


MEDICAL POLICY	Prostate Specific Antigen (Medicare Only)
Effective Date: 11/1/2021 	Medical Policy Number: 320
	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:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
<i>Prostate specific antigen (PSA)</i>	NCD for Prostate Specific Antigen (190.31) (For ICD-10 code guidance, see “Billing Guidelines” below)

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](#). 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 190.31 in column A. This resource can also be accessed directly from the NCD noted above, under “Revision History” and by

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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 190.31 must be met. Thus, inclusion of a diagnosis (ICD-10) code on this list may not warrant automatic coverage.

For additional billing guidance, including test coverage and utilization limitations, see the applicable NCD above.

CPT/HCPCS CODES

Medicare Only	
No Prior Authorization Required	
84153	Prostate specific antigen (PSA); total

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.