

Benign Prostatic Hyperplasia Treatment

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Oscar may delegate utilization management decisions of certain services to third-party delegates, who may develop and adopt their own clinical criteria.

The clinical guidelines are applicable to all commercial plans. Services are subject to the terms, conditions, limitations of a member's plan contracts, state laws, and federal laws. Please reference the member's plan contracts (e.g., Certificate/Evidence of Coverage, Summary/Schedule of Benefits) or contact Oscar at 855-672-2755 to confirm coverage and benefit conditions.

Summary

Benign prostatic hyperplasia (BPH) is the inappropriate enlargement of the prostate gland found most frequently in older men. Because urine from the bladder must pass through the prostate, men with BPH may experience symptoms such as decreased urinary flow, straining, or urinary tract infections.

Treatment of BPH depends on individual risk factors and careful consideration of the risks/benefits of each therapy. Options for treatment include medications, minimally invasive procedures, and surgical interventions. Oscar utilizes benign prostatic hyperplasia treatment guidelines from the American Urological Association along with current medical literature in determining coverage criteria and exclusions. This guideline does not address the pharmaceutical treatment of BPH, which can be found in the appropriate drug benefit guideline. Certain procedures may require prior authorization.

Indexes Used to Evaluate BPH-related Symptoms:

"The American Urological Association Symptom Index (AUA-SI)" is a self-administered 7-item questionnaire assessing the severity of various urinary symptoms. Total AUA-SI scores range from 0 to 35, with overall severity categorized as mild (≤ 7), moderate (8-19), or severe (20-35).

"The International Prostate Symptom Score (I-PSS)" incorporates the questions from the AUA-SI with an additional quality of life question. The first seven questions of the I-PSS are identical to the questions appearing on the AUA-SI and are scored identically. The answers to the quality of life question range

from “delighted” to “terrible” or 0 to 6. Total I-PSS scores range from 0 to 35, with overall severity categorized as mild (≤ 7), moderate (8-19), or severe (20-35).

Definitions

“Benign Prostatic Hyperplasia” (i.e., BPH) is a condition that causes an increase in the size of the prostate gland in men, commonly causing difficulty with urination; also referred to as benign prostatic hypertrophy although this term is technically incorrect.

“Ablation” is to surgically remove or excise tissue from the body.

“Cryosurgery” is a treatment performed with an instrument that destroys tissue by applying very cold temperature.

“Enucleation” is to remove an intact organ or tissue without cutting into the surrounding capsule.

“Hyperplasia” is an enlargement of an organ or tissue because of an increase in the number of cells. It is contrasted by hypertrophy which is defined as an increase in the size of individual cells.

Medical Therapies

- **“5-Alpha Reductase Inhibitors”** are medications that block the production of a type of testosterone involved in prostate development and growth.
- **“Alpha Adrenergic Blockers”** are medications that relax the muscles of the prostate and bladder; they can improve urine flow and reduce blockage.
- **“Phosphodiesterase-5 Inhibitors”** are medications that have been found to relax smooth muscle fibers of the bladder and prostate.

Surgical and Minimally Invasive Therapies:

- **“Contact Laser Ablation of the Prostate (CLAP)”** is a procedure where the tip of an Nd:YAG laser is placed in direct contact with prostate tissue, vaporizing it.
- **“Holmium Laser Procedures of the Prostate (HoLAP, HoLEP, HoLRP)”** are procedures that use a holmium laser fiber to either ablate (HoLAP), enucleate (HoLEP), or resect (HoLRP) prostate tissue.
- **“Interstitial Laser Coagulation of the Prostate (ILCP)”** is an outdated procedure involving laser heat treatment to reduce prostatic obstruction. It has largely been replaced by newer approaches.

- **“Surgical Prostatectomy”** is a surgical procedure that can be done open (e.g., with large incisions to access the prostate), laparoscopically (e.g., with small incisions through which small cameras and/or instruments can be inserted), or robotic-assisted (e.g., laparoscopically and controlled by a surgeon operating the instruments robotically).
- **“Photoselective Vaporization (PVP)”** is a procedure that involves using a laser to vaporize obstructive prostatic tissue.
- **“Prostatic Urethral Lift”** or **“UroLift”** is a procedure to lift or hold the enlarged prostate tissue to keep from blocking the urethra.
- **“Temporary Prostatic Stenting”** refers to a plastic or metal stent placed into the prostatic urethra to temporarily prevent closure due to a stricture or external compression from the surrounding prostatic tissue; it is FDA approved for 30 days of use and is not a permanent solution.
- **“Transurethral Convective Water Vapor Thermal Ablation or water induced tomotherapy (WIT)”** is an ablative procedure that involves using water vapor to ablate tissue and reduce prostatic obstruction.
- **“Transurethral Electroevaporation of the Prostate (TUVP)”** is an ablative procedure that involves utilizing heat from a high-voltage electrical current to minimize obstructive prostatic tissue.
- **“Transurethral Incision of the Prostate (TUIP)”** is a procedure that involves making an incision in the prostate for men with small-to-moderate sized prostates; usually limited to treating glands equal to or less than 30 grams.
- **“Transurethral Microwave Thermotherapy (TUMT)”** is a procedure that involves using microwave energy to heat and destroy excess prostate tissue.
- **“Transurethral Needle Ablation (TUNA)”** is a procedure that involves using radio frequency energy to ablate prostatic tissue with the goal of relieving symptoms associated with BPH.
- **“Transurethral Resection of the Prostate (TURP)”** is a procedure that involves cutting away a section of the prostate accessed through the urethra. It is the Gold Standard treatment for BPH when conservative therapy has failed.
- **“Transurethral Ultrasound Guided Laser Induced Prostatectomy (TULIP)”** is an outdated procedure that involves laser ablation delivered under ultrasound guidance. It has been surpassed by newer procedures with more reproducible outcomes and fewer adverse effects.
- **“UroLume”** is a prostatic stent surgically inserted into the prostatic urethra to prevent closure due to a stricture or external compression from the surrounding prostatic tissue; it is meant as a more permanent solution in patients who are poor surgical candidates.
- **“Visually Guided Laser Ablation of the Prostate (VLAP)”** is a non-contact laser ablation procedure where a Nd:YAG laser is held a short distance (approximately 2 mm) from the prostate tissue, destroying it by coagulation and allowing it to slough away over several weeks;

reserved for treating small or moderately small prostates (less than 80 grams). It has been surpassed by newer procedures with more reproducible outcomes and fewer adverse effects.

Clinical Indications and Coverage Exclusions

Length of Stay

Oscar covers the following treatments and procedures for benign prostatic hyperplasia, when the treatment-specific criteria are met in an **ambulatory or outpatient** (same day surgery) setting. Exceptions to this where postoperative inpatient admission may be necessary and covered are as follows:

- Complications of the procedure such as, but not limited to, bleeding or acute urinary retention; **or**
- Medical comorbidities requiring further acute treatment; **or**
- Radical Prostatectomy, which is covered for 1 day postoperative (1 midnight).

General Clinical Indications

ONE of the following conditions must be met in order to qualify for the following services:

1. Documented diagnosis of moderate to severe BPH (I-PSS or AUA-SI score is ≥ 8); **or**
 2. Any one or more of the following urological complications as a result of BPH:
 - a. Bladder stones
 - b. Hydronephrosis
 - c. Large bladder diverticula
 - d. Recurrent hematuria
 - e. Recurrent or persistent retention refractory to medical therapy
 - f. Recurrent or persistent urinary tract infection
 - g. Renal insufficiency
 - h. Urosepsis.
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1. Transurethral Resection of the Prostate (TURP) is considered medically necessary for BPH when **ALL** of the following criteria are met:
 - a. General clinical indications (above) are met; **and**
 - b. Patients who request surgery, fail medical management, or have a contraindication to medical management.
 2. **Transurethral Microwave Thermotherapy (TUMT)** is considered medically necessary for the treatment of benign prostatic hyperplasia as an alternative to transurethral resection of the prostate (TURP) when **ALL** of the following criteria are met:
 - i. General clinical indications (above) are met; **and**

- ii. Patients who request surgery, fail medical management, or have a contraindication to medical management; **and**
 - iii. Prostate volume is between 30cc and 100cc, as documented by ultrasound measurement; **and**
 - iv. There is no history of prior prostatic surgery.
3. **Transurethral Electroevaporation of the Prostate (TUVP)** is considered medically necessary for the treatment of benign prostatic hyperplasia as an alternative to transurethral resection of the prostate (TURP) when **ALL** of the following criteria are met:
- i. General clinical indications (above) are met; **and**
 - ii. Patients who request surgery, fail medical management, or have a contraindication to medical management.
4. **Transurethral Incision of the Prostate (TUIP)** is considered medically necessary for the treatment of benign prostatic hyperplasia as an alternative to transurethral resection of the prostate (TURP) when **ALL** of the following criteria are met:
- i. General clinical indications (above) are met; **and**
 - ii. Patients who request surgery, fail medical management, or have a contraindication to medical management; **and**
 - iii. Prostate volume is less than or equal to 30cc, as documented by ultrasound measurement.
5. **Contact Laser Ablation of the Prostate (CLAP)** is considered medically necessary for the treatment of benign prostatic hyperplasia as an alternative to transurethral resection of the prostate (TURP) when **ALL** of the following criteria are met:
- i. General clinical indications (above) are met; **and**
 - ii. Patients who request surgery, fail medical management, or have a contraindication to medical management.
6. **Holmium Laser Procedures of the Prostate (HoLAP, HoLEP, HoLRP)** is considered medically necessary for the treatment of benign prostatic hyperplasia as an alternative to transurethral resection of the prostate (TURP) when **ALL** of the following criteria are met:
- i. General clinical indications (above) are met; **and**
 - ii. Patients who request surgery, fail medical management, or have a contraindication to medical management.
7. **Photoselective Vaporization (PVP)** is considered medically necessary for the treatment of benign prostatic hyperplasia as an alternative to transurethral resection of the prostate (TURP) when **ALL** of the following criteria are met:
- i. General clinical indications (above) are met; **and**

- ii. Patients who request surgery, fail medical management, or have a contraindication to medical management.
8. **Transurethral Needle Ablation (TUNA)** is considered medically necessary for the treatment of benign prostatic hyperplasia as an alternative to transurethral resection of the prostate (TURP) when **ALL** of the following criteria are met:
- i. General clinical indications (above) are met; **and**
 - ii. Patients who request surgery, fail medical management, or have a contraindication to medical management; **and**
 - iii. Prostate volume is less than or equal to 80cc, as documented by ultrasound measurement.
9. **Prostatic Urethral Lift** e.g. UroLift is considered medically necessary for the treatment of benign prostatic hyperplasia as an alternative to transurethral resection of the prostate (TURP) when **ALL** of the following criteria are met:
- i. General clinical indications (above) are met; **and**
 - ii. Documented diagnosis of moderate to severe BPH (I-PSS or AUA-SI score is ≥ 8); **and**
 - iii. Patients who fail or do not tolerate medical management after at least 6 months of appropriate therapy, or have a contraindication to medical management; **and**
 - iv. 50 years of age or older; **and**
 - v. Prostate volume is less than or equal to 80cc, as documented by ultrasound measurement; **and**
 - vi. None of the following features are present:
 - i. Obstructive or protruding median lobe on cystoscopy;
 - ii. Active urinary tract infection;
 - iii. Anatomic urethral conditions or malformations that prevent insertion of the device;
 - iv. Current gross hematuria;
 - v. Known allergy or hypersensitivity to nickel
10. **UroLume Permanent Stent** is considered medically necessary to relieve prostatic obstruction due to benign prostatic hyperplasia when **ALL** of the following criteria are met:
- i. Prostate length of at least 2.5cm; **and**
 - ii. Member has life expectancy of less than 12 months; **and**
 - iii. Member meets **ONE** of the following criteria:
 - i. Member meets **BOTH** of the following:
 - 1. Member is under 60 years of age or older; **and**
 - 2. General clinical indications (above) are met.
 - ii. Member meets **BOTH** of the following:

1. Member is under 60 years of age; **and**
2. Member is a poor surgical candidate due to other comorbidities or anatomical irregularities.

11. **Surgical Prostatectomy** (including simple open prostatectomy, laparoscopic prostatectomy, or robotic-assisted laparoscopic prostatectomy) is considered medically necessary for the treatment of benign prostatic hyperplasia as an alternative to transurethral resection of the prostate (TURP) when **ALL** of the following criteria are met:

- i. General clinical indications (above) are met; **and**
- ii. Patients who request surgery, fail medical management, or have a contraindication to medical management; **and**
- iii. Prostate is so large (defined as at least 80cc) that TURP is likely to be incomplete, result in excessive bleeding, or place the member at higher risk of developing TURP syndrome.

Coverage Exclusions

Any treatment for BPH for which safety and efficacy has not been established and proven is considered experimental, investigational, or unproven, and is therefore **NOT** covered by Oscar.

Non-covered treatment options include, but are not limited to, the following:

- **Absolute ethanol injection (transurethral) (TEAP)**
 - *Rationale for non-coverage:* Published clinical guidelines by the European Association of Urology (2013), the Canadian Urology Association (2010), and the National Institute for Clinical Excellence (NICE; 2010) all recommend against ethanol injection in the treatment of BPH. Furthermore, there is a lack of randomized, controlled clinical trials comparing TEAP to other standard therapies for BPH. Sakr et al (2009) and Magno et al (2008) are two small, prospective, nonrandomized studies without comparisons to other techniques. These studies demonstrate improved outcomes but are limited in their study design and small number of patients (total between studies, 71 patients). In the Sakr et al study, there were high rates (100%) of acute urinary retention in the postoperative period for a mean of 6.7 days. Another trial by El-Husseiny et al (2011) demonstrated 23% failure rate in 56 men treated with TEAP. A more recent study by Arsan et al (2014) on 123 patients revealed a similar 22.2% failure rate, and concluded that "The procedure is easy, inexpensive, safe, and rapid to us. Yet, long-term and multi-centered studies with larger patient series are needed to define further benefits." ^{9, 22, 38, 65, 75, 79, 94}
- **Aquablation (waterjet-hydrodissection) (including PROCEPT Aquablation system, AquaBeam System, or other comparable products)**

- *Rationale for non-coverage:* The existing evidence consists of canine studies and a small (n=15), prospective, nonrandomized, single-center trial. Further evidence of efficacy and comparison to existing treatments is required to determine potential clinical benefit.^{42, 50}
- **Bipolar plasma enucleation of the prostate (BPEP)**
 - *Rationale for non-coverage:* The current literature is limited to few studies directly comparing BPEP to proven techniques of treating BPH. Geavlete et al (2013) compared BPEP to open prostatectomy in 140 patients in a randomized study and found similar outcomes in terms of symptoms reduction and side effects. However, further long-term studies are needed to determine potential clinical benefit of this technique.⁴⁷
- **Botulinum toxin**
 - *Rationale for non-coverage:* Several studies have sought to determine a potential clinical benefit of botulinum toxin in BPH. This is currently not an FDA approved indication given a lack of sufficient evidence, and the vast majority of clinical studies have concluded that botulinum toxins for BPH are in the experimental phase. While results of some trials are promising, the level of clinical evidence is low and future large, placebo-controlled, randomized studies with long-term follow up are needed.^{11, 26, 78, 105}
- **Cryosurgical ablation (i.e. cryosurgery)**
 - *Rationale for non-coverage:* Per the American Urological Association consensus guidelines for the treatment of BPH, “The level of evidence regarding the safety and utility of endoscopic balloon dilation, cryosurgical ablation, HIFU ablation, and the placement of stents, including a lack of treatment outcome analysis for temporary prostatic stents, is insufficient to draw any conclusions.”⁵
- **Endoscopic balloon dilation of the prostate (i.e. Transurethral balloon dilation of the prostatic urethra)**
 - *Rationale for non-coverage:* Per the American Urological Association consensus guidelines for the treatment of BPH, “The level of evidence regarding the safety and utility of endoscopic balloon dilation, cryosurgical ablation, HIFU ablation, and the placement of stents, including a lack of treatment outcome analysis for temporary prostatic stents, is insufficient to draw any conclusions.” Furthermore, the 4th International Consultation on BPH states “Balloon dilation is not recommended as a treatment option for patients with symptoms of BPH.”⁵
- **Histotripsy**
 - *Rationale for non-coverage:* The existing evidence is primarily limited to canine models. Clinical benefit in human subjects with BPH has yet to be demonstrated in large scale, randomized, controlled trials.^{30, 54, 63, 96}
- **Interstitial Laser Coagulation of the Prostate (ILCP)**

- *Rationale for non-coverage:* ILCP has been supplanted by newer techniques with fewer side effects and improved efficacy. Daehlin et al (2007) treated 49 men with ILCP for BPH and found that while there was a decrease in I-PSS score and increased urinary flow, 50% of the patients eventually required retreatment including 15% within the first year. The authors conclude "...long-term follow-up is necessary to determine the role of ILC".^{28, 116}
- **Plasma kinetic vaporization (PlasmaKinetic Tissue Management System) (PKVP)**
 - *Rationale for non-coverage:* Koca et al (2014) looked at 75 patients randomized to TURP vs. PKVP. Only 36 patients enrolled and completed the full 6-year follow-up period. They authors concluded, "Compared to standard TURP, PKVP was found to be unsuccessful in the treatment of BPH when long-term outcomes were considered".⁵⁹
- **Prostatic arterial embolization (PAE) (e.g. transcatheter embolization)**
 - *Rationale for non-coverage:* The National Institute of Health and Care Excellence and the Society for Interventional Radiology consensus panels have stated that the current evidence on the safety and efficacy of PAE is inadequate and that PAE should currently only be utilized for research purposes. Gao et al (2014) conducted a prospective randomized study on 114 men comparing PAE to TURP, and found technical success rates of 100% vs. 94.7% (TURP vs. PAE) with nearly 3 times the clinical failure rates for PAE (TURP 3.9% vs. PAE 9.4%). Additionally, they concluded TURP has greater degree of improvement in IPSS, QOL, peak urinary flow, PVR compared to PAE, and that there were significantly more adverse events in PAE. A later study by Russo et al (2015) with prospective, matched cases on 160 men with BPH found that PAE was inferior to open prostatectomy at 1 year.^{46, 76, 83, 92, 100}
- **Temporary prostatic urethral stent**
 - *Rationale for non-coverage:* Per the American Urological Association consensus guidelines for the treatment of BPH, "The level of evidence regarding the safety and utility of endoscopic balloon dilation, cryosurgical ablation, HIFU ablation, and the placement of stents, including a lack of treatment outcome analysis for temporary prostatic stents, is insufficient to draw any conclusions."⁵
- **Transrectal thermal therapy (including transrectal microwave hyperthermia, transrectal radiofrequency hyperthermia, transrectal electrothermal hyperthermia, and transrectal high-intensity focused ultrasound, regardless of whether MRI guided or not)**
 - *Rationale for non-coverage:* Per the American Urological Association consensus guidelines for the treatment of BPH, "The level of evidence regarding the safety and utility of endoscopic balloon dilation, cryosurgical ablation, HIFU ablation, and the placement of stents, including a lack of treatment outcome analysis for temporary

prostatic stents, is insufficient to draw any conclusions." Furthermore, study on long-term outcomes by Madersbacher et al (2000) revealed that 43.8% of patients undergoing HIFU had to receive TURP within 4 years of therapy. There are very few recent trials examining this technique further.^{5, 64}

- **Water-induced tomotherapy (WIT), including Transurethral Convective Water Vapor Thermal Ablation, Rezum device, hot-water balloon thermoablation, thermourethral hot-water therapy**
 - *Rationale for non-coverage:* Minardi et al (2004) found that WIT reduced prostate volume 5.4% vs. 48.4% in TURP. The urine flow rate was also improved to a much greater extent with TURP (75.3% vs. 16.7%). Outcomes vastly favored TURP for relief of bladder obstruction and flow rates. Published guidelines from the Canadian Urology Association (2010), and the National Institute for Clinical Excellence (NICE - 2010) do not recommend WIT for BPH. The California Technology Assessment Forum (2002) stated that "studies have not yet demonstrated that WIT results in better health outcomes as much as or more than the established alternative of TURP, TUNA, or microwave thermotherapy."^{21, 72}
- **Transurethral Ultrasound Guided Laser Induced Prostatectomy (TULIP)**
 - *Rationale for non-coverage:* TULIP is increasingly considered an outdated technique given higher rates of incontinence, difficult technical usage, delayed onset of improvement in outcomes, and loss of tissue available for histological assessment. In light of these findings, TULIP is no longer a recommended treatment option for BPH.⁴³
- **Visually Guided Laser Ablation of the Prostate (VLAP)**
 - *Rationale for non-coverage:* VLAP is increasingly considered an outdated technique given higher rates of incontinence, difficult technical usage, delayed onset of improvement in outcomes, and loss of tissue available for histological assessment. In light of these findings, VLAP is no longer a recommended treatment option for BPH and has largely been replaced by laser vaporization techniques.⁴³
- The following **injectable and oral treatments** have scarce published data in the peer-reviewed scientific literature demonstrating effectiveness and/or clinical benefit for BPH:
 - Intra-prostatic injections of vitamin D3 receptor analogs
 - Luteinizing hormone-releasing hormone antagonists
 - Beta-3 Agonist Mirabegron
 - Phytotherapeutic agents or phytotherapy (*Serenoa repens*, *Pygeum africanum*, *hypoxis rooperi*, *pinus*, *picea*, *urtica dioica*, and *secale cereale*).¹¹⁷⁻¹¹⁸

Applicable Billing Codes (CPT/HCPCS/ICD-10 Codes)

CPT/HCPCS Codes covered if criteria are met:	
<i>Code</i>	<i>Description</i>
52282	Cystourethroscopy, with insertion of permanent urethral stent
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant [UroLift]
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure) [UroLift]
52450	Transurethral incision of prostate [TUIP]
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included) [laser prostatectomy]
52630	Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed) [TUVP] Contact laser ablation of the prostate (CLAP), Photoselective vaporization of the prostate (PVP)
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed) [not covered for bipolar plasma enucleation] Holmium laser ablation, enucleation, resection (HoLAP, HoLEP, HoLRP)
53850	Transurethral destruction of the prostate tissue; by microwave thermotherapy [TUMT]
53852	Transurethral destruction of the prostate tissue by radiofrequency thermotherapy [TUNA]

C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants
L8699	Prosthetic implant, not otherwise specified
ICD-10 codes covered if criteria are met:	
N02-N02.9	Recurrent and persistent hematuria
N13.0 – N13.3	Hydronephrosis
N18.9	Chronic kidney disease, unspecified
N21.0	Calculus in bladder
N32.3	Large bladder diverticula
N35.010 - N35.9	Urethral stricture
N39.0	Urinary tract infection, site not specified
N40.0 - N40.1	Enlarged prostate (EP)
N40.2 - N40.3	Nodular prostate
N30-N30.91, and N34-N34.3	Urosepsis (e.g., Urethritis, Cystitis, Trigonitis)

CPT/HCPCS codes not covered for indications in this guideline:	
<i>Code</i>	<i>Description</i>
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms,pseudoaneurysms) [PAE]
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52647	Non-contact laser coagulation of prostate (code descriptor revised 1/1/06 - Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation,

	and internal urethrotomy are included if performed) [VLAP, ILCP]
52648-52649	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed) [TULIP]
53000 - 53010	Urethrotomy or urethrostomy, external (separate procedure)
53600 - 53621	Dilation of urethral stricture
53855	Insertion of a temporary prostatic urethral stent , including urethral measurement
53899	Unlisted procedure, urinary system [when specified as transurethral destruction of prostate tissue: by transurethral ethanol ablation of prostate (TEAP)]
53899	Unlisted procedure, urinary system [when specified as transurethral balloon dilation of the prostatic urethra]
53899	Unlisted procedure, male genital system [when specified as transurethral destruction of prostate tissue: by water-when specified as destruction of prostate tissue by transurethral convective water vapor thermal ablation]
53899	Unlisted procedure, male genital system [when specified as High-Intensity Focused Ultrasound HIFU]
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement)
55899	Unlisted procedure, urinary system [when specified as transurethral destruction of prostate tissue: by water-induced thermotherapy (WIT) or when specified as destruction of prostate tissue by transurethral convective water vapor thermal ablation]
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg
J3315	Injection, triptorelin pamoate, 3.75 mg
J9155	Injection, Degarelix, 1 mg
J9202	Goserelin acetate implant, per 3.6 mg
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
J9218	Leuprolide acetate, per 1 mg

J9219	Leuprolide acetate implant, 65 mg
J9226	Histrelin implant (Supprelin LA), 50 mg
S0090	Sildenafil citrate, 25 mg
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed
J0585	Injection, onabotulinumtoxinA, 1 unit (Botox®)
J0586	Injection, abobotulinumtoxinA, 5 units (Dysport®)
J0587	Injection, rimabotulinumtoxinB, 100 units (Myobloc®)
J0588	Injection, incobotulinumtoxinA, 1 unit (Xeomin®)

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