in this policy is considered not medically necessary.

## TREATMENT OF MALE SEXUAL DYSFUNCTION

The following treatments may be considered medically necessary for male sexual dysfunction:

- Vacuum constriction devices (e.g., ErecAid); or
- Vasodilator injection (e.g., papaverine, phentolamine, alprostadil); or
- Vasodilator suppository (e.g., alprostadil); or
- Collagenase clostridium histolyticum injection (e.g., Peyronie's disease).

Treatment of male sexual dysfunction not meeting the criteria as indicated in this policy is considered not medically necessary.

## PENILE PROSTHESES AND EXTERNAL DEVICES

Treatment of male sexual dysfunction with an internal penile prosthesis or an external device may be considered medically necessary when EITHER of the following criteria is met:

- Erectile dysfunction is due to an organic disease or injury and is not psychological in nature;  
or

- There is failure, a contraindication or an intolerance to pharmacological therapy.

The surgical implantation of an internal penile prosthesis may be considered medically necessary when the above criteria have been met.

The removal of an internal penile prosthesis may be considered medically necessary for ANY ONE of the following indications:

- Infection; or
- Mechanical failure; or
- Urinary obstruction; or
- Intractable pain.

Following the removal of an internal penile prosthesis it may be considered medically necessary for surgical re-implantation of an internal penile prosthetic device.

An external device or an internal penile prosthesis insertion or removal not meeting the criteria as indicated in this policy is considered not medically necessary.

### **PENILE REVASCULARIZATION**

Penile revascularization may be considered medically necessary for the treatment of erectile dysfunction when ALL of the following criteria are met:

- The individual presents with erectile dysfunction preceded by blunt perineal or pelvic trauma; and
- The individual has erectile dysfunction that is secondary to a focal arterial occlusion, as evidenced by an arteriogram or duplex ultrasonography conclusive for focal arterial obstruction; and
- There is no evidence of generalized vascular disease (e.g., diabetes mellitus, hypertension, coronary artery disease), Peyronie's plaques, intracavernosal masses, nodules, or sensory neuropathy; and
- There is evidence of normal corporeal venous function; and
- Alternative nonsurgical treatment modalities have been fully explained to the individual, and the individual is determined to achieve spontaneous erections without the need for pharmacological, external, or internal support devices; and
- The individual is not actively smoking.

Venous ligation performed as a treatment for erectile dysfunction is considered not medically necessary.

Penile revascularization not meeting the criteria as indicated in this policy is considered not medically necessary.

### **ELIGIBLE PROCEDURE CODES**

36245	Selective Catheter Placement, Arterial System; Each First Order Abdominal, Pelvic Or Lower Extremity Artery Branch, Within A Vascular Family.
36246	Selective Catheter Placement, Arterial System; Initial Second Order Abdominal, Pelvic Or Lower Extremity Artery Branch, Within A Vascular Family.
36247	Selective Catheter Placement, Arterial System; Initial Third Order Or More Selective Abdominal, Pelvic Or Lower Extremity Artery Branch, Within A Vascular Family.

36248	Selective Catheter Placement, Arterial System; Additional Second Order, Third Order, And Beyond, Abdominal, Pelvic Or Lower Extremity Artery Branch, Within A Vascular Family (list In Addition To Code For Initial Second Or Third Order Vessel As Appropriate).
37788	Penile Revascularization, Artery, With Or Without Vein Graft.
37790	Penile Venous Occlusive Procedure.
51792	Stimulus Evoked Response (e.g., Measurement Of Bulbocavernosus Reflex Latency Time).
54115	Removal Foreign Body From Deep Penile Tissue (e.g., Plastic Implant).
54205	Injection Procedure For Peyronie Disease; With Surgical Exposure Of Plaque.
54230	Injection Procedure For Corpora Cavernosography.
74445	Corpora Cavernosography, Radiological Supervision And Interpretation.
75736	Angiography, Pelvic, Selective Or Supraselective, Radiological Supervision And Interpretation.
84410	Testosterone; Bioavailable, Direct Measurement (eg, Differential Precipitation).
93975	Duplex Scan Of Arterial Inflow And Venous Outflow Of Abdominal, Pelvic, Scrotal Contents And/or Retroperitoneal Organs; Complete Study.
93976	Duplex Scan Of Arterial Inflow And Venous Outflow Of Abdominal, Pelvic, Scrotal Contents And/or Retroperitoneal Organs; Limited Study.
93978	Duplex Scan Of Aorta, Inferior Vena Cava, Iliac Vasculature, Or Bypass Grafts; Complete Study.
93979	Duplex Scan Of Aorta, Inferior Vena Cava, Iliac Vasculature, Or Bypass Grafts; Unilateral Or Limited Study.
93980	Duplex Scan Of Arterial Inflow And Venous Outflow Of Penile Vessels; Complete Study.
93981	Duplex Scan Of Arterial Inflow And Venous Outflow Of Penile Vessels; Follow-up Or Limited Study.
95870	Needle Electromyography; Limited Study Of Muscles In 1 Extremity Or Non-limb( axial) Muscles (unilateral or Bilateral), Other Than Thoracic Paraspinal, Cranial Nerve Supplied Muscles, Or Sphincters.

**Eligible Diagnosis Codes for Procedure Codes 54115, 54205, 54230, and 74445**

N48.6	N52.01	N52.02	N52.03	N52.1
N52.2	N52.31	N52.32	N52.33	N52.34
N52.35	N52.36	N52.37	N52.39	N52.8
N52.9	T83.21XA	T833.22XA	T83.23XA	T83.24XA
T83.24XD	T83.24XS	T83.25XA	T83.25XD	T83.25XS
T83.29XA	T83.29XD	T83.29XS	T83.410A	T83.410D
T83.410S	T83.411A	T83.411D	T83.411S	T83.418A
T83.418D	T83.418S	T83.420A	T83.420D	T83.420S
T83.421A	T83.421D	T83.421S	T83.428A	T83.428D
T83.428S	T83.490A	T83.490D	T83.490S	T83.491A
T83.491D	T83.491S	T83.498A	T83.498D	T83.498S
T83.61XA	T83.61XD	T83.61XS	T83.62XA	T83.62XD
T83.62XS	T83.69XA	T83.69XD	T83.69XS	T83.81XA
T83.81XD	T83.81XS	T83.82XA	T83.82XD	T83.82XS
T83.83XA	T83.83XD	T83.83XS	T83.84XA	T83.84XD
T83.84XS	T83.85XA	T83.85XD	T83.85XS	T83.86XA
T83.86XD	T83.86XS	T83.89XA	T83.89XD	T83.89XS
T83.9XXA	T83.9XXD	T83.9XXS		

## References

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**POLICY UPDATE HISTORY**

09/28/2022	Approved in Medical Policy Committee
10/2022	Approved in QI/UM