Medical Coverage Policy

Malignant Melanoma Surveillance Technologies

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Coverage Policy

Each of the following technologies for the early detection, screening or surveillance of melanoma is considered experimental, investigational or unproven:

- total body photography
- visual image analysis
- electrical impedance devices
- multispectral image analysis
- ultrasound
- optical coherence tomography [OCT]
- reflectance confocal microscopy [RCM])
- multiphoton microscopy
- Raman spectroscopy
- 3D imagery
- photoacoustic microscopy
- 3D color histogram mapping
- stepwise two-photon-laser spectroscopy
- quantitative infrared imaging
- multiphoton tomography
- thermal imaging
Dermoscopy is considered to be an integral part of a normal evaluation of a pigmented skin lesion and not separately reimbursable.

Overview

This Coverage Policy addresses technologies that have been proposed for the early detection, screening or surveillance of malignant melanoma.

General Background

Melanoma, also called cutaneous melanoma or malignant melanoma, is a malignant disease of the skin and one of the most dangerous forms of skin cancer. Although melanoma accounts for less than 5% of skin cancer cases, it accounts for approximately three-fourths of all skin cancer deaths. Early detection and treatment are the best strategies to reduce the mortality and morbidity associated with melanoma.

High-risk individuals for melanoma include those with a personal history of melanoma, prior primary melanoma, presence of pigmented lesions (e.g., atypical nevi, dysplastic nevi) or a first-(i.e. parent, sibling or child) or second-degree relative with melanoma (National Comprehensive Cancer Network® [NCCN], 2018; National Cancer Institute [NCI], 2017; van der Rhee, et al., 2011; Goodson, et al., 2010; Banky, et al., 2005; Oliveria, et al., 2004; Robinson, et al., 2004; Haenssle, et al., 2004).

The assessment of suspicious skin lesions begins with a physical examination and visual inspection of the skin with the naked eye. Dermoscopy including digital epiluminescence microscopy (DELM) has evolved into an established technology used as an adjunct to a normal eye exam and is considered to be an integral part of the exam depending on the lesions being examined. Additional noninvasive technologies are proposed to provide better examination of lesions and assist the examiner in deciding whether a lesion should be biopsied. None of these devices can diagnosis skin cancer. Biopsy is considered the diagnostic “gold standard”. Noninvasive technologies include: total-body photography (TBP); visual image analysis; electrical impedance devices; multispectral image analysis; ultrasound, optical coherence tomography [OCT]; and reflectance confocal microscopy (RCM). There is insufficient evidence in the peer-reviewed literature to support the use of these noninvasive technologies for the evaluation and surveillance of melanoma.

Total Body Photography (TBP)

TBP, also known as whole body photography, surveillance photography, total body mapping, has been proposed for screening and monitoring for the early detection of skin cancers, especially for people at high risk for melanoma. A proposed disadvantage of TBP is the poor resolution of images and loss of follow-up in noncompliant patients. The majority of melanomas are pigmented, but 2–8% are hypopigmented and detection by a TBP imaging system may be less reliable than with pigmented lesions. Historically, TBP has been performed via 2D imaging and is now evolving into 3D capabilities. The intent is that 3D imaging will improve diagnostic accuracy, be time and cost efficient and more accessible to patients. TBP involves a series of multiple photographs (25–40) of head-to-toe images of the patient’s entire cutaneous (skin) surface and is proposed for high-risk patients with multiple lesions. The photographs may be enlarged to show the details of lesions. New photographs can be compared with previous photographs to determine if a lesion has Photographs are generally useful for 5–8 years. Available software can automatically match lesions on two standardized photographs and highlight new or changed lesions. Examples of this software are the Fotofinder™ bodystudio LITE (FotoFinder Systems Inc. Columbia, MD) and MIRROR™ Body Mapping Module (Digitale Photographie Gmbh, Fairfield, NJ). Although the use of TBP is increasing the clinical evidence behind the technology is limited and formal criteria to define suspicious lesions identified through TBP are lacking (Rayner, et al., 2018; Mayer, et al., 2014; Guitera and Menzies, 2011).

US Food and Drug Administration (FDA): Because the cameras used for surveillance are not considered medical devices, they are not regulated by the FDA.

Literature Review: Watts et al. (2015) conducted a systematic review of published international clinical practice guidelines for the identification, screening and follow-up of individuals at high risk for primary cutaneous
melanoma. Thirty-four guidelines from 20 countries were included. Consistently reported high-risk characteristics included: many melanocytic nevi, dysplastic nevi, family history, large congenital nevi, and Fitzpatrick Type I and II skin types. Monitoring of high risk individuals was recommended but only half of the guidelines recommended screening based on level of risk. There were high levels of evidence for targeted, regular monitoring using dermoscopy and sequential digital dermoscopy imaging (SDDI) but low levels of evidence for the use of total-body photography (TBP).

In a Directory Report (2011; reviewed 2012–2015) Hayes concluded that there was insufficient evidence to support the use of single lesion, partial body or whole body photography for melanoma screening. There is a lack of evidence showing that patient outcomes improved by reducing the frequency of unnecessary biopsies or improving the early detection of malignant melanoma. Studies were primarily in the form of uncontrolled trials. Outcomes were conflicting, there was absence of a control group and lack of reporting of lesion thickness. There was insufficient evidence to establish definitive patient selection criteria for single-lesion, selected-region or total body photography.

Salerni et al. (2011) reported surveillance of 618 patients at high risk for melanoma using digital total body photography and digital dermatoscopy. A total of 11,396 lesions were monitored (mean 18.44/patient) during a median follow-up of 96 months (median 10 visits/patient). Data analysis revealed that older age at inclusion and higher number of lesions excised during follow-up were the variables most associated with melanoma diagnosis during surveillance ($p=0.003$ and $p<0.001$, respectively). A total of 98 melanomas (8.5% of excised lesions) were diagnosed in 78 patients (12.6%). No conclusions regarding the impact of TBP on long-term health outcomes can be drawn from this study as there were no control groups.

In a prospective trial, Goodson et al. (2010) sought to determine whether biopsy rate, rate of melanoma detection, and melanoma derivation (nevus derived versus de novo) differed, using total body and digital epiluminescence microscopy (DELM) photography. A total of 889 new patients and 187 established patients were included. Most patients had one or more of the following melanoma risk factors: three or more clinically atypical nevi, more than 50 nevi, personal history of melanoma, and two or more family members with history of melanoma. Follow-ups occurred for 6-12 months. A total of 110 patients were lost to follow-up. The patients underwent total body photography and were monitored using photographs obtained at the initial visit. Risk factors and median monitoring periods for these patients were comparable with those of patients previously monitored using DELM photography. A total of 275 biopsies were performed on 467 patients on follow-up visits. The authors cited low biopsy rates on follow-up visits with both approaches (0.59 biopsies per patient with total body photography versus 1.1 per patient with DELM photography, statistically significant). The significantly higher biopsy rate with DELM photography may be a consequence of the greater sensitivity for detecting morphologic changes in nevi because of higher resolution of these photographs and the fact that lesions exhibiting photographic change were more likely to be biopsied.

Banky et al. (2005) conducted a prospective case series (n=309) to assess the effectiveness of total body photography and dermoscopy in the evaluation of new, changed and regressed nevi and melanomas. Included patients were referred to a dermatologist for clinical examination and had at least one of the following risk factors for melanoma: four or more clinically dysplastic nevi, 100 or more melanocytic nevi, a personal history of melanoma, or a family history of melanoma. Individuals with one of these risk factors underwent total body photography. Biopsy specimens were not obtained of all changed and new pigmented lesions. If melanoma could not be confidently excluded by clinical examination and dermoscopy, an excisional biopsy was performed. The median number of follow-up visits following photography was three. The median length of follow-up was 34 months. A total of 311 changed nevi and 262 new pigmented lesions were detected. Eighty-six nevi regressed completely. Eighteen melanomas were detected in 16 patients. The benign-malignant ratio of biopsied specimens was almost 3:1.

**Visual Image Analysis**

Visual image analysis involves image acquisition, segmentation (a step that often has to be overseen by the human operator), extraction of morphological data and numeric conversion of the data. A classification by mathematical algorithm is used to give a diagnosis. To date, no mechanized systems have proven to be reliable enough to produce a fully automated diagnosis with high diagnostic accuracy. Image-based systems require the
lesion to be pigmented which means light-colored lesions are usually poorly diagnosed (Guitera and Menzies, 2011).

**Electrical Impedance Devices**

These devices utilize resistance or impedance measured between two electrodes in contact with the epidermis and provides a score based on the cellular irregularity of the skin. Different tissues have different electrical impedance spectra. Normalized conductivity and capacitance recorded on growing skin tumors have been shown to change relative to the lesion. Necrosis, present in larger lesions, is associated with a decrease in the electrical conductivity. Studies are still investigating the role of electrical impedance in the diagnosis of melanoma.

**US Food and Drug Administration (FDA):** The Nevisense™ (Scibase AB, Stockholm, Sweden) received FDA PMA approval in June 2017. The device is indicated for use on “cutaneous lesions with one or more clinical or historical characteristics of melanoma, when a dermatologist chooses to obtain additional information when considering biopsy. Nevisense should not be used on clinically obvious melanoma. The Nevisense result is one element of the overall clinical assessment. The output of Nevisense should be used in combination with clinical and historical signs of melanoma to obtain additional information prior to a decision to biopsy. Nevisense is indicated only for use on:

- primary skin lesions with a diameter between 2 mm and 20 mm;
- lesions that are accessible by the Nevisense probe;
- lesions where the skin is intact (i.e., non-ulcerated or non-bleeding lesions);
- lesions that do not contain a scar or fibrosis consistent with previous trauma;
- lesions not located in areas of psoriasis, eczema, acute sunburn or similar skin conditions;
- lesions not in hair-covered areas;
- lesions which do not contain foreign matter;
- lesions not on special anatomic sites (i.e., not for use on acral skin, genitalia, eyes, mucosal areas)."

The device includes a control unit, probe and probe cable.

**Literature Review:** Malvehy et al. (2014) conducted a prospective multicenter case series to assess the safety and effectiveness of the Nevisense system in the distinction of benign skin lesions from melanoma with electrical impedance spectroscopy. There were multiple exclusion criteria including: age <18 years, metastases or recurrent lesions, lesions <2 mm or >20 mm in diameter, location of lesion, and skin conditions. All eligible skin lesions were examined with the EIS-based Nevisense system, photographed, removed by excisional biopsy and subjected to histopathological evaluation. A total of 1951 patients with 2416 lesions were enrolled in the study and 473 lesions were excluded. A total of 265 lesions were diagnosed as melanomas (112 in situ and 153 invasive). Compared to histopathology the observed sensitivity of Nevisense was 96.6% (256 of 265 melanomas), observed specificity was 34.4% (would not have been biopsied), positive predictive value was 21.1% and the negative predictive value was 98.2%. The observed sensitivity for nonmelanoma skin cancer was 100% (55 of 48 BCCs and seven SCCs). A high proportion of seborrheic keratoses were inaccurately classified as positive by the system. It was proposed that a trained dermatologist would not apply Nevisense to these lesions. Nine melanoma lesions were classified as a false negative by Nevisense. No serious adverse events were reported. Additional studies are needed to validate the outcomes of this study and establish the clinical utility of Nevisense.

In a multi-center study, Har-Shai et al. (2005) prospectively evaluated the ability of electrical impedance scanning to differentiate between benign and malignant skin lesions in 382 patients (449 lesions), including 53 melanomas from the trunk and extremities. Results were correlated with histopathologic findings. Electrical impedance scanning detected melanomas of the trunk and extremities with 91% sensitivity and 64% specificity. Visual examination identified 67% of small, thin malignant lesions (n=27) compared to 100% by electrical impedance scanning (p=0.002). Clinical examination detected 96% of larger or thicker melanomas (n=26) compared to 81% by electrical impedance scanning.

**Multispectral Image Analysis**
Computer-aided multispectral imaging analysis or scanning technique is proposed to allow analysis of sequences of images taken at different wavelengths. With similar segmenting and image analysis as the first devices, they may also provide information on skin chromophores (mostly collagen, melanin and hemoglobin). In a review article, Winklemann et al. (2017) reported an overall sensitivity of 62%–94%, specificity 25%–79% and biopsy accuracy of 65%–80% using multispectral digital skin lesion analysis. Studies evaluating spectrophotometric intracutaneous analysis (SIAscope, Biocompatibles, Farnham, Surrey, UK) reported a sensitivity of 80%–100% with a specificity of 76%–91%. The authors noted that the risk of missing melanomas using multispectral analysis has prevented these devices from being routinely used in clinical practice. Biopsies are still required.

**U. S. Food and Drug Administration (FDA):** An example of a multispectral device is the MelaFind® (MELA Sciences, Irvington, New York) which received FDA pre-market approval (PMA) for "use on clinically atypical cutaneous pigmented lesions with one or more clinical or historical characteristics of melanoma, excluding those with a clinical diagnosis of melanoma or likely melanoma". The device is proposed to help a dermatologist make a decision to biopsy. It is not to be used alone for making biopsy decisions. MelaFind is indicated “only for use on lesions with a diameter between 2 mm and 22 mm, lesions that are accessible by the MelaFind imager, lesions that are sufficiently pigmented (i.e. not for use on non-pigmented or skin-colored lesions), lesions that do not contain a scar or fibrosis consistent with previous trauma, lesions where the skin is intact (i.e., non-ulcerated or non-bleeding lesions), lesions greater than one centimeter away from the eye, lesions which do not contain foreign matter, and lesions not on special anatomic sites (i.e., not for use on acral, palmar, plantar, mucosal, or subungual areas). MelaFind is not designed to detect pigmented non-melanoma skin cancers, so the dermatologist should rely on clinical experience to diagnose such lesions” (FDA, 2011).

SIAScope II® (Astron Clinica Ltd., Cambridge, UK), a Class II device, is a non-invasive skin analysis system proposed to show the location of blood, collagen and pigment. Using spectrophotometric intracutaneous analysis (SIAscopy) to identify and graphically display the separate components of the skin, the device provides color bitmaps called SIAscans. SIAscopy uses a digital camera and light (both visible and near-infrared) to investigate the skin's interior structure.

**Literature Review:** Monheit et al. (2011) conducted a prospective multicenter study to evaluate the safety and effectiveness of MelaFind (n=1612 lesions; 114 melanomas). The pooled data on melanoma reported a sensitivity of 98.4%, specificity ranged from 0%–25% (average 9%), negative predictive value was > 98%, and biopsy ratio of 10.8:1. MelaFind had an average specificity of 9.5% which was significantly higher than that of investigators (3.7%) (p=0.02). The study also included a pilot study of biopsy sensitivity (reader study) using 25 randomly selected melanomas and 25 nonmelanomas which showed that dermatologists misdiagnosed thin melanomas. The average biopsy sensitivity of 39 dermatologist readers was 78%. An author noted limitation of the study was that only pigmented lesions were scheduled for biopsy and these benign lesions are not representative of lesions in the general population. Thus, the specificity in this study is not applicable to the general population for clinicians or MelaFind.

In a prospective study, Haniffa et al. (2007) evaluated the ability of the spectrophotometric device, SIAscope, to aid in the diagnosis of melanomas. The investigator’s diagnosis before and after spectrophotometry were compared to the histological diagnosis where available or with the expert’s clinical diagnosis. Of 860 patients, 179 biopsies were performed, with 31 melanomas diagnosed. Sensitivity and specificity for melanoma diagnosis before and after spectrophotometry were 94% and 91% vs. 87% and 91%, respectively, with no significant difference in the area under the receiver operating characteristic curves.

**Ultrasound**

Ultrasound/reflex transmission imaging relies on the properties of reflected sound waves through tissue. The ultrasound impulse is administered by a probe and transmitted to the skin. The probe acts as a receptor that will collect the backscattered or diffused ultrasound and transform it into an electric signal. Ultrasound creates an image of the strain on the tissue imposed by presence of an abnormal growth. Ultrasound is not currently a widely accepted technology for evaluating melanomas due to the lack of resolution in the epidermis and dermis which does not allow for the differentiation of tumors. Refinement of the technology and equipment and its clinical utility are still being investigated (Welzel and Schuh, 2017).
U.S. Food and Drug Administration (FDA): Ultrasounds are approved by the FDA as a Class II, 510(k) device. An example of an approved device is the DermaScan C Ultrasonic System (Cortex Technology, Denmark). The device is intended “to be used to visualize the layers of the skin, including blood vessels, and to make approximate measurements of dimensions in the layers of the skin and blood vessels by ultrasonic means” (FDA, 1999).

Literature Review: Rallan et al. (2007) conducted a prospective study (n=87) to determine if high-resolution ultrasound reflex transmission imaging (RTI) could differentiate common benign pigmented lesions (BPLs) from melanoma. RTI was used to determine the lesion attenuation properties. The study also assessed if the “lesional backspatter image” (LBI) which depicts intralesional sound reflection characteristics and the “entry echo image” (EEI), which depicts surface sound reflectance characteristics, could aid in diagnosis. Twenty-five malignant melanomas (MM) and 62 noncancerous lesions, as classified by a dermatologist, were analyzed by RTI. Of the noncancerous lesions, 24 were seborrheic keratosis (SK) and 38 were BPLs. When the sensitivity of diagnosing melanoma was set at 100%, RTI, LBI, and EEI were compared in the diagnosis of SK. A total of nine of the 24 SK were detected by RTI and LBI for a specificity of 38%. EEI detected seven out of 24 for a specificity of 29%. Each of the three methods was compared in its ability to diagnose BPLs (with sensitivity set at 100%). The specificity of EEI, LBI, and RTI were 30%, 15%, and 10%, respectively.

Reflectance Confocal Microscopy
Reflectance confocal microscopy (RCM), also known as confocal scanning laser microscopy (CSLM), uses a near infrared laser that emits near-infrared light (830 nm) to obtain images of the top layers of the skin. The images are magnified and information regarding cell structure and the architecture of the surrounding tissues is evaluated. Combinations of features are assessed to give a positive or negative diagnosis of melanoma. RCM is proposed to be comparable to conventional histology and proposed for use as an adjunctive diagnostic tool to examination and dermoscopy in difficult to diagnose lesions and therefore, aid in determining if a lesion is benign or is a melanoma. It enables high-resolution, noninvasive, real-time imaging of the epidermis and upper dermis at cellular resolution. Its primary field of application is the differential diagnosis of pigmented lesions. Studies evaluating the accuracy of confocal scanning laser RCM/CSLM in assessing skin lesions for melanoma have reported sensitivity, specificity, positive and negative predictive values ranging from 90.74% to 97.5%, 83% to 99%, 70.6% to 97.5%, and 98.17% to 99%, respectively.

RCM is considered an evolving technology with several limitations. The depth of imaging is confined to the epidermis and papillary dermis which may result in false negatives. Penetration of RCM light may be hampered by hyperkeratosis, reflective creams and surface particles. Another limitation is the challenge that the interpreter has of distinguishing between cells with similar reflection index and shape (e.g., Langerhans cells versus dendritic melanocytes at the spinous layer). RCM is a time consuming exam taking an average of seven minutes per lesion. Clinical-dermatoscopic skills are required, as well as adequate training and experience to read RCM images and make the correct interpretation. It has yet to be determined if the advantages of the clinical utility of RCM as an adjunctive diagnostic tool are greater than the risk of over-excising benign lesion and misdiagnosing melanomas as benign. In some cases RCM may be used for cosmetically sensitive areas to avoid excision (Que, et al., 2016; Stevenson, et al., 2013; Gerger, 2008; Langley, 2007; Gerger, 2006). There is insufficient evidence to support the clinical utility of RCM.

U.S. Food and Drug Administration (FDA): Confocal microscopes are approved by the FDA 510(k) process. Examples of these devices include the VivaScope System 1500 and the handheld VivaScope 3000 (Lucid, Inc., Rochester, New York). The VivaScope is intended “to acquire, store, retrieve, display and transfer in vivo images of tissue, including blood, collagen and pigment, in exposed unstained epithelium and the supporting stroma for review by physicians to assist in forming a clinical judgment”. The VivaScope 3000 is a hand-held device designed to access hard to reach areas such as nose, ears, or eyes. The 1500 and 3000 systems can be used alone or together. The SIAscope II (Astron Clinica Limited, Crofton MD) is FDA approved as a “non-invasive skin analysis system, which provides a synthesized ‘image’ showing the relative location of blood collagen and pigment” (FDA, 2008; 2003).

Literature Review: Edwards et al. (2016) conducted a systematic review and health technology assessment on the clinical effectiveness of the VivaScope 1500 and 3000 systems in the diagnosis of equivocal skin lesions. VivaScope 3000 was also evaluated for the assessment of lesion margin delineation prior to surgical excision of
lesions. Eleven prospective observational studies and five retrospective reviews were included. No randomized controlled trials (RCTs) were found. One study suggested that VivaScope used subsequent to dermoscopy may improve diagnostic accuracy of equivocal skin lesions compared with dermoscopy alone, especially for malignant melanomas. Another study reported that the sensitivity for dermoscopy plus VivaScope 1500 were the same (100%). Clinical data regarding margin delineation are scarce. The studies were too heterogeneous to be used in a meta-analysis. The authors noted that apart from diagnostic accuracy and lesion recurrence rate (only reported by one study), none of the outcomes specified in the protocol were reported in the outcomes and in some of the studies, there was paucity of reported data on number of patients with positive and negative test results. Other limitations of the studies included: lack of a comparator; retrospective study design; small patient populations; heterogeneity in cancer types (melanoma, basal cell and squamous cell carcinoma); and variation in reporting results as patient based or lesion based. The authors suggested that high-quality RCTs are required to assess diagnostic accuracy of dermoscopy plus VivaScope compared with dermoscopy alone in people with equivocal skin lesions, as well as the margin delineation accuracy of VivaScope compared with dermoscopy alone. RCTs focusing on clinical outcomes, test failure rates, number of biopsies performed, repeat biopsies, recurrence rates and morbidity associated with surgery are required.

Pellacani et al. (2014) conducted a prospective case series (n=1005) to assess the impact of reflectance confocal microscopy (RCM) in the routine diagnosis of melanoma. Patients had atypical moles and were initially referred to either no further examination or to RCM. The RCM group was further subdivided into RCM documentation (suspicious lesions already qualified for excision) or RCM consultation (i.e., RCM would determine if the lesion was excised or monitored with digital dermoscopy). RCM did not affect the outcome in patients already scheduled for excision. Patients referred for RCM had a higher number of nevi (>100 nevi; 19%) and atypical nevi (>5; 15%) compared to patients referred for RCM documentation and patients without RCM referral (p<0.0001). Personal and/or familial history of melanoma was recorded in approximately 8% of patients. A total of 493 lesions were referred to RCM of which 183 underwent RCM documentation and 308 RCM consultations. Histopathology identified 23 melanomas. RCM proposed the same diagnosis as histopathology in 82.6% of melanomas. A total of 109 of 308 RCM consultation lesions were excised, six cases of melanoma were diagnosed and five cases were confirmed as melanomas. Twenty-eight lesions deferred to follow-up were excised based on dermoscopic changes. Overall RCM proposed diagnosis was concordant with histopathological diagnosis in 76.3% of cases and reduced the number of excision by 46.5%. Limitations of the study include: 12.3% of patients were lost to follow-up; 11 patients either refused RCM or were unable to undergo RCM; and the study population was a low risk group referred for screening.

Stevenson et al. (2013) conducted a systematic review of the literature to determine the diagnostic accuracy of reflectance confocal microscopy (RCM) as an adjunctive tool to dermoscopy for the evaluation of melanoma. No systematic reviews or meta-analysis were found. Studies were primarily in the form of case series, case reports, and descriptive correlation studies that only described RCM features and narrative reviews. Five studies (n=909 lesions) met inclusion criteria and were eligible for meta-analysis. Meta-analysis returned a per lesion sensitivity of 93% (range 91%–97%) and a specificity of 76% (range 68%–86%). The average prevalence of melanoma was 36%. The authors noted that a weakness of the study was that the studies may not have focused on the pertinent patient populations to test the ability of RCM as an add-on test to dermoscopy. Limitations of the studies included use of various types of melanoma scoring systems and outcome measures, heterogeneity of lesion locations, and two studies did not list number of patients evaluated.

Other Noninvasive Technologies
Multiple other noninvasive technologies have been proposed for use in melanoma diagnosis and surveillance. To date, some of these technologies have not been FDA approved nor has the accuracy and/or clinical utility been established. Other proposed noninvasive diagnostic surveillance techniques include: optical coherence tomography (OCT), ultra-high resolution/high-definition OCT (HD-OCT), multiphoton microscopy, Raman spectroscopy, 3D imagers, photoacoustic microscopy system, and 3-D histograms of color mapping or color histogram analysis. Additional evolving technologies include the stepwise two-photon-laser spectroscopy, multiphoton tomography, and quantitative dynamic infrared imaging proposed for assessment of preselected lesions. Thermal imaging measures differences in the infrared emission between healthy tissue and the lesion during the thermal recovery process after the removal of a cooling stress. These technologies are in the investigative phase and clinical utility has not been established (Fink and Haenssle, 2017; Godoy, et al., 2017;
There is insufficient evidence to support the accuracy and clinical utility of other noninvasive technologies for the screening, diagnosis and surveillance of melanoma. Studies are primarily in the form of small case series, case reports and retrospective reviews with conflicting outcomes.

Meyer et al. (2014) conducted a single-center prospective study (n=131 patients; 138 lesions) to evaluate the accuracy and reliability of high-frequency ultrasonography (HFUS) and 930-nm optical coherence tomography (OCT) compared to histopathological measurements in assessing the thickness of melanoma lesions. The objective of the study was to test whether these two imaging methods could improve preoperative management of skin melanoma by estimating lesion thickness and allowing a single-step excision with defined surgical margins. Each lesion underwent OCT and HFUS assessments twice (at least one week apart) before excision and pathological examination. HFUS was conducted on a Dermcup 2020 scanner (Atys Medical, Soucieu en Jarrest, France) and OCT was conducted on a Ganymede 930 (Thorlabs, Newton, NJ). A total of 67 lesions were diagnosed as melanoma by histopathology. OCT measurements were not obtained on 11 patients due to technical issues. The mean difference between OCT and histopathological assessments was high at 0.53 mm. In a subgroup analysis of melanomas with a Breslow index below 1 mm, the mean difference was 0.62 showing that OCT underestimated melanoma thickness. The repeatability and inter-rater reproducibility of HFUS were high (G=0.99 and G=0.97, respectively). The mean difference between HFUS and pathological assessment of tumor thickness was 0.01 mm. The difference between OCT and HFUS vs. histopathology increased with tumor thickness for both devices. The study was limited by the small patient population, lack of comparison of results between the devices, heterogeneity of lesions and the number of lesions not measured by OCT. The authors noted that these outcomes are inconsistent with similar studies.

Professional Societies/Organizations

**American Academy of Dermatology (AAD):** AAD (2011) stated that biopsy is the first step for a definitive diagnosis of cancer. They do not discuss the use of noninvasive technologies in their guidelines for the management of melanoma.

**National Cancer Institute (NCI):** According to NCI, risk factors for melanoma include sun exposure, pigmented characteristics, multiple nevi, family and personal history of melanoma, immunosuppression and environment exposures. Fair-skinned individuals exposed to the sun are at high risk and certain types of pigmented lesions (dysplastic or atypical nevi), with several large nondysplastic nevi, with many small nevi, or with moderate freckling have a twofold to threefold increased risk of developing melanoma. Familial dysplastic nevus syndrome or the presence of several dysplastic or atypical nevi increases the risk of developing melanoma greater than fivefold. NCI stated that the only widely proposed screening procedure for skin cancer is visual examination of the skin, including both self-examination and clinical examination. More than 90% of melanomas can be recognized with the naked eye. A biopsy should be performed for any suspicious lesion (2018a; 2018b).

**National Comprehensive Cancer Network® (NCCN®):** In the discussion for follow-up following diagnosis and treatment of melanoma, NCCN’s Clinical Practice Guidelines in Oncology™ (2018) states that patients cured of an initial primary melanoma are at increased risk for a second melanoma. Patients with risk factors that increase the chance for recurrence (e.g., prior multiple primary melanomas, family history of melanoma and presence of atypical/dysplastic nevi) should be enrolled in a more intensive surveillance program and may benefit from adjuncts such as high-resolution total body photography. These risk factors include multiple primary melanomas, positive family history and the presence of multiple dysplastic nevi.

**U.S. Preventive Services Task Force (USPSTF):** U.S. Preventive Services Task Force (USPSTF): The USPSTF published a 2016 updated systematic review on visual screening for skin cancer. Thirteen studies, mostly observational cohort studies and retrospective reviews (n=10), met inclusion criteria. Acceptable screening tests were defined as whole or partial visual skin examination with or without tools to aid examination (e.g., dermatoscopy, whole body photography). The report noted that definitive diagnosis of non-melanoma and melanoma skin cancer is made by shave, punch or excision biopsy depending on the type of skin cancer. The authors concluded that due to the limited evidence, no firm conclusions on skin cancer screening and melanoma mortality could be made. Noted limitations of the fair-quality studies included: various follow-up times; short-term
follow-ups; noncomparative study design; subjects tended to be younger women even though the incidence of skin cancer is highest in older men; lack of complete data presented; and lack of rigorous studies on skin cancer screening conducted in the United States with an application in primary care or internal medicine settings.

**Use Outside of the US**

It has been reported that there has been a global trend of increasing melanoma incidence in people of European descent. One of the highest incidences is in Croatia which has had a four-fold increase in the past 40 years. Central and Eastern Europe had the largest share of deaths (35.5%) among the four geographic European regions. Melanoma mortality remains the highest in Australia and New Zealand (Mayer et al., 2014). The Nevisense has been CE Marked since 2013, and is currently commercially available in Europe including Sweden, Germany, Switzerland, Australia, United Kingdom, Belgium, and Austria. Nevisense has Therapeutic Goods Administration TGA in Australia.

**Brazilian Dermatology Society:** The Brazilian guidelines on the diagnosis and treatment of primary cutaneous melanoma included recommendations on total body photography with digital dermoscopy (body mapping [BM]). The recommendations stated that follow-up with BM has benefits for patients with an increased risk of melanoma (grade A - experimental or observational studies of higher consistency). BM is not typically indicated for low-risk individuals (grade B - experimental or observational studies of lower consistency) but may be indicated in a low-risk individual who has an isolated suspicious lesions without specific criteria for melanoma (grade A). Follow-up with BM complements but does not replace clinical and dermoscopic examination of the entire skin surface. The Society noted that isolated BM, not aimed at follow-up, is frequently used in Brazil as a diagnostic test to replace/complement dermoscopic examination during dermatological consultations and stated that this indication is far from ideal. BM may be justified in situations where dermoscopy of the entire body surface cannot be performed (grade D recommendation - opinion without critical evaluation, based on consensus, physiological studies or animal models) (Castro, et al., 2016).

**European Society for Medical Oncology (ESMO):** In their 2015 (updated 2016) clinical practice guidelines for the diagnosis, treatment and follow-up of cutaneous melanoma, ESMO stated that dermoscopy by an experienced physician enhances diagnostic accuracy. The Society does not discuss the use of other photographic surveillance techniques.

**National Institute for Health and Clinical Excellence (NICE):** The 2015 NICE guidelines (United Kingdom) on the assessment and management of melanoma included a review of the literature on dermoscopy and other visualization techniques. NICE stated that dermoscopy is an accepted practice but the accuracy and clinical utility depends on the experience of the practitioner who is using it and recommended its use in the assessment of lesions when performed by a trained professional. Based on the literature review, NICE did not recommend the routine use of confocal microscopy or computer-assisted diagnostic tools. NICE recommended that baseline photography (preferably dermoscopic) be used for a clinically atypical melanocytic lesion that does not need excision and to review the clinical appearance with the images every three months. NICE noted that photography (mole mapping), might help to identify changes in moles but the quality is variable. The Guideline Development Group was uncertain about the most appropriate timing for sequential photography to detect significant changes in pigmented lesions to aide in the diagnosis of early melanoma.

Based on a systematic review of the literature, NICE stated that there is insufficient evidence to recommend the routine use of VivaScope 1500 and 3000 imaging systems to help decide whether to biopsy and excise skin lesions in people with suspected melanoma. Thirteen studies (randomized, prospective cohort and retrospective) met inclusion criteria and reported on the use of VivaScope or reflectance confocal microscopy (RCM) in diagnosing suspected or equivocal melanoma lesions and three reported its use in lesion margin delineation. Six studies used VivaScope 1500 and one used VivaScope 1500 or 3000. Six studies used earlier versions of VivaScope. Comparators included dermoscopy and histopathology. Meta-analysis could not be performed due to the heterogeneity of the studies including: study design; patient population (e.g., prior history of melanoma); and variation in reporting results as patient based or lesion based (NICE, 2015).

**Coding/Billing Information**
Note: 1) This list of codes may not be all-inclusive.
   2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Experimental/Investigational/Unproven:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96904</td>
<td>Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma</td>
</tr>
<tr>
<td>96931</td>
<td>Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion</td>
</tr>
<tr>
<td>96932</td>
<td>Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion</td>
</tr>
<tr>
<td>96933</td>
<td>Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion</td>
</tr>
<tr>
<td>96934</td>
<td>Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>96935</td>
<td>Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>96936</td>
<td>Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>96999</td>
<td>Unlisted special dermatological service or procedure</td>
</tr>
<tr>
<td>0400T</td>
<td>Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia; one to five lesions</td>
</tr>
<tr>
<td>0401T</td>
<td>Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia; six or more lesions</td>
</tr>
<tr>
<td>0470T</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion</td>
</tr>
<tr>
<td>0471T</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

Not separately reimbursable when dermoscopy is performed as part of a normal evaluation of a pigmented skin lesion.

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References


