MEDICAL COVERAGE POLICY	
SERVICE: Dermatoscopy	
Policy Number:	**049**
Effective Date:	**09/01/2020**
Last Review:	**07/30/2020**
Next Review Date:	**07/30/2021**

Important note:
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Dermatoscopy

PRIOR AUTHORIZATION: Not applicable.

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for coverage details.

For Medicare plans, please refer to appropriate Medicare LCD (Local Coverage Determination). If there is no applicable LCD, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

SWHP/FirstCare consider **dermatoscopy** (also known as dermoscopy, epiluminescence microscopy (ELM, DELM), skin surface microscopy, skin videomicroscopy, or incidence light microscopy) using either direct inspection, digitization of images, or computer-assisted analysis, incidental to a dermatologic exam and not separately reimbursable. There is no established code for this procedure.

SWHP/FirstCare consider **confocal microscopy** multi-photon laser scanning microscopy, reflectance confocal microscopy unproven because its clinical value has not been established.

SWHP/FirstCare consider **multispectral digital skin lesion analysis** unproven because its clinical value has not been established.

SWHP/FirstCare consider **optical coherence tomography for microstructural and morphological imaging of skin** unproven because its clinical value has not been established.

OVERVIEW: Dermatoscopy describes a family of noninvasive techniques that allow in vivo microscopic examination of skin lesions, and is intended to help distinguish between benign and malignant pigmented skin lesions. The technique involves application of immersion oil to the skin, which eliminates light reflection from the skin surface and renders the stratum corneum transparent. Using a magnifying lens, the structures of the epidermis and epidermal-dermal junction can then be visualized. A handheld or stereomicroscope may be used for direct visual examination. Digitization of photographic images, typically after initial visual assessment, permits storage and facilitates their

retrieval, and is often used for comparison purposes if a lesion is being followed up over time.

A variety of dermatoscopic features have been identified that are suggestive of malignancy, including pseudopods, radial streaming, the pattern of the pigment network, and black dots. These features in combination with other standard assessment criteria of pigmented lesions, such as asymmetry, borders, and color, have been organized into algorithms to enhance the differential diagnosis of pigmented skin lesions. Dermatoscopic images may be assessed by direct visual examination or by review of standard, digitized or ultraviolet photographs. Digitization of images, either surface or dermatoscopic images, may permit qualitative image enhancement for better visual perception and discrimination of certain features, or actual computer-assisted diagnosis.

There is a lack of rigorous data that demonstrates the impact of this technology on clinical outcomes, and no studies were identified relating specifically to the use of ultraviolet photography used for dermatoscopy. While there is extensive literature regarding dermatoscopy, the literature is inconclusive regarding its clinical role in the management of pigmented skin lesions, (i.e., as a technique to either select or deselect lesions for excision), which is considered the gold standard. There is inadequate documentation regarding the clinical value of dermatoscopy in various clinical situations.

Confocal microscopy is similar to dermatoscopy, using a laser beam projected onto the skin and then detecting the light reflected. The reflected light is recorded as an image by a computer.

Multispectral digital skin lesion analysis (MSDSLA) devices shine visible light on the suspicious lesion. The light is of 10 wavelengths. This 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 (i.e., high degree of morphologic disorganization) or negative (i.e., low degree of morphologic disorganization) according to the algorithms. Positive lesions are recommended for biopsy

Optical coherence tomography (OCT) is a non-invasive imaging technology that utilizes reflected light to produce cross-sectional subcutaneous images of tissue at a resolution equivalent to a low-power microscope. Doing so provides tissue morphology imagery at a higher resolution than MRI or ultrasound.

MANDATES: None

CODES:

CPT Codes Not Covered:	96931- 96936 Reflectance confocal microscopy. 96904 - Whole body integumentary photography. 0400T - 0401T Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions 0470T - 0471T Optical coherence tomography (OCT) for microstructural and morphological imaging of skin

CMS: There are no NCDs or LCDs issued.

POLICY HISTORY:

Status	Date	Action
New	12/6/2010	New policy
Reviewed	12/6/2011	Reviewed.
Reviewed	10/4/2012	Reviewed.
Reviewed	5/23/2013	Revised references and codes
Reviewed	4/24/2014	No significant changes made.
Reviewed	4/30/2015	No changes made.
Reviewed	5/12/2016	Added confocal microscopy.
Reviewed	4/18/2017	No changes
Reviewed	2/27/2018	No changes
Reviewed	6/26/2019	Updated policy statement.
Reviewed	7/30/2020	Added language for FirstCare use

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. Bafounta, M., Beauchet, A., et al. Is dermoscopy (epiluminescence microscopy) useful in the diagnosis of melanoma? Results of a meta-analysis using techniques adapted to the evaluation of diagnostic tests. Archives of Dermatology (2001) 137(10):1343-50.
2. Bono, A., Bartoli, C., et al. Melanoma detection. A prospective study comparing diagnosis with the naked eye, dermatoscopy and telespectrophometry. Dermatology (2002) 205(4):362-6.
3. Mackie, R.M., Fleming C., et al. The use of the dermatoscope to identify early melanoma using the three-colour test. British Journal of Dermatology (2002) 146(3):481-4.
4. Stolz, W., Semmelmayer, U., et al. Principles of dermatoscopy of pigmented skin lesions. Seminars in Cutaneous Medicine and Surgery (2003 March) 22(1):9-20.
5. Kuo, H.W., Ohara, K. Pigmented eccrine poroma: a report of two cases and study with dermatoscopy. Dermatologic Surgery (2003 October) 29(10):1076-9.
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7. Fleischer, A.B. Dermatoscopy and the 51naked eye51. Journal of the American Academy of Dermatology (2005 January) 52(1):178-9.
8. Angenziano, G., Puig, S., et al. Dermoscopy improves accuracy of primary care physicians to triage lesions suggestive of skin cancer. Journal of Clinical Oncology (2006) 24(12):1877-82.
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Dermatology (2007) 56(5):759-67.

12. Rakowska, A; Slowinska, M; Czuwara, J; Olszewska, M; Rudnicka, L . Dermoscopy as a tool for rapid diagnosis of monilethri". Journal of Drugs in Dermatology (2007) 6 (2): 222–4. PMID 17373184
13. Farnetani F, Scope A, Braun R, et al. Skin Cancer Diagnosis with Reflectance Confocal Microscopy Reproducibility of Feature Recognition and Accuracy of Diagnosis. JAMA Dermatol. 2015; 151(10):1075-1080