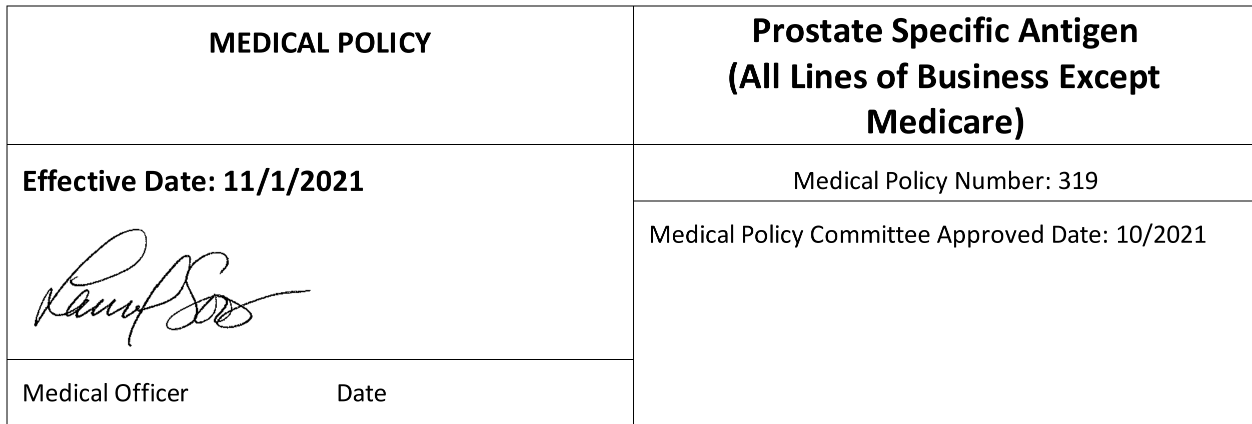

MEDICAL POLICY	Prostate Specific Antigen (All Lines of Business Except Medicare)
Effective Date: 11/1/2021	Medical Policy Number: 319
	Medical Policy Committee Approved Date: 10/2021
Medical Officer Date	

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

All lines of business

BENEFIT APPLICATION

Medicaid Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

DOCUMENTATION REQUIREMENTS

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request. Medical records to include documentation of all of the following:

- All medical records and chart notes pertinent to the request. This includes:
  - History
  - Physical examination
  - Treatment plan

POLICY CRITERIA

Note: The following policy criteria are based on the Centers for Medicare & Medicaid (CMS)

National Coverage Determination (NCD) for Prostate Specific Antigen (190.31)[1] and the Medicare NCD Coding Policy Manual and Change Report (ICD-10-CM).[2]

I. Prostate specific antigen testing may be considered **medically necessary and covered** when any of the following criteria are met (A.-D.):

   A. To differentiate benign from malignant disease in men with lower urinary tract signs and symptoms (e.g., hematuria, slow urine stream, hesitancy, urgency, frequency, nocturia and incontinence); **or**
   B. For the treatment of patients with palpably abnormal prostate glands on physician exam; **or**
   C. For the treatment of patients with other laboratory or imaging studies that suggest the possibility of a malignant prostate disorder; **or**
   D. To follow the progress of prostate cancer once a diagnosis has been established (e.g. detecting metastatic or persistent disease in patients who may require additional treatment; **or**
   E. For the differential diagnosis of patients presenting with as yet undiagnosed disseminated metastatic disease.

II. Prostate specific antigen testing is considered **not medically necessary and not covered** when criterion I. above is not met, including but not limited to either of the following (A.-B.):

   A. More than one test per year for patients with lower urinary tract signs or symptoms unless there is a change in the patient's medical condition;
   B. More than one test with a diagnosis of in situ carcinoma, unless the result is abnormal.

Link to Policy Summary

BILLING GUIDELINES

The following CPT/HCPCS codes may be covered when billed with one of the ICD-10 codes that Medicare has included as medically necessary in the most recent *Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report (ICD-10-CM)*. Available for download at: Lab NCDs – ICD-10.[2] Select the "Lab Code List ICD10 (ZIP)" file option that aligns with the date services were or will be rendered from the Downloads section. Open a spreadsheet and look for NCD 190.33 in column A. This resource can also be accessed directly from the NCD noted above, under "Revision History" and by selecting the applicable "Covered Code List" version. While these services do not require prior authorization, utilization may be subject to audit and all criteria from NCD 190.33 must be met. Thus, inclusion of a diagnosis (ICD-10) code on this list may not warrant automatic coverage.

Prostate specific antigen testing (CPT 84153) may only be covered when billed with one of the diagnosis codes with one of the ICD-10 codes included in the most recent "Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report (ICD-10-CM)," available for download at "Lab NCDs – ICD-10."[2] Diagnosis codes listed below are current as of 8/25/2021:

C61
C675
C774-C775
C778
C7951-C7952
C7982
D075
D400
D49511-D49512
D49519
D4959
M3303
M3313
M3393
N139
N320
N400-N403
N419
N429
R310-R311
R3121
R3129
R319
R32
R339
R350-R351
R3911-R3912
R3914-R3916
R935-R937
R948
R9720-R9721
Z8546

CPT/HCPCS CODES

All Lines of Business Except Medicare	
No Prior Authorization Required	
84153	Prostate Specific Antigen (PSA), total

DESCRIPTION

Prostate Specific Antigen (PSA), a tumor marker for adenocarcinoma of the prostate, can predict residual tumor in the post-operative phase of prostate cancer. Three to six months after radical prostatectomy, PSA is reported to provide a sensitive indicator of persistent disease. Six months following introduction of antiandrogen therapy, PSA is reported as capable of distinguishing patients with favorable response from those in whom limited response is anticipated.

PSA when used in conjunction with other prostate cancer tests, such as digital rectal examination, may assist in the decision making process for diagnosing prostate cancer. PSA also, serves as a marker in following the progress of most prostate tumors once a diagnosis has been established. This test is also an aid in the management of prostate cancer patients and in detecting metastatic or persistent disease in patients following treatment.

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed

annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

REFERENCES

1. Centers for Medicare & Medicaid Services. National Coverage Determination (NCD: Prostate Specific Antigen (190.31) https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=152&ncdver=1&bc=0. Published 2003. Accessed 9/7/2021.
2. Centers for Medicare & Medicaid Services. Lab NCDs - ICD-10. https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10. Published 2021. Accessed 9/7/2021.