



MASSACHUSETTS

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Medical Policy Multispectral Digital Skin Lesion Analysis

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Policy Number: 748

BCBSA Reference Number: 2.01.101 (For Plan internal use only)
NCD/LCD: N/A

Related Policies

None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Multispectral digital skin lesion analysis is considered **INVESTIGATIONAL** in all situations including but not limited to:

- Evaluating pigmented skin lesions
- Serially monitoring pigmented skin lesions
- Defining peripheral margins of skin lesions suspected of malignancy prior to surgical excision.

Prior Authorization Information

Pre-service approval is required for all inpatient services for all products.

See below for situations where prior authorization may be required or may not be required.

Yes indicates that prior authorization is required.

No indicates that prior authorization is not required.

N/A indicates that this service is primarily performed in an inpatient setting.

Outpatient

Commercial Managed Care (HMO and POS)	This is not a covered service.
Commercial PPO and Indemnity	This is not a covered service.
Medicare HMO BlueSM	This is not a covered service.
Medicare PPO BlueSM	This is not a covered service.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

CPT Codes

There are not specific CPT codes for this service

Description

Melanoma is a form of skin cancer that originates in the pigment-producing melanocytes. Most melanocytes produce melanin and the tumors are commonly pigmented brown or black. Melanoma is less common than basal and squamous cell skin cancer, but it is more likely to metastasize than other skin cancers. Prognosis is highly associated with stage of the disease at diagnosis, characterized by the depth of the tumor, the degree of ulceration and the extent of spread to lymph nodes and distant organs. For example, for thin (ie, <1.0 mm) localized stage 1 cancers the 5-year survival rate is over 90% and this decreases to around 15% to 20% for metastatic stage IV cancers.¹ Thus, early detection of disease is important for increasing survival.

Differentiating melanoma lesions from benign pigmented lesions in the clinical setting is challenging. Diagnostic aids such as the ABCDE rule have been developed to assist clinicians when they visually inspect suspicious lesions. The diagnostic accuracy of the ABCDE criteria varies depending on whether they are used singly or together. Use of a single criterion is sensitive but not specific, which would result in many benign lesions being referred or biopsied. Conversely, use of all criteria together is specific but not sensitive, meaning that a number of melanomas are missed.

There is interest in noninvasive approaches that will improve the diagnosis of malignant skin lesions. One technique is dermatoscopy (also called dermoscopy), which enables the clinician to perform direct microscopic examination of diagnostic features in pigmented skin lesions. Devices consist of a 10x magnifier lens in combination with a liquid medium or polarized light to eliminate reflection and allow for more-detailed examination of suspicious skin lesions. The available evidence from prospective randomized controlled trials and other studies suggests that dermatoscopy used by specialists may lead to a decrease in the number of benign lesions excised and, when used by primary care physicians, may lead to fewer benign lesions being referred to specialists.

Another technology that can potentially improve melanoma detection and outcomes is multispectral digital skin lesion analysis (MSDSL). A U.S. Food and Drug Administration (FDA)-approved MSDSL device uses a handheld scanner to shine visible light on the suspicious lesion. The light is of 10 wavelengths, varying from blue (430 nm) and near infrared (950 nm). The light can penetrate up to 2.5 mm under the surface of the skin. The data acquired by the scanner are analyzed by a data processor; the characteristics of each lesion are evaluated using proprietary computer algorithms. Lesions are classified as positive (ie, high degree of morphologic disorganization) or negative (ie, low degree of morphologic disorganization) according to the algorithms. Positive lesions are recommended for biopsy. For negative lesions, other clinical factors are considered in the decision of whether to refer for biopsy. The FDA-approved system (see details in the Regulatory Status section) is intended only for suspicious pigmented lesions on intact skin and for use only by trained dermatologists.

Summary

There is interest in noninvasive devices that will improve the diagnosis of malignant skin lesions. One such approach is multispectral digital skin lesion analysis (MSDSL). This technique has the potential to improve diagnostic accuracy for suspicious skin lesions and may increase the detection rate of malignant skin lesions and/or reduce the rate of unnecessary biopsies.

The evidence for MSDSL in patients who have pigmented lesions being evaluated for melanoma includes 2 prospective diagnostic accuracy studies and several online studies or simulation exercises

addressing clinical utility. Relevant outcomes are overall survival, disease-specific survival, test accuracy and validity, other test performance measures, and change in disease status. The diagnostic accuracy study found that MSDSLA had a sensitivity of 98.2% for recommending biopsy of melanoma lesions (8% of the pigmented lesions were melanoma). The average specificity of MSDSLA was 9.5% compared with 3.7% among clinicians. However, the study included only lesions that had already been determined by a clinician to be sufficiently suspicious to warrant excision. The online randomized controlled trial included images of a subset of lesions from the diagnostic accuracy study. The sensitivity and specificity of a correct biopsy decision was significantly higher among dermatologists who had MSDSLA results than among those who only had clinical information and digital images. Study participants did not actually examine patients. There are no studies conducted in a clinical setting that evaluate the utility of MSDSLA as a diagnostic tool in the initial evaluation of pigmented lesions. In addition, there are no studies conducted in clinical settings that compared patient management decisions and health outcomes with and without these devices. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy History

Date	Action
1/2021	Clarified coding information
2/2018	Annual policy review. New references added.
1/2017	Annual policy review. New references added.
5/2016	New medical policy describing investigational indications. Effective 5/1/2016.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

References

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