Anthem

Clinical UM Guideline

Subject: Prostate Specific Antigen Testing
Guideline #: CG-LAB-28
Status: Reviewed
Publish Date: 04/10/2024
Last Review Date: 02/15/2024

Description

This document addresses the use of laboratory testing for prostate specific antigen (PSA) levels. Low levels of serum total PSA are normal, higher levels of serum PSA may indicate a malignancy. PSA testing is considered a relatively non-specific tool as elevated PSA levels may also have benign causes.

Note: This document does not address the use of following PSA laboratory tests:

- Complexed PSA
- Free PSA
- Prostate Health Index (PHI)

Clinical Indications

Medically Necessary:

Prostate specific antigen (PSA) testing is considered **medically necessary** for any of the following indications:

- Screening for prostate cancer, **or**
- Evaluation of signs or symptoms suggestive of prostate cancer; **or**
- Individuals with previous elevated or rising PSA levels; **or**
- Individuals with current or past history of prostate cancer.

Not Medically Necessary:

PSA testing is considered **not medically necessary** for all other indications not listed above.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services are Medically Necessary:

CPT	
84153	Prostate specific antigen (PSA); total
HCPCS	
G0103	Prostate cancer screening; prostate specific antigen test (PSA)
ICD-10 Diagnosis	
C61	Malignant neoplasm of prostate
C67.0-C67.9	Malignant neoplasm of bladder
C77.4-C77.5	Secondary and unspecified malignant neoplasm of inguinal and lower limb or intrapelvic lymph nodes
C77.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions
C79.51-C79.52	Secondary malignant neoplasm of bone, bone marrow
C79.82	Secondary malignant neoplasm of genital organs
D07.5	Carcinoma in situ of prostate
D40.0	Neoplasm of uncertain behavior of prostate
D49.511-D49.519	Neoplasm of unspecified behavior of kidney
D49.59	Neoplasm of unspecified behavior of other genitourinary organs
M33.03	Juvenile dermatomyositis without myopathy
M33.13	Other dermatomyositis without myopathy
M33.93	Dermatopolymyositis, unspecified without myopathy
N13.8-N13.9	Other/unspecified obstructive and reflux uropathy
N32.0	Bladder-neck obstruction
N40.0-N40.3	Benign prostatic hyperplasia
N41.8-N41.9	Other/unspecified inflammatory diseases of prostate
N42.30-N42.39	Dysplasia of prostate
N42.9	Disorder of prostate, unspecified
R31.0-R31.9	Hematuria
R32	Unspecified urinary incontinence
R33.8-R33.9	Other/unspecified retention of urine
R35.0-R35.89	Polyuria
R39.11-R39.198	Other difficulties with micturition
R93.5-R93.7	Abnormal findings on diagnostic imaging of other abdominal regions, including retroperitoneum, limbs, or other parts of musculoskeletal system
R94.8	Abnormal results of function studies of other organs and systems

R97.20-R97.21	Elevated prostate specific antigen [PSA]
Z00.00-Z00.01	Encounter for general adult medical examination
Z12.5	Encounter for screening for malignant neoplasm of prostate
Z85.46	Personal history of malignant neoplasm of prostate

When services are Not Medically Necessary:
For the procedure codes listed above for all other diagnoses.

Discussion/General Information

Prostate cancer is one of the most common types of cancer with approximately 268,490 new cases diagnosed and 34,500 deaths estimated in 2022. More than half of the cases are diagnosed in individuals aged 65 or older. (American Cancer Society [ACS], 2022). PSA is a glycoprotein which is normally concentrated in the prostate tissue, but detectable levels are also found in blood. An elevated PSA may be an early sign of prostate cancer, PSA is considered a highly sensitive, but poorly specific test. An elevated PSA is a sign of prostate pathology but is not specific to prostate cancer. Prostatitis, benign prostatic hyperplasia (BPH) or prostate infection are examples of benign conditions which may be associated with an elevated PSA (NCI, 2022).

In 1986 the Food and Drug Administration (FDA) approved the first PSA test to be used to monitor disease progression in individuals already diagnosed with prostate cancer. The FDA expanded the approved indications for the PSA test to be used in conjunction with a digital rectal exam (DRE) as a screening test in individuals aged 50 and older.

Screening

Asymptomatic individuals aged 55 to 69 years old may decide to undergo prostate cancer screening after discussing the risk and potential harms associated with screening with their healthcare provider. Prostate cancer screening using PSA testing has the potential to reduce prostate specific mortality. PSA testing could result in overdiagnosis and overtreatment and lead to conditions which may adversely affect quality of life including increased stress levels, incontinence and erectile dysfunction.

Using retrospective data from 128 US Veterans Health Administration (VHA) facilities, Bryant and colleagues (2022) assessed whether variation in PSA screening rates is associated with subsequent metastatic prostate cancer incidence. Between 2005 and 2019, counts of individuals undergoing PSA screening, prostate biopsies and incidence of prostate cancer cases were calculated yearly and grouped by age. The PSA screening rate at a facility was calculated by dividing the number of individuals aged 40 or older who underwent PSA screening by the total number of individuals who received any care at the facility who would have been eligible for PSA screening test. In 2005, the eligible VHA population included 4.678,412 individuals. In 2008, the overall screening rate rose to a high of 50.8% from the 2005 baseline of 47.2%. In 2019, the overall screening rate decreased to 37.0%. This decrease was reported across all age groups. The long-term results showed that higher yearly metastatic prostate cancer incidence rates beginning 2010 through 2019 was associated with lower facility-level screening rates 5 years earlier. Data comparing long-term non-screening rates and incidence of metastatic prostate cancer report similar results. The authors suggest that the study conclusions be used to inform individuals within the context of the current United States Preventive Services Task Force (USPSTF) shared decision making model noting:

> Our results also do not directly implicate changes in USPSTF recommendations or the publication of PSA screening trial results to the absolute increase in metastatic prostate cancer incidence since 2012, and the magnitude of our observed incidence rate ratios are not consistent with changes in PSA screening patterns being the sole factor associated with the increase in metastatic prostate cancer incidence.

In 2023, the American Urological Association (AUA) and the Society of Urologic Oncology (SUO) published a guideline on prostate cancer screening which includes the following recommendations:

1. Clinicians should engage in shared decision-making (SDM) with people for whom prostate cancer screening would be appropriate and proceed based on a person's values and preferences. (Clinical Principle)
2. When screening for prostate cancer, clinicians should use PSA as the first screening test. (Strong Recommendation; Evidence Level: Grade A)
3. For people with a newly elevated PSA, clinicians should repeat the PSA prior to a secondary biomarker, imaging, or biopsy. (Expert Opinion)
4. Clinicians may begin prostate cancer screening and offer a baseline PSA test to people between ages 45 to 50 years. (Conditional Recommendation; Evidence Level: Grade B)
5. Clinicians should offer prostate cancer screening beginning at age 40 to 45 years for people at increased risk of developing prostate cancer based on the following factors: Black ancestry, germline mutations, strong family history of prostate cancer. (Strong Recommendation; Evidence Level: Grade B)
6. Clinicians should offer regular prostate cancer screening every 2 to 4 years to people aged 50 to 69 years. (Strong Recommendation; Evidence Level: Grade A)
7. Clinicians may personalize the re-screening interval, or decide to discontinue screening, based on patient preference, age, PSA, prostate cancer risk, life expectancy, and general health following SDM. (Conditional Recommendation; Evidence Level: Grade B)
8. Clinicians may use digital rectal exam (DRE) alongside PSA to establish risk of clinically significant prostate cancer. (Conditional Recommendation; Evidence Level: Grade C)
9. For people undergoing prostate cancer screening, clinicians should not use PSA velocity as the sole indication for a secondary biomarker, imaging, or biopsy. (Strong Recommendation; Evidence Level: Grade B)

The USPSTF gives the recommendation that asymptomatic individuals aged 55 to 69 years old undergo periodic testing a grade "C" (no recommendation for or against routine provision of the service). The National Comprehensive Cancer Network (NCCN) clinical practice guideline on the early detection of prostate cancer considers PSA testing an early detection technique which has demonstrated survival benefits, particular when used in combination with digital rectal examination or other ancillary testing (V2.2023)

Signs or symptoms suggestive of prostate cancer

The early stages of prostate cancer are typically asymptomatic. In more advanced stages, genitourinary symptoms may be present including problems with urination, blood in urine or semen or erectile dysfunction (ACS, 2022). Prostate cancer can also manifest as lower extremity weakness or paresthesia or loss of bladder or bowel control due to tumor impinging on the spinal cord (ACS, 2022). Bony metastatic disease to the axis skeleton is common and may cause back pain (Rawla, 2019). PSA levels, along with other clinical and pathologic features, are used in the initial risk stratification and staging workup of prostate cancer. Individuals with an initial PSA < 10 ng/mL are considered very low risk group for cancer recurrence and prostate cancer specific mortality while a PSA > 20 ng/mL indicates high-risk for cancer recurrence and prostate cancer specific mortality. The PSA level prior to treatment predicts tumor response to local therapy and prostate cancer-specific and overall mortality (AUA, 2013). The AUA and the American Society for

Radiation Oncology (ASTRO) guideline for clinically localized prostate cancer (2022) includes the following recommendation:

> Clinicians should use clinical T stage, serum prostate-specific antigen (PSA), Grade Group (Gleason score), and tumor volume on biopsy to risk stratify patients with newly diagnosed prostate cancer. (Strong Recommendation; Evidence Level: Grade A)

The most common sites of prostate metastasis include bones, lymph nodes, lungs and liver. The NCCN recommends workup for potential metastasis include PSA testing (NCCN, 4.2023).

PSA testing may be indicated in individuals with primary non-prostate cancers. This testing may be part of the initial workup or during disease management. In advanced disease in adjacent organs, such as bladder cancer, the tumor may invade the prostate. The NCCN CPG for bladder cancer (V3.2023) recommends PSA testing in cases of suspected urothelial carcinoma of the prostate. An estimated 24-51% of individuals with muscle invasive bladder cancer are shown to have incidental prostate cancer (Lopez-Beltran, 2017). The NCCN recommends periodic screening for secondary primary cancers be utilized following treatment during the surveillance period (Colon, V2.2022; NCCN, Hodgkin V1.2024)

Monitoring

Active Surveillance (AS) also known as Active Monitoring

Prostate cancer can be characterized as aggressive or indolent. Individuals at low risk for aggressive cancer, such as those with localized prostate cancer, may be candidates for active surveillance (AS) or definitive treatment. The concept of AS is to potentially avoid or delay the negative side effects of prostate cancer therapy. The United States Preventive Services Task Force (USPSTF) notes:

> “Early, active treatment for screen-detected prostate cancer may reduce the risk of metastatic disease, although the long-term impact of early, active treatment on prostate cancer mortality remains unclear. Active treatments for prostate cancer are frequently associated with sexual and urinary difficulties.”

The AS protocol involves actively monitoring the course of prostate cancer with the intent to initiate curative treatment if the cancer progresses (NCCN, V1.2024). ASCO recommends PSA testing every 3 to 6 months (Chen, 2016). Other societies recommend PSA rechecks no more often than every 6 months in AS, unless clinically indicated (NCCN, V1.2024; Eastham, 2015). During AS, an increase in a PSA level should trigger a PSA retest, as transient increases are not unusual (Eastham, 2015). A 2020 Agency for Healthcare Research and Quality (AHRQ) comparative effectiveness review on clinically localized prostate cancer notes:

> Active monitoring [AM] using PSA-based monitoring probably results in little to no difference in all-cause or prostate cancer mortality compared with RP [radical prostatectomy] or EBR [external beam radiation] plus AD [androgen deprivation] over 10 years. Metastases were infrequent, but AM probably results in a small increase compared with RP and EBR+AD. Effects may not vary by patient or tumor risk factors. Harms were lowest with AM compared with RP or EBR plus AD or AS versus photodynamic therapy.

Monitoring During Therapy

PSA levels are indicative of treatment response. An increase in PSA by 2 ng/mL above the nadir following radiation therapy with or without hormone treatment is the standard definition of disease recurrence. The PSA nadir following treatment is also a prognostic factor (Shah, 2016). A PSA rise following local therapy may aid in distinguishing between a local and distant recurrence (AUA, 2013).

PSA levels are monitored during treatment as levels may guideline treatment decisions. The AUA/ASTRO guideline for clinically localized prostate cancer (2022) includes the following recommendations:

> Clinicians should risk stratify patients with positive lymph nodes identified at radical prostatectomy based on pathologic variables and postoperative PSA. (Expert Opinion)
>
> Clinicians may offer patients with positive lymph nodes identified at radical prostatectomy and an undetectable postoperative PSA adjuvant therapy or observation. (Conditional Recommendation; Evidence Level: Grade C)
>
> Clinicians should monitor patients with prostate cancer post therapy with PSA and symptom assessment. (Clinical Principle)

Recurrence Surveillance

Following prostate cancer treatment, PSA levels should be checked every 6 -12 months for the first 5 years to detect cancer recurrence. Following the first 5 years, an annual PSA level measurement is recommended. Some individuals may require more frequent PSA monitoring based upon individual risk factors for recurrence and specific circumstances (Resnick, 2015).

There are several disease states associated with advanced prostate cancer. Biochemical recurrence is typically the first sign of prostate cancer recurrence and almost always precedes the clinical detection of metastases. Hormone-sensitive or castration-resistant prostate cancer are defined by individual response to androgen deprivation therapy (ADT) therapy. These individuals are typically followed with serial PSA testing and clinical evaluations to follow disease progression (AUA/ASTRO/SGO, 2020). PSA doubling-time (PSADT) along with time to PSA recurrence following therapy is considered a prognostic factor in individuals who experience clinical recurrence.

The 2023 AUA/ SUO guidelines on advanced prostate cancer recommend PSA measurements to monitor treatment in the following conditions:

> <u>Biochemical Recurrence Without Metastatic Disease After Exhaustion of Local Treatment Options</u>
> Prognosis
> 4. Clinicians should inform patients with PSA recurrence after exhaustion of local therapy regarding the risk of developing metastatic disease and follow such patients with serial PSA measurements and clinical evaluation. Clinicians may consider radiographic assessments based on overall PSA and PSA kinetics. (Clinical Principle)
>
> <u>Metastatic Hormone-Sensitive Prostate Cancer (mHSPC)</u>
> Prognosis
> 12. Clinicians should obtain a baseline PSA and serial PSAs at three- to six-month intervals after initiation of ADT in mHSPC patients and consider periodic conventional imaging. (Clinical Principle)
>
> <u>Non-Metastatic Castration-Resistant Prostate Cancer (nmCRPC)</u>
> Prognosis
> 20. In nmCRPC patients, clinicians should obtain serial PSA measurements at three- to six-month intervals, and

calculate a PSADT starting at the time of development of castration-resistance. (Clinical Principle)

Metastatic Castration-Resistant Prostate Cancer (mCRPC)
Prognosis
25. In mCRPC patients, clinicians should obtain baseline labs (e.g., PSA, testosterone, LDH, Hgb, alkaline phosphatase level) and review location of metastatic disease (lymph node, bone, visceral), disease-related symptoms, and performance status to inform discussions of prognosis and treatment decision-making. (Clinical Principle)

Dermatomyositis

Dermatomyositis is a rare idiopathic systematic inflammatory autoimmune disease. Individuals with dermatomyositis have an approximately fivefold increased risk of developing cancer (Olazagasti, 2015, Qiang, 2017). The exact underlying connection between dermatomyositis and cancer is unknown but has been proposed to be due to crossover immunity. Individuals with dermatomyositis are encouraged to undergo conventional cancer screening with a comprehensive history and physical, laboratory and imaging testing and tumor markers including PSA testing in the appropriate population (Olazagasti, 2015; Oldroyd, 2021; Udkoff, 2016).

Definitions

Biochemical Recurrence: Rising PSA levels in individuals with prostate cancer post-treatment (surgery or radiation), with or without symptoms. The increase in the PSA level may indicate the cancer has returned. Also called biochemical relapse or PSA failure.

Indolent Cancer: A slow growing type of cancer which may be inconsequential and may not become symptomatic to the affected individual or contribute to death.

PSA Doubling Time (PSADT): The number of months needed for the PSA value to increase 2-fold.

PSA nadir: The lowest PSA level reached following radiation therapy to treat prostate cancer.

Urothelial Cancer: Cancer which develops the cells lining the urethra, bladder, ureters, renal pelvis or prostate. Also called transitional cell cancer.

References

Peer Reviewed Publications:

1. Bryant AK, Lee KM, Alba PR, et al. Association of prostate-specific antigen screening rates with subsequent metastatic prostate cancer incidence at US Veterans health administration facilities. JAMA Oncol. 2022; 8(12):1747-1755.
2. Desai MM, Cacciamani GE, Gill K, et al. Trends in incidence of metastatic prostate cancer in the US. JAMA Netw Open. 2022; 5(3):e222246.
3. Ji G, Huang C, Song G, et al. Are the pathological characteristics of prostate cancer more aggressive or more indolent depending upon the patient age? Biomed Res Int. 2017;2017:1438027.
4. Lopez-Beltran A, Cheng L, Montorsi F, et al. Concomitant bladder cancer and prostate cancer: challenges and controversies. Nat Rev Urol. 2017; 14(10):620-629.
5. Olazagasti JM, Baez PJ, Wetter DA, Ernste FC. Cancer risk in dermatomyositis: a meta-analysis of cohort studies. Am J Clin Dermatol. 2015; 16(2):89-98.
6. Oldroyd AGS, Allard AB, Callen JP, et al. A systematic review and meta-analysis to inform cancer screening guidelines in idiopathic inflammatory myopathies. Rheumatology (Oxford). 2021; 60(6):2615-2628.
7. Qiang JK, Kim WB, Baibergenova A, Alhusayen R. Risk of malignancy in dermatomyositis and polymyositis. J Cutan Med Surg. 2017; 21(2):131-136.
8. Rawla P. Epidemiology of Prostate Cancer. World J Oncol. 2019; 10(2):63-89.
9. Shah TT, Peters M, Kanthabalan A, et al. PSA nadir as a predictive factor for biochemical disease-free survival and overall survival following whole-gland salvage HIFU following radiotherapy failure. Prostate Cancer Prostatic Dis. 2016; 19(3):311-316.
10. Udkoff J, Cohen PR. Amyopathic Dermatomyositis: A concise review of clinical manifestations and associated malignancies. Am J Clin Dermatol. 2016; 17(5):509-518.

Government Agency, Medical Society, and Other Authoritative Publications:

1. Agency for Healthcare Research and Quality (AHRQ). Comparative Effectiveness Review Number 230. Therapies for Clinically Localized Prostate Cancer. September 2020. Available at: https://effectivehealthcare.ahrq.gov/sites/default/files/product/pdf/prostate-cancer-therapies-report.pdf. Accessed on December 14, 2023.
2. American Urological Association (AUA). PSA testing for the pretreatment staging and posttreatment management of prostate cancer: 2013 revision of 2009 best practice statement. Available at: https://www.auanet.org/documents//education/clinical-guidance/Prostate-Specific-Antigen.pdf. Accessed on December 14, 2023.
3. American Urological Association (AUA)/ American Society for Radiation Oncology (ASTRO). Accessed on December 14, 2023.
    - Advanced Prostate Cancer. AUA/ASTRO/SUO Guideline 2020. Available at: https://www.auanet.org/guidelines-and-quality/guidelines/advanced-prostate-cancer.
    - Clinically Localized Prostate Cancer: AUA/ASTRO Guideline 2022. Available at: https://www.auanet.org/guidelines-and-quality/guidelines/clinically-localized-prostate-cancer-aua/astro-guideline-2022.
4. Centers for Medicare and Medicaid Services (CMS). Local Coverage Determination (LCD): MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer.
    - LCD L38985. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38985&ver=13&keyword=Prostate%20Specific%20Antigen&keywordType=starts&areaId=all&docType=F&contractOption=all&sortBy=relevance&bc=1. Accessed on December 14, 2023.
    - LCD L389997. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38997&ver=7&keyword=Prostate%20Specific%20Antigen&keywordType=starts&areaId=all&docType=F&contractOption=all&sortBy=relevance&bc=1. Accessed on December 14, 2023.
    - LCD L39005. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39005&ver=6&keyword=Prostate%20Specific%20Antigen&keywordType=starts&areaId=all&docType=F&contractOption=all&sortBy=relevance&bc=1. Accessed on December 14, 2023.
    - LCD L39007. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39007&ver=7&keyword=Prostate%20Specific%20Antigen&keywordType=starts&areaId=all&docType=F&contra

ctOption=all&sortBy=relevance&bc=1. Accessed on December 14, 2023.
- LCD L39042. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39042&ver=5&keyword=Prostate%20Specific%20Antigen&keywordType=starts&areaId=all&docType=F&contractOption=all&sortBy=relevance&bc=1. Accessed on December 14, 2023.

5. Centers for Medicare and Medicaid Services (CMS). Local Coverage Determination (LCD): MolDX: Prostate Cancer Genomic Classifier Assay for Men with Localized Disease.
   - LCD L38292. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38292&ver=10&keyword=Prostate%20Specific%20Antigen&keywordType=starts&areaId=all&docType=F&contractOption=all&sortBy=relevance&bc=1. Accessed on December 14, 2023.
   - LCD L38303. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38303&ver=7&keyword=Prostate%20Specific%20Antigen&keywordType=starts&areaId=all&docType=F&contractOption=all&sortBy=relevance&bc=1. Accessed on December 14, 2023.
   - LCD L38339. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38339&ver=12&keyword=Prostate%20Specific%20Antigen&keywordType=starts&areaId=all&docType=F&contractOption=all&sortBy=relevance&bc=1. Accessed on December 14, 2023.
   - LCD L38341. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38341&ver=9&keyword=Prostate%20Specific%20Antigen&keywordType=starts&areaId=all&docType=F&contractOption=all&sortBy=relevance&bc=1. Accessed on December 14, 2023.
   - LCD L38433. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38433&ver=5&keyword=Prostate%20Specific%20Antigen&keywordType=starts&areaId=all&docType=F&contractOption=all&sortBy=relevance&bc=1. Accessed on December 14, 2023.
6. Chang SS, Boorjian SA, Chou R, et al. Diagnosis and treatment of non-muscle invasive bladder cancer: AUA/SUO guideline. J Urol. 201; 196(4):1021-1029. Amended 2020.
7. Chen RC, Rumble RB, Loblaw DA, et al. Active Surveillance for the Management of Localized Prostate Cancer (Cancer Care Ontario Guideline): American Society of Clinical Oncology Clinical Practice Guideline Endorsement. J Clin Oncol. 2016; 34(18):2182-2190.
8. Eastham JA, Auffenberg GB, Barocas DA, et al. Clinically localized prostate cancer: AUA/ASTRO guideline, Part I: Introduction, risk assessment, staging, and risk-based management. J Urol. 2022; 208(1):10-18.
9. Fenton JJ, Weyrich MS, Durbin S, et al. Prostate-Specific Antigen-Based Screening for Prostate Cancer: A Systematic Evidence Review for the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (US); 2018. Report No.: 17-05229-EF-1.
10. Lowrance W, Dreicer R, Jarrard DF, et al. Updates to advanced prostate cancer: AUA/SUO Guideline (2023). J Urol. 2023; 209(6):1082-1090.
11. National Cancer Institute (NCI). Available at: PDQ® Cancer Information - NCI. Accessed on December 7, 2023.
    - Prostate Cancer Screening (PDQ®). Modified October 26, 2023.
    - Prostate Cancer Treatment (PDQ®). Modified February 13, 2023.
12. National Clinical Practice Guidelines in Oncology™: ©2023. National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: http://www.nccn.org/index.asp. Accessed on December 7, 2023.
    - Bladder Cancer. V3.2023. May 25, 2023.
    - Bone Cancer. V1.2024. August 7, 2023.
    - Colon Cancer. V3.2022. January 25, 2023.
    - Hodgkin Lymphoma. V1.2024. October 12, 2023.
    - Prostate Cancer. V4.2023. September 7, 2023.
    - Prostate Cancer Early Detection. V2.2023. September 26, 2023.
    - Survivorship. V1.2023. March 24, 2023.
13. Resnick MJ, Lacchetti C, Penson DF; American Society of Clinical Oncology. Prostate cancer survivorship care guidelines: American Society of Clinical Oncology practice guideline endorsement. J Oncol Pract. 2015;11(3):e445-e449.
14. United States Preventive Services Task Force (USPSTF). Prostate Cancer: Screening. May 8, 2018. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prostate-cancer-screening. Accessed on December 14, 2023.
15. Wei JT, Barocas D, Carlsson S, et al. Early Detection of Prostate Cancer: AUA/SUO Guideline Part I: Prostate Cancer Screening. J Urol. 2023; 210(1):46-53.

Websites for Additional Information

1. National Cancer Institute (NCI). NCI dictionary of cancer terms. Available at: https://www.cancer.gov/publications/dictionaries/cancer-terms. Accessed on December 14, 2023.
2. National Cancer Institute (NCI). Prostate-Specific Antigen (PSA) Test. Available at: https://www.cancer.gov/types/prostate/psa-fact-sheet. Reviewed March 11, 2022. Access on December 14, 2023.
3. National Institute of Health. National Library of Medicine. Prostate-Specific Antigen (PSA) Test. Available at: Prostate-Specific Antigen (PSA) Test: MedlinePlus Medical Test. Accessed on December 7, 2023.

Index

The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.

History

Status	Date	Action
Reviewed	02/15/2024	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated Description, Discussion and References sections.
	12/06/2023	Revised References section.
New	02/16/2023	MPTAC review. Initial document development.

UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan’s or line of business’s members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.