Discordance Between Clinical Guidelines and Payer Policies for the Evaluation and Treatment of Erectile Dysfunction

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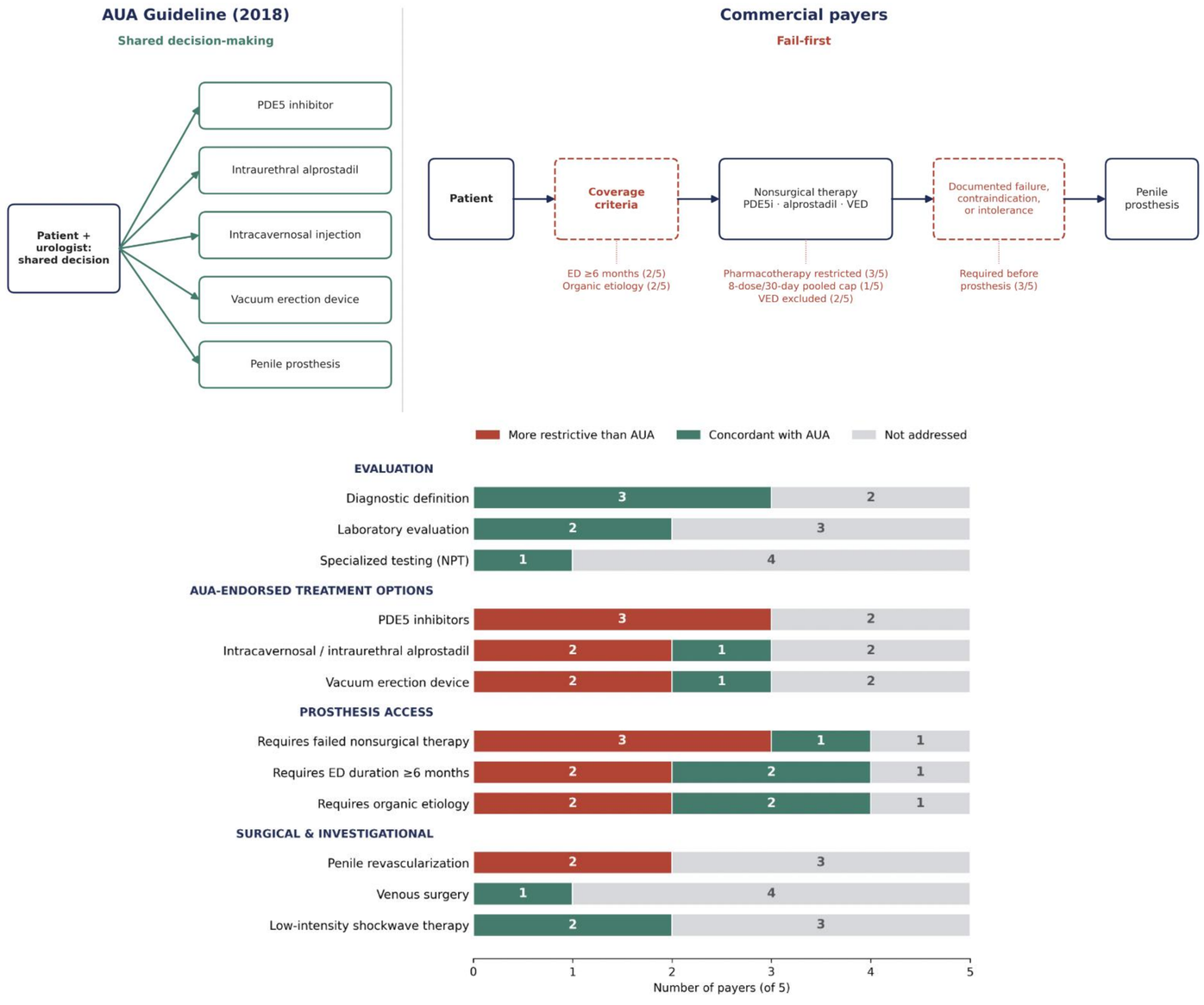
Background

- The 2018 AUA ED Guideline replaced the traditional stepwise treatment algorithm with shared decision-making, in which any evidence-based therapy may be offered first based on patient values and goals
- Payer medical and pharmacy policies determine which of those options patients can access, and in what order
- Whether payer policies reflect this shift has not been evaluated

Methods

- Comparison of the AUA ED Guidelines with payer policies
  - Aetna, Blue Cross Blue Shield (BCBS), Cigna, UnitedHealthcare (UHC), and Medicare
- Policies were evaluated across diagnostic definitions, laboratory evaluation, specialized testing including nocturnal penile tumescence, pharmacotherapy coverage and quantity limits, vacuum erection device, penile vascular surgery, and investigational therapies
- Each domain was classified as more restrictive than, concordant with, or not addressed relative to AUA guidance

The AUA abandoned stepwise ED treatment in 2018. Why do payers still require it?



Results

- Many payers required failure of nonsurgical therapy before covering a penile prosthesis
- Some time restrictions requiring ≥6 months of ED; 2 of 5 required organic etiology
- No payer covered pharmacotherapy without restriction: statutory exclusion, plan-level exclusion, or dosage
- However, evaluation criteria were largely concordant with AUA guidance

Impact Statement

Payers require patients to fail treatments the AUA no longer requires them to try, delaying definitive care and replacing shared decision-making between patient and physician with coverage rules.

Conclusions

- Payer policies largely agree with the AUA on how to evaluate ED but not on how to treat it
- Fail-first requirements reimpose the stepwise model the AUA replaced with shared decision-making, while quantity limits and device exclusions can make the required trials difficult to complete
- Quantity limits and benefit exclusions may constrain adequate therapeutic trials, and Medicare's exclusions may leave surgery as the principal covered option for beneficiaries without supplemental coverage
- Aligning coverage policy with current guidance would return treatment selection to patients and physicians
- These disparities warrant evaluation of their effects on treatment sequencing, patient outcomes, and utilization of surgical therapy.

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