UnitedHealthcare®

Coverage Summary

Impotence Treatment

Policy Number: I-004	**Products:** UnitedHealthcare Medicare Advantage Plans	**Original Approval Date:** 07/16/2008
Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee		**Last Review Date:** 08/20/2019

Related Medicare Advantage Policy Guidelines:

- Cavernous Nerves by Electrical Stimulation with Penile Plethsmography (NCD 160.26)
- Diagnosis and Treatment of Impotence (NCD 230.4)
- Testosterone Replacement Therapy

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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I. COVERAGE

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

Guidelines/Notes:

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

a. Non-surgical treatment (e.g., medical or psychotherapeutic treatment); *see the Coverage Summary for Mental Health Services and Procedures*.

b. 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.*
- *See the NCD for Diagnosis and Treatment of Impotence (230.4). (Accessed December 20, 2019)*

2. 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. *See the DME MAC for LCD for Vacuum Erection Devices (L34824). (Accessed December 20, 2019)*

   For additional info, see the CMS MLN Matters NumberSE1511 Discontinued Coverage of Vacuum Erection Systems (VES) Prosthetic Devices in Accordance with the Achieving a Better Life Experience Act of 2014. (Accessed July 29, 2019)

3. 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. *See the NCD for Cavernous Nerves by Electrical Stimulation with Penile Plethysmography (160.26). (Accessed July 29, 2019)*

4. Prescription or injectable medications for the 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.

   See the Medicare Prescription Drug Benefit Manual, Chapter 6, Section 20.1 - Excluded Categories. (Accessed December 20, 2019)

   Also see the Coverage Summary for Medications/Drugs (Outpatient/Part B).

5. Elective or voluntary procedures, services, supplies and medications for the enhancement of sexual performance are not covered except as covered in #1 above.

   See the Medicare Benefit Policy Manual, Chapter 16, Section 20 - Services Not Reasonable and Necessary. (Accessed July 29, 2019)

   Also see the Medicare Prescription Drug Benefit Manual, Chapter 6, Section 20.1 - Excluded Categories. (Accessed December 20, 2019)

6. 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,*** *see the UnitedHealthcare Commercial Medical Policy for Nerve Graft to Restore Erectile Function During Radical Prostatectomy. (**IMPORTANT NOTE**: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)*
- ***Committee approval date**: **August 20, 2019***
- *Accessed July 29, 2019*

II. DEFINITIONS

III. REFERENCES

See above.

IV. REVISION HISTORY

08/20/2019	**Guideline 4 (Prescription or Injectable Medications)** • Removed list of examples of erectile dysfunction drugs (no CMS reference available) **Definitions** • Removed definition of "Electrical Stimulation of the Cavernous and Associated Parasympathetic Nerves"