Clinical Policy: Sexual Dysfunction and Impotence

Reference Number: IL.CP.MP.514 Coding Implications
Last Review Date: 03/22 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Appropriate evaluation of ED leads to accurate advice, management and referral of patients. The diagnostic evaluation of a patient with ED should include a detailed medical and psychosexual history and focused physical examination. Adjunctive testing, such as a vascular assessment and neurological assessment may be indicated in select patients. Treatment will vary depending on the severity and cause of the dysfunction. First-line medical therapy of ED usually consists of phosphodiesterase-5 (PDE-5) inhibitors.

There are several second-line therapies that have been shown to be effective: penile self-injectable drugs, intraurethral alprostadil, and vacuum devices. Surgical implantation of a penile prosthesis should be reserved for men who cannot use or who have not responded to first and second-line therapies

For more severe disease, usually associated with advanced diabetes, surgical or radiation treatment for prostate or bladder cancer or Peyronie's disease, drug treatment or treatment with an external vacuum device may be ineffective. Implantation of a penile prosthesis is a therapeutic alternative. There are three basic kinds of penile implants: semi-rigid (malleable) implant, two-piece inflatable implant, and three-piece inflatable implant.

Policy/Criteria

I. It is the policy of MeridianHealth affiliated with Centene Corporation® that evaluation for cause of impotence (organic vs. non-organic) is considered medically necessary and is therefore covered as a medical service subject to the limitations of contract or benefit. This would include, but is not limited to:
   A. A medical, psychosocial and sexual history; physical examination; and appropriate laboratory and diagnostic evaluation.
   B. External male erectile vacuum devices are covered at the Durable Medical Equipment benefit level in Michigan only. Coverage requirements include:
      i. Males at least 18 years of age with a diagnosis of organic ED.
      ii. An appropriate evaluation must be done to determine the necessity for the external penile vacuum pump.
      iii. Contraindicated in patients with blood dyscrasias, including sickle cell disease, or those taking anticoagulants.
      iv. Only one external penile vacuum pump is permitted per lifetime
   C. All requests for penile implants will be reviewed with InterQual criteria
   D. The following items are **NOT** a covered benefit:
      i. Treatment and testing with drugs for Medicaid members, unless permitted by State or Federal Contract
      ii. Psychological counseling for erectile dysfunction

iii. Exogenous testosterone replacement therapy or PDE-5 inhibitor medications given with the intent of treating ED, penile self-injections with vasoactive drugs or intraurethral suppositories.
iv. Penile revascularization for most men with vascular ED has a low success rate thus is not recommended but may be considered for young, nonsmoking otherwise healthy men with recently acquired ED due to a focal arterial occlusion.
v. Extracoporeal shock wave therapy for Peyronie's disease or low-intensity shock therapy (LIST).
vi. Intracavernosal stem cell therapy is considered investigation
vii. Platelet-rich (PRP) therapy is considered experimental
viii. Hyperbaric oxygen therapy is considered experimental
ix. Sexual dysfunction requests regarding treatment of a female unless verified by benefit packages when applicable.

Coding Implications

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CPT®* Codes	Description

HCPCS ®* Codes	Description

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date		12/16/11
Annual Review with no changes		03/21
Annual Review – policy will be retired		03/22

References

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3. Cochrane Database of Systematic Reviews, Prostaglandin E1 for treatment of erectile dysfunction, Uriuoli, R., et al., Issue 2, 2006. Retrieved from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001784.pub2/full
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6. Miller, T. A., Diagnostic Evaluation of Erectile Dysfunction, American Family Physician, Vol. 61 No. 1, January 1, 2000. Retrieved from: http://www.aafp.org/afp/2000/0101/p95.html
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8. Schapiro, R., Managing Symptoms of Multiple Sclerosis, Neurological Clinics, Vol. 23, Issue 1,177-187, February 2005
9. Schroder, M., et al., Clitoral therapy device for treatment of sexual dysfunction in irradiated cervical cancer patients, Int J Radiat Oncol Biol Phys., Vol. 61, Issue 4, 1078-86, March 2005
10. State of Illinois Contract between the Department of Healthcare and Family Services and Meridian Health Plan of Illinois, 2018-24-601, Preauthorization and Concurrent Review Requirements, 1.1.2.3.3
11. "Up to Date" Treatment of Male Sexual dysfunction. Literature review current through: Feb 2021. Last updated Jun 23, 2020.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria

set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.