

02.04.25 Prostate-Specific Antigen Screening for Prostate Cancer

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Related Policies:

- None

Summary

Description

The goal of screening for prostate cancer is to identify high-risk, localized prostate cancer that can be successfully treated, thereby preventing the morbidity associated with advanced or metastatic prostate cancer. Screening asymptomatic individuals for prostate cancer has become a widespread practice in the United States. Tests used for prostate cancer screening include digital rectal examination (DRE) and serum prostate specific antigen (PSA). *This evidence review will address prostate cancer screening testing using serum prostate specific antigen (PSA).*

Summary of Evidence

For asymptomatic individuals who receive prostate cancer screening utilizing prostate serum prostate specific antigen (PSA), the evidence includes 3 very large randomized controlled trials (RCTs), each with at least a decade of median follow-up: the US-based Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial, the European Randomized Study of Screening for Prostate Cancer (ERSPC), and the Cluster Randomized Trial of PSA Testing for Prostate Cancer (CAP). Relevant outcomes are overall survival, disease-specific survival, clinical management decision changes, and test accuracy and validity. The RCTs address the impact of PSA screening on the stage of cancer detection and on disease-specific survival rates, as well as evaluate the relative sensitivities and specificities of derivative types of PSA testing. Even though PSA testing is widely utilized there remains controversy regarding the question of whether PSA-based screening reduces prostate cancer mortality. In addition, PSA-based screening is associated with risks of overdiagnosis and overtreatment; and treatment complications (incontinence and erectile dysfunction). To determine whether this service is appropriate clinicians should consider the balance of benefits and harms based on family history, race/ethnicity, and comorbid medical conditions through shared decision-making. The evidence is insufficient to determine that technology results in a meaningful improvement in the net health outcomes. However, even though there is paucity in the scientific evidence regarding prostate cancer screening utilizing PSA testing in preventing morbidity associated with advanced or metastatic prostate cancer this testing is widely considered to be in accordance to generally accepted standards of medical practice in the United States (see [Practice Guidelines and Position Statements](#)), and in certain carefully-selected individuals PSA testing for prostate cancer screening will be considered medically necessary when the criteria below is met, see [Policy](#).

OBJECTIVE

The objective of this evidence review is to determine whether screening asymptomatic individuals for prostate cancer that identifies individuals with high-risk, localized prostate cancer prevents the morbidity associated with advanced or metastatic prostate cancer. The specific test considered is prostate specific antigen (PSA).

PRIOR APPROVAL

Not applicable.

POLICY

Prostate cancer screening in asymptomatic individuals using prostate specific antigen (PSA) may be considered **medically necessary** for any of the following indications after informed decision-making with a health care provider:

- Individuals 40-75 years of age who are at high- risk of prostate cancer due to any of the following:
 - Black/African American individuals; **or**
 - Individuals with concerning family or personal history (see [Practice Guideline and Position Statements](#)); **or**
 - Individuals with germline variants that increase the risk of prostate cancers (see [Practice Guideline and Position Statements](#)), **or**
- Individuals aged 45-75 years with average risk and life expectancy of at least 10 years.

Prostate cancer screening using PSA not meeting the above criteria in asymptomatic individuals is considered **not medically necessary**.

POLICY GUIDELINES

NOTE: Iowa House File 2668 (Iowa Code section 514C.36) requires that certain health plans issued or renewed on or after January 1, 2025 “provide coverage for biomarker testing for the purposes of diagnosing, treating, appropriately managing, or monitoring a disease or condition in a covered person when the biomarker testing has demonstrated clinical utility.” Iowa House File 2668 defines clinical utility as “sufficient medical and scientific evidence indicating that the use of a biomarker test will provide meaningful information that affects treatment decisions and guides improvement of net health outcomes, including an improved quality of life or longer survival.” Wellmark has reviewed this Medical Policy in light of Iowa House File 2668.

Repeat Testing

After the initial prostate cancer screening using prostate specific antigen (PSA) is determined, the current NCCN guidelines for Prostate Cancer Early Detection panel members recommend the following time interval for repeat screening testing using prostate specific antigen (PSA) dependent upon the prostate specific antigen (PSA) value, which is the following:

- Individuals with average risk and PSA < 1 ng/mL repeat testing may be performed at 2 - 4 -year intervals.
- Individuals with average risk and PSA 1-3 ng/mL repeat testing may performed 1-3 year intervals
- Individuals with high-risk and PSA is ≤ 3 ng/mL, repeat testing may be performed at 1-2 year intervals.

Clinical judgement and shared decision-making should be used to determine the testing interval.

Coding

See the [Codes](#) table for details.

BACKGROUND

Prostate Cancer

Prostate cancer is the most commonly diagnosed cancer and the second leading cause of cancer deaths in American individuals. In 2026, it is estimated that 333,830 individuals will be diagnosed with prostate cancer and 36,320 will die of this disease (American Cancer Society Cancer Facts and Figures 2026). During the same period, individuals in the United States will be confronted with important decisions regarding early detection for prostate cancer. “Individuals in the United States have about 1 chance in 8 (12.8%) of eventually being diagnosed with this malignancy and about 1 chance in 49 (2.0%) of eventually dying of it” (*current NCCN guideline*).

“Black Individuals and those with African ancestry have a 60% to 67% higher incidence of prostate cancer compared with white individuals. Data also suggest that Black/African American individuals have an

earlier onset of prostate cancer”(current NCCN guideline). Per current NCCN guidelines the NCCN Panel recommends that “Black/African American individuals consider beginning shared decision-making about PSA screening at age 40 years and they consider screening at annual rather than then less frequent screening intervals. However, no current evidence shows that testing individuals of African descent at an earlier age will result in decreased morbidity and mortality compared to testing at age 45 years, and earlier screening may increase overdiagnosis.” [See also Policy Guidelines and Practice Position Statements](#)

Prostate cancer represents a spectrum of disease that ranges from non-aggressive, slow growing disease that may not require treatment to aggressive, fast-growing disease that does require treatment. The goal of screening for prostate cancer is to identify high-risk, localized prostate cancer that can be successfully treated, thereby preventing the morbidity associated with advanced or metastatic prostate cancer. Screening asymptomatic individuals for prostate cancer has become a widespread practice in the United States. Tests used for prostate cancer screening include digital rectal examination (DRE) and serum prostate specific antigen (PSA).

Prostate cancer risk calculators have been developed to estimate an individual's risk for prostate cancer from multiple factors. Common calculators are the Sunnybrook, ERSPC and PCPT based risk calculators. These online tools combine clinical variables including but not limited to age, family history, race, DRE, and PSA, to estimate both the risk for biopsy detectable prostate cancer and the risk for biopsy detectable high grade prostate cancer. Such information potentially allows for more informed decision-making. However, such calculators have not been assessed in randomized controlled trials (RCTs) and cut points of risk associated with reductions in prostate cancer mortality remain unknown. Such calculators have as much value in determining who might not need biopsy as in identifying those at higher risk. The use of risk calculators alone to determine whether a biopsy is indicated is not recommended.

Testing

Best evidence supports the use of serum PSA for the early detection of prostate cancer. Still, many experts continue to recommend DRE for screening, as some clinically significant prostate cancer may potentially be missed using serum PSA cut point alone. Studies have consistently shown that prostate cancer cases detected through PSA testing are more often confined to the prostate than those detected solely by DRE. Currently, 81% of prostate cancers are pathologically organ-confined at time of diagnosis.

The value of DRE as a stand-alone test for prostate detection is limited, even though DRE picks up some cases of advanced cancer that would otherwise be missed. DRE is recommended to be used as a complementary test with serum PSA in asymptomatic individuals who had a risk/benefit discussion and decided to pursue screening for prostate cancer. Those individuals with a very suspicious DRE should be considered for biopsy referral regardless of PSA results because it may identify high-grade cancers in such situations. DRE should be considered in all individuals with an abnormal serum PSA to aid in decisions regarding biopsy.

Although PSA was originally introduced as a tumor marker to detect cancer recurrence or disease progression following treatment, it became widely adopted for cancer screening. PSA is a glycoprotein produced by the prostate epithelial cells. PSA enters the circulation through unknown mechanisms. PSA levels may be elevated in individuals with prostate cancer because PSA production is increased and because tissue barriers between the prostate gland lumen and the capillary are disrupted, releasing more PSA into the serum. Elevations of serum PSA may also be associated with other prostatic diseases including benign prostatic hypertrophy (BPH) which is a major clinical problem with PSA screening. It is recommended that the interpretation of PSA values should always consider the following: age, the presence of urinary tract infection or prostate disease, recent diagnostic prostate procedures and prostate directed treatments.

PSA Derivatives

Serum total PSA was the only PSA based test available in early detection programs for prostate cancer. Since then, several PSA derivatives have been developed and proposed to improve the performance of the PSA measurement, thus possibly increasing specificity and decreasing unnecessary biopsies. These PSA derivatives include:

- **Percent free PSA (%fPSA):** Unbound or free PSA (fPSA), expressed as a ratio of tPSA, is a clinically useful molecular form of PSA, with the potential to improve early detection, staging and monitoring of prostate cancer. The FDA approved the use of %fPSA for the early detection of prostate cancer in men with a normal DRE and PSA levels between 4ng/mL and 10 ng/mL.
- **PSA Velocity (PSAV):** The rate of change in PSA overtime is broadly termed PSA velocity (PSAV), determined by at least 3 separate PSA values calculated over at least an 18- month period. $PSAV \geq 0.35$ ng/mL/y is only one criterion to consider when deciding whether to perform biopsy for men with low PSA levels. Other factors such as age, comorbidity, race, and family history also should be considered. Also, the predictive value of PSAV can be influenced by PSA levels, PSAV is not useful in individuals with a very high > 10 ng/mL PSA values. An abnormal PSA result should be confirmed by retesting.
- **cPSA:** PSA exists in free and several complex forms. Direct measurement of the complexed form with alpha-1-antichymotrypsin is now available. For practical purposes, tPSA consists essentially of fPSA and the alpha-1-antichymotrypsin complex form (cPSA). The threshold levels are therefore not equivalent: cPSA levels of 2.2 ng/mL and 3.4 ng/mL are equivalent to tPSA levels of 2.5 ng/mL and 4.0 ng/mL, respectively. The ratio of cPSA to tPSA should provide information comparable to the fPSA to tPSA ratio. The use of cPSA has been approved as an aid in the detection of prostate cancer in men aged 50 years or older in conjunction with DRE. However, because cPSA has not gained widespread acceptance in a day-to-day clinical practice, it has not been incorporated into early detection guidelines as a baseline measure.
- **PSA Density (PSAD):** PSAD requires measurement of prostate volume by TRUS and is expressed as the PSA value (in nanograms per milliliter; ng/mL) divided by the prostate volume (in cc, cubic centimeters). PSAD is a means of discriminating prostate cancer from BPH: the lower the PSAD, the greater the probability of BPH. Therefore, PSAD potentially identifies men who do not have prostate cancer but have high PSA secondary to large volume prostates. The lack of precision of measurement of both PSA and prostate volume has prevented the widespread clinical use of PSAD. PSAD has not been incorporated into early detection guidelines as a baseline measure because PSAD alone may offer little added benefit over other tests and requires ultrasound.

The potential benefit of screening for prostate cancer is because of treatment. It is important for individuals to consider both the potential benefits and harms of treatment (including surveillance) as they consider whether to be screened. Individuals who are not able or willing to tolerate treatment should not be screened for prostate cancer.

Most cases of prostate cancer advance very slowly, if at all, the 10- year survival rate for screen-detected, localized prostate cancer is very high. In recent major trial that enrolled more than 1500 men randomized to receive either active treatment or active surveillance, the 10-year survival rate in all groups was 99%. The good prognosis for early- stage prostate cancer makes it difficult to study the effectiveness of treatment.

Multiple treatment options exist for prostate cancer, the three most common treatment options for individuals with screen-detected localized prostate cancer are surgical removal of prostate gland (radical prostatectomy), radiation therapy, and active surveillance. Available evidence on treatment evaluating the effectiveness of screening found that current evidence suggests that treatment of early-stage, screen-

detected prostate cancer with radical prostatectomy or radiation therapy likely reduces the risk of clinical progression and metastatic disease and may reduce prostate cancer mortality.

Active surveillance is a treatment approach that seeks to limit the harms of treatment by allowing individuals with apparent low-risk prostate cancer to forego surgery or radiation in favor of ongoing monitoring of their cancer. Although protocols vary, active surveillance usually includes regular, repeated PSA testing and often repeated digital rectal examination (DRE) and prostate biopsy, with the potential for exposure to repeated harms from biopsies. Individuals whose cancer is found to be changing are offered definitive treatment with surgery or radiation therapy. Active surveillance has become a more common treatment choice in the United States over the past several years. Active treatment of prostate cancer can result in major adverse effects.

Regulatory Status

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments (CLIA). Laboratories that offer laboratory developed tests must be licensed by the Clinical Laboratory Improvement Amendments for high complexity testing.

RATIONALE

This evidence review was created in October 2009 and has been updated regularly with searches of the PubMed database. The most recent literature update was performed through June 2026.

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

Clinical Context and Test Purpose

The goal of screening for prostate cancer is to identify high-risk, localized prostate cancer that can be successfully treated, thereby preventing the morbidity associated with advanced or metastatic prostate cancer.

Screening asymptomatic individuals for prostate cancer has become a widespread practice in the United States. A test used for prostate cancer screening and this evidence review will address is serum prostate specific antigen (PSA) to inform a decision about biopsy versus surveillance (follow-up) of prostate cancer screening.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is asymptomatic individuals and identifying those individuals at high-risk of developing prostate cancer (current NCCN guideline for Early Detection of Prostate Cancer accessed June 2026):

- Early Detection Evaluation
 - Age 45-75 years for:
 - Black/African American individuals.
 - Those with germline variants that increase the risk for prostate cancer (see [Practice Guideline and Position Statements](#)).
 - Those with concerning or personal history.
 - Age 45-75 years for all others.

Interventions

The test being considered is serum PSA.

Comparators

Active surveillance usually includes regular, repeated PSA testing and often repeated digital rectal examination (DRE) and prostate biopsy, with the potential for exposure to repeated harms from biopsies.

Outcomes

Relevant outcomes are overall survival, disease specific survival, clinical management decision changes, and test accuracy and validity.

Clinically Valid

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Clinically Useful

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if individuals receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence

Direct evidence of clinical utility is provided by studies that have compared health outcomes for individuals managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

Chain of Evidence

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Review of Evidence

Even though some guidelines (i.e., USPSTF) may not recommend the routine use of screening tests for prostate cancer, which the benefits do not outweigh the harms in the target population, they do recognize the common use of PSA screening in practice today and that some physicians will continue to offer it. The decision to initiate or continue PSA screening should reflect an understanding of the possible benefits and harms and respect the individual's preferences. Physicians should not offer or order PSA screening unless they are prepared to engage in shared decision making that enables an informed choice by the individual. Similarly, individuals requesting PSA screening should be provided with the opportunity to make informed choices to be screened that reflect their values about specific benefits and harms.

Prostate cancer screening has been a controversial issue. There is evidence that PSA based screening leads to substantial over-diagnosis of prostate tumors and there is a high incidence for physicians and individuals to elect to treat most cases of screen detected cancer, given the current inability to distinguish tumors that will remain indolent from those destined to be lethal. Thus, many individuals are being subjected to the harms of treatment of prostate cancer that will never become symptomatic. Even for individuals whose screen-detected cancer would otherwise have been later identified without screening, most experience the same outcome and are, therefore, subjected to the harms of treatment for much longer period. There is convincing evidence that PSA based screening for prostate cancer results in considerable overtreatment and its associated harms.

Despite its limitations, recent population-based prostate cancer screening studies have demonstrated survival benefits using PSA, sometimes in combination with digital rectal examination (DRE).

PSA-based screening for prostate cancer has been studied in 3 very large RCTs, each with at least a decade of median follow-up: the US-based Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial, the European Randomized Study of Screening for Prostate Cancer (ERSPC), and the Cluster Randomized Trial of PSA Testing for Prostate Cancer (CAP). These trials used varying screening intervals (from 1-time screening to every 1 to 4 years) and PSA thresholds (2.5 to 10.0 ng/mL) for diagnostic biopsy.

In 2018, de Koning et. al. reported on the efficacy of prostate-specific antigen screening and the impact of the key components in the European Randomized Study for Prostate Cancer (ERSPC) and the U.S. Prostate, Lung, Colorectal and Ovarian (PLCO) trials. The European Randomized Study of Screening for Prostate Cancer (ERSPC) demonstrated that prostate-specific antigen (PSA) screening significantly reduced prostate cancer mortality (rate ratio, 0.79; 95% confidence interval, 0.69-0.91). The U.S. Prostate, Lung, Colorectal, and Ovarian (PLCO) trial indicated no such reduction but had a wide 95% CI (rate ratio for prostate cancer mortality, 1.09; 95% CI, 0.87-1.36). Standard meta-analyses are unable to account for key differences between the trials that can impact the estimated effects of screening and the trials' point estimates. The authors calibrated 2 microsimulation models to individual-level incidence and mortality data from 238,936 men participating in the ERSPC and PLCO trials. A cure parameter for the underlying efficacy of screening was estimated by the models separately for each trial. The authors changed step-by-step major known differences in trial settings, including enrollment and attendance patterns, screening intervals, PSA thresholds, biopsy receipt, control arm contamination, and primary treatment, to reflect a more ideal protocol situation and differences between the trials. Using the cure parameter estimated for the ERSPC, the models projected 19% to 21% and 6% to 8%, respectively, prostate cancer mortality reductions in the ERSPC and PLCO settings. Using this cure parameter, the

models projected a reduction of 37% to 43% under annual screening with 100% attendance and biopsy compliance and no contamination. The cure parameter estimated for the PLCO trial was 0. The authors concluded that the observed cancer mortality reduction in screening trials appears to be highly sensitive to trial protocol and practice settings. Accounting for these differences, the efficacy of PSA screening in the PLCO setting is not necessarily inconsistent with ERSPC results.

Section Summary:

There are several clinical studies identified in the peer-reviewed medical literature that address the impact of PSA screening on the stage of cancer detection and on disease-specific survival rates, as well as studies that evaluate the relative sensitivities and specificities of derivative types of PSA testing. The primary goal of PSA based screening is to find individuals from whom treatment would reduce morbidity and mortality. Based on the peer reviewed medical literature from randomized clinical trials (RCTs), prostate cancer screening using PSA has at most a small benefit in reducing prostate cancer mortality and the risk of developing metastatic disease.

SUPPLEMENTAL INFORMATION

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Urological Association

In 2026, the American Urological Association and the Society of Urology Oncology (SUO) updated their 2023 guideline for early detection of prostate cancer which included the following guideline statements related to prostate cancer screening:

“PSA Screening

1. When screening for prostate cancer, clinicians should use PSA as the first screening test (*Strong Recommendation; Evidence Level: Grade A*)
2. For people with a newly elevated PSA, clinicians should repeat the PSA prior to a secondary biomarker, imaging or biopsy. (*Expert Opinion*)
3. 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 shared decision making (SDM). (Conditional Recommendation; Evidence Level: Grade B)
4. Clinicians may use digital rectal exam (DRE) alongside PSA to establish risk of clinically significant prostate cancer. (*Conditional Recommendation; Evidence Level: Grade C*)

American Cancer Society

In 2023, the American Cancer Society revised recommendations for prostate cancer early detection, which includes the following: “Individuals have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks and potential benefits of prostate cancer screening.

The discussion about screening should take place at:

- Age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years.
- Age 45 for men at high risk of developing prostate cancer. This includes African Americans and men who have first degree relative (father or brother) diagnosed with prostate cancer at an early age (younger than age 65).
- Age 40 for men at higher risk (those with more than one first degree relative who had prostate cancer at an early age).

After this discussion, men who want to be screening should get the prostate-specific antigen (PSA) blood test. The digital rectal exam (DRE) may also be done as part of screening.

If no prostate cancer is found as a result of screening, the time between future screening depends on the result of the PSA blood test:

- PSA of less than 2.5 ng/mL may only need to be retested every 2 years.
- Screening should be done yearly for PSA level 2.5 ng/mL or higher.”

“Because prostate cancer often grows slowly, men without symptoms of prostate cancer who have less than a 10-year life expectancy should not be offered prostate cancer screening, because they aren’t likely to benefit from it. Overall health status, and not age alone, is important when making decisions about screening.”

“Even after a decision about testing has been made, the discussion about the pros and cons of testing should be repeated as new information about the benefits and risks of testing becomes available. Further discussions are also needed to take into account changes in a man’s health, preferences, and values.”

National Comprehensive Cancer Network (NCCN)

Prostate Cancer Early Detection Version 2.2026

- “Early Detection Evaluation with baseline PSA and can consider digital rectal examination (DRE) in addition to baseline PSA
 - Age 40-75 for:
 - Black/African American individuals^d
 - Those with germline variants that increase the risk for prostate cancer^{b,c,d}
 - Those with concerning family or personal history^{b,d}.”
 - Age 45-75 years for all others
 - Age >75 years in select patients (category 2B)ⁱ

Footnotes:

- “^bFamily or personal cancer history and/or family or personal history of high-risk germline mutation can inform when to begin shared decision-making regarding prostate cancer early detection. Patients with suspicious family history should undergo genetic testing.”

- ^c“If there is a known or suspected cancer susceptibility gene, referral to a cancer genetics professional is recommended. Individuals harboring germline mutations in prostate cancer risk genes may have an elevated lifetime risk of prostate cancer and, in the case of certain genes or mutations, an elevated risk of early-onset and/or potentially lethal prostate cancer (e.g., BRCA2). For prostate cancer susceptibility genes and cancer risk management based on genetic testing results see NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast, Ovarian, Pancreatic and Prostate (Gene-A and BRAC-A).”
- ^d“If genetic testing does not show the presence of germline mutation in a prostate cancer risk gene but family history is concerning, shared decision-making is recommended regarding the timing and frequency of PCA testing.”
- ^e“Black/African American individuals have a significantly higher incidence of prostate cancer, earlier age at diagnosis, and increased prostate cancer mortality compared to white individuals. The higher incidence and earlier age at diagnosis are attributable to a greater incidence of preclinical prostate cancer and a higher likelihood that a preclinical tumor will spread. The survival disparities seen in Black/African American individuals are related to these factors and to social determinants of health, lack of access to care, and treatment disparities, and not to race itself or differences in the frequency of tumor-acquired genomic variants. (Vince RA, et al. JAMA Netw Open 2023;6:e2250416; Schumacher FR, et al. JCO Precis Oncol 2021;5:PO.21.00324). In fact, data show that Black patients who receive equitable prostate cancer treatment have similar outcomes to white patients (Riviere P, et al. Cancer 2020;126:1683-1690). Therefore, there is a need for higher vigilance in this population in the form of appropriate screening and treatment. Although there is currently little evidence to support that screening at an earlier age will result in decreased morbidity and mortality compared to testing at age 45, and earlier screening may increase overdiagnosis (Tsodikov A, et al. Cancer 2017;123:2312-2319), data show that Black individuals benefit more from screening than white individuals (Basourakos SP, et al. NEJM Evid 2022;1:10.1056/evidoa2200031). Therefore, many support the recommendation for Black/African American individuals to consider beginning shared decision making about PSA screening at age 40 years and to consider screening at annual intervals rather than every other year”
- ^f“Individuals ≥ 60 years with PSA < 1.0 ng/mL and those > 75 years of age with a PSA < 3.0 ng/mL have a very low risk of prostate cancer metastases in their lifetime. This low risk is especially true for those in the latter category. The testing interval ranges were not a unanimous decision by the Panel. There are some Panel members who believe that 2-4 years is too long for individuals aged 40-75 years with PSA > 1.0 ng/mL. However, the Panel majority supported the intervals as listed.

“The panel recommends repeat testing at 2-to-4-year intervals for individuals with average risk and a PSA < 1 ng/mL. For those with high risk and PSA ≤ 3 ng/mL and those with average risk and PSA 1-3 ng/mL, 1- to 2 -year intervals are recommended. Further evaluation can be considered for younger patients and for those who have PSA levels that are above the median age group, even if they do not meet the threshold of > 3 ng/mL. For patients > 75 years of age, repeat testing is recommended at 1 to 3-year intervals if PSA is < 4 ng/mL, but only very healthy people with little or no comorbidity. Discontinuation of screening can be considered if clinically appropriate. Clinical judgement and shared decision-making should be used to determine testing interval within these ranges for individuals.”

Genetic Syndromes

“Evidence indicates that patients with prostate cancer may have germline variants in 1 of 16 DNA repair genes: BRCA2 (5%), ATM (2%), CHEK2 (2%), BRCA1 (1%), RAD51D (0.4%), PALB2 (0.4%), ATR (0.3%), and NBN, PMS2, GEN1, MSH2, MSH6, RAD51C, MRE11A, BRIP1 or FAM175A. Individuals with these inherited variants may have an increased risk for prostate cancer.”

Family History

“Having a first-degree relative with prostate cancer diagnosed before the age of 60 increases the likelihood of prostate cancer diagnosed by 2.1 to 2.5-fold. Furthermore, in individuals who have a sibling with aggressive prostate cancer, the overall risk (OR) for aggressive prostate cancer is 1.21. Prostate cancer risk is also elevated in patients with a family history of breast cancer.”

United States Preventative Services Task Force (USPSTF)

In 2018, The United States Preventative Services Task Force (USPSTF) published updated recommendations regarding prostate cancer screening that states the following:

Men aged 55–69:

“For men aged 55 to 69 years, the decision to undergo periodic prostate-specific antigen (PSA)–based screening for prostate cancer should be an individual one. Before deciding whether to be screened, men should have an opportunity to discuss the potential benefits and harms of screening with their clinician and to incorporate their values and preferences in the decision. Screening offers a small potential benefit of reducing the chance of death from prostate cancer in some men. However, many men will experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and erectile dysfunction. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of family history, race/ethnicity, comorbid medical conditions, patient values about the benefits and harms of screening and treatment-specific outcomes, and other health needs. Clinicians should not screen men who do not express a preference for screening.

Grade C Recommendation”

Men aged 70 and older:

“The USPSTF recommends against PSA-based screening for prostate cancer in men aged 70 years and older.

Grade D Recommendation

This recommendation applies to adult men in the general U.S. population without symptoms or a previous diagnosis of prostate cancer. It also applies to men at increased risk of death from prostate cancer because of race/ethnicity or family history of prostate cancer.”

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review can be located at clinicaltrials.gov.

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CODES

To report provider services, use appropriate CPT codes, HCPCS codes, Revenue codes, and/or ICD diagnosis codes.

Codes	Number	Description
CPT		
	84152	Prostate-specific antigen (PSA); complexed (direct measurement)
	84153	Prostate-specific antigen (PSA); total
	84154	Prostate-specific antigen (PSA); free
HCPCS		
	G0103	Prostate cancer screening, prostate specific antigen test (PSA)
Type of Service	Laboratory	
Place of Service	Outpatient/Physician Office	

POLICY HISTORY

Date	Action	Action
June 2026	Annual Review	Policy Renewed
June 2025	Annual Review	Policy Renewed
June 2024	Annual Review	Policy Renewed
June 2023	Annual Review	Policy Revised
June 2022	Annual Review	Policy Revised
June 2021	Annual Review	Policy Revised
June 2020	Annual Review	Policy Renewed
June 2019	Annual Review	Policy Renewed
June 2018	Annual Review	Policy Revised
June 2017	Annual Review	Policy Revised
June 2016	Annual Review	Policy Revised
December 2015	Annual Review	Policy Revised
February 2015	Annual Review	Policy Revised
March 2014	Annual Review	Policy Revised
April 2013	Annual Review	Policy Revised
February 2013	Interim Review	Policy Revised
April 2012	Annual Review	Policy Renewed
May 2011	Annual Review	Policy Renewed

New information or technology that would be relevant for Wellmark to consider when this policy is next reviewed may be submitted to:

Wellmark Blue Cross and Blue Shield
 Medical Policy Analyst
 PO Box 9232
 Des Moines, IA 50306-9232

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