Impotence Treatment

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Instructions for Use

Table of Contents Page

Related Medicare Advantage Policy Guidelines

- Cavernous Nerves by Electrical Stimulation with Penile Plethysmography (NCD 160.26)
- Testosterone Pellets (Testopel®)

Coverage Guidelines

The treatment of impotency is covered when Medicare criteria are met.

Diagnosis and Treatment of Sexual Impotency

Diagnosis and treatment of sexual impotency may be covered. Depending on the cause of the condition, treatment may be:

- Non-surgical treatment (e.g., medical or psychotherapeutic treatment); refer to the Coverage Summary titled Mental Health Services and Procedures.
- Surgical treatment (e.g., implantation of penile prosthesis)

Notes:

- Since causes, and therefore, appropriate treatment varies, if abuse is suspected it may be necessary to request documentation of appropriateness in individual cases. Documentation of a history or radical prostatectomy would be an indication for treatment.
- Refer to the National Coverage Determination (NCD) for Diagnosis and Treatment of Impotence (230.4). (Accessed July 26, 2021)

External Vacuum Erection Devices (VED) (L7900) or Constriction Rings (L7902) (e.g., ErecAid)

For dates of service on or after July 1, 2015, vacuum erection devices and related accessories are statutorily non-covered based on the Achieving a Better Life Experience (ABLE) Act of 2014. Refer to the DME MAC LCD for Vacuum Erection Devices (L34824). (Accessed July 26, 2021)

Electrical Stimulation

Electrical stimulation of the cavernous and associated parasympathetic nerves with penile plethysmography is not covered for members undergoing nerve-sparing prostatic or colorectal surgical procedures. Refer to the NCD for Cavernous Nerves by Electrical Stimulation with Penile Plethysmography (160.26). (Accessed July 26, 2021)

Prescription or Injectable Medications

Treatment of sexual or erectile dysfunction are not covered. ED drugs will meet the definition of a Part D drug when prescribed for medically-accepted indications approved by the FDA other than sexual or erectile dysfunction (such as pulmonary hypertension). However, ED drugs will not meet the definition of a Part D drug when used off-label, even when the off label use is listed in one of the compendia found in section 1927(g)(1)(B)(i) of the Act: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information (or its successor publications), and DRUGDEX® Information System. Refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Section 20.1 – Excluded Categories.
(Accessed July 26, 2021)

Also refer to the Coverage Summary titled Medications/Drugs (Outpatient/Part B).

Nerve Graft to Restore Erectile Function During Radical Prostatectomy

Medicare does not have a National Coverage Determination (NCD) nerve graft to restore erectile function during radical prostatectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Nerve Graft to Restore Erectile Function During Radical Prostatectomy.
Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Policy History/Revision Information

Date	Summary of Changes
08/17/2021	**Related Medicare Advantage Policy Guidelines** • Removed reference link to the policy titled *Diagnosis and Treatment of Impotence (NCD 230.4)* (retired) **Coverage Guidelines** ***External Vacuum Erection Devices (VED) (L7900) or Constriction Rings (L7902) (e.g., ErecAid)*** • Removed reference link to the *Medicare Learning Network (MLN) Matters # SE1511 –Discontinued Coverage of Vacuum Erection Systems (VES) Prosthetic Devices in Accordance with the Achieving a Better Life Experience Act of 2014* **Supporting Information** • Archived previous policy version MCS048.01

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare

Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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