



American Academy  
of Value Based Care

# Prostate Cancer

## Quick Reference Guide

2025

## AAVBC Quick Reference Guide - Prostate Cancer

### 1. CLINICAL SNAPSHOT

**Definition:** Prostate cancer (PCa) is a malignant neoplasm of the prostate gland (usually an adenocarcinoma), often slow-growing, arising primarily from glandular epithelium.<sup>1,2</sup>

**ICD-10 codes:** **C61** – Prostate cancer (primary malignant neoplasm of prostate)<sup>3</sup>

Use additional codes to capture disease status and complexity: **Z19.1** – Hormone sensitive malignancy status (indicates androgen-dependent disease, typically prior to advanced therapy); **Z19.2** – Castration-resistant malignancy status (indicates progression despite androgen deprivation, i.e. castration-resistant prostate cancer, CRPC); **R97.21** – Elevated PSA following treatment for prostate cancer (biochemical recurrence indicator).

Coding note: If the patient's prostate cancer is in remission after treatment, use **Z85.46** (personal history of malignant neoplasm of prostate) instead of **C61** until recurrence is confirmed. **R97.21** is ICD-10 for rising PSA after treatment and indicates active cancer not in remission

**HCC/RAF V28 Mapping:** **C61** is ICD-10 code for prostate cancer maps to **HCC 23** with a RAF (**0.186**); **C79.51** is ICD-10 for secondary malignant neoplasm of bone maps to **HCC18** with RAF (**2.341**)<sup>4,5</sup>

#### Prevalence:

- Most commonly diagnosed non-cutaneous cancer in men; over 60% of cases are diagnosed after age 65
- Estimated 313,780 new cases of prostate cancer in the United States in 2025 or about ~30% of new cancer cases in men<sup>1</sup>
- Second leading cause of male cancer death, over 35,000 deaths in 2025
- Incidence fell nearly 40% from 2007–2014, but has since risen ~3% annually. Reduced PSA screening after the 2012 USPSTF recommendation was followed by an increase in regional and metastatic presentations.
- Large inequities exist in incidence of and mortality from prostate cancer across racial and ethnic groups. The incidence rate in Black individuals is 67% higher than in White individuals and the mortality rate in this population is 2 to 4 times higher than all other racial and ethnic groups.

#### Cost Burden

- National spending on prostate cancer care exceeds \$10 billion annually, including diagnostics, treatment, and long-term management.<sup>6</sup>
- **Localized Disease** – Cost Efficiency of Active Surveillance (AS)<sup>1,6,7</sup>
  - Low-risk patients (Grade Group 1) managed with **Active Surveillance** reduce expenditures by **50–70% in the first 2 years** versus immediate prostatectomy or radiation (typical procedure episode cost **\$20,000–\$30,000**)
  - Correctly identifying Grade Group 1 patients and assigning them to AS can reduce **PMPY costs by \$10,000–\$15,000** over 10 years.
- **Intermediate/High-Risk Localized Disease**<sup>1,6,7</sup>

- Definitive therapy (radical prostatectomy, external beam radiation, brachytherapy) often exceeds \$25,000–\$40,000 including hospital, anesthesia, pathology, and follow-up
- Salvage radiation or ADT after recurrence adds substantial long-term expenditures that must be risk-stratified and managed proactively.
- **Metastatic & Advanced Disease (Highest Cost Segment)<sup>1, 6, 7</sup>**
  - Transition to metastatic hormone-sensitive (mHSPC) or castration-resistant prostate cancer (CRPC) drives the **steepest cost escalation**.
  - Advanced therapy regimens: AR-targeted agents (abiraterone, enzalutamide, apalutamide), docetaxel, PSMA-PET imaging, and bone-targeted therapies—commonly exceed **\$100,000 PMPY**

## Medicare screenings:<sup>1-5, 8</sup>

| Test                                      | Clinical need (who/when)  | Coverage   | CPT Code                       | Notes  |
|---|---|--|--------------------------------|--|
| <b>PSA (Prostate-Specific Antigen)</b>    | <ul style="list-style-type: none"> <li>● Men 55–69: Individual decision (USPSTF Grade C) after shared decision-making</li> <li>● Men <math>\geq 70</math>: Not recommended for routine screening (Grade D)</li> <li>● Consider earlier if <b>high-risk</b> (family history, BRCA2)</li> </ul> | Medicare covers PSA <b>annually</b> for men $\geq 50$ when ordered by a clinician. | 84153 (total PSA)              | Screening frequency usually every 2 years if chosen. Elevated PSA requires repeat testing + shared decision-making before biopsy |
| <b>Digital Rectal Exam (DRE)</b>          | Assess prostate nodules/asymmetry in symptomatic men or those with abnormal PSA   | Covered when part of an evaluation for urinary symptoms or abnormal PSA            | G0102 (screening DRE—Medicare) | AUA/NCCN: DRE is <b>optional</b> in screening but recommended during diagnostic workup   |
| <b>Free PSA (% free PSA)</b>              | Men with <b>borderline PSA (4–10 ng/mL)</b> to assess risk of clinically significant cancer   | Covered when ordered to investigate an abnormal CBC or specific clinical signs     | 84154                          | Lower % free PSA $\rightarrow$ higher likelihood of prostate cancer; helps determine need for biopsy                             |
| <b>4Kscore® (Kallikrein panel)</b>        | Adjunct test for men with elevated PSA considering an initial or repeat biopsy  | Coverage varies by MAC; often covered with appropriate ICD-10 (e.g., R97.2)        | Unlisted Lab (varies)          | Improves prediction of high-grade cancer; reduces unnecessary biopsies.  |
| <b>Prostate MRI (Multiparametric MRI)</b> | Pre-biopsy evaluation in men with elevated PSA; staging for known cancer  | Covered when medically necessary for diagnosing prostate cancer                    | 80700, 80702 (Prostate), 78842 | Higher yield of high-grade cancers compared with standard biopsy   |

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