Medical Policy
Gene Expression Profiling for Uveal Melanoma

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Policy Number: 683
BCBSA Reference Number: 2.04.120
NCD/LCD: Local Coverage Determination (LCD): MolDX: DecisionDx-UM (Uveal Melanoma) (L37033)

Related Policies
- Charged-Particle (Proton or Helium Ion) Radiation Therapy, #437

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

Gene expression profiling for uveal melanoma with DecisionDx-UM is considered MEDICALLY NECESSARY for patients with primary, localized uveal melanoma.

Gene expression profiling for uveal melanoma that do not meet the above criteria is INVESTIGATIONAL.

Medicare HMO BlueSM and Medicare PPO BlueSM Members

Medical necessity criteria and coding guidance for Medicare Advantage members living in Massachusetts can be found through the link below.

Local Coverage Determination (LCD): MolDX: DecisionDx-UM (Uveal Melanoma) (L37033)

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at https://www.cms.gov.

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 for outpatient services.
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) | No |
| Commercial PPO and Indemnity | No |
| Medicare HMO Blue℠ | No |
| Medicare PPO Blue℠ | No |

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.

CPT Codes
No specific CPT codes

Description
UVEAL MELANOMA
The uveal tract is the middle layer of the wall of the eye; it has 3 main parts: the choroid (a tissue layer filled with blood vessels), ciliary body (muscle tissue that changes the shape of the pupil and the lens), and the iris (the colored part of the eye). Uveal melanoma arises from melanocytes in the stroma of the uveal tract. Approximately 90% of uveal melanomas arise in the choroid, 7% in the ciliary body, and 3% in the iris.¹

Uveal melanoma, although rare, is the most common primary intraocular malignancy in adults. Mean age-adjusted incidence of uveal melanoma in the United States is 6.3 per million people among whites, 0.9 among Hispanics, and 0.24 among blacks.¹ Uveal melanoma has a progressively rising, age-specific, incidence rate that peaks near age 70. Host susceptibility factors associated with the development of this cancer include white race, fair skin, and light eye color.

Treatment
Treatment of primary, localized uveal melanoma can be by surgery or radiotherapy. In general, larger tumors require enucleation surgery and smaller tumors can be treated with radiotherapy, but specific treatment parameters are lacking. The most common treatment of localized uveal melanoma is radiotherapy, which is preferred because it can spare vision in most cases. For smaller lesions, randomized controlled trials (RCTs) have shown that patients receiving radiotherapy or enucleation progress to metastatic disease at similar rates after treatment.²³ Radiotherapy can be delivered by various mechanisms, most commonly brachytherapy and proton beam therapy.¹² Treatment of primary uveal melanoma improves local control and spares vision, however, the 5-year survival rate (81.6%) has not changed over the last 3 decades, suggesting that life expectancy is independent of successful local eye treatment.⁴

Uveal melanomas disseminate hematogenously, and metastasize primarily to the liver and lungs. Treatment of hepatic metastases is associated with prolonged survival and palliation in some patients. Therapies directed at locoregional treatment of hepatic metastases include surgical and ablative techniques, embolization, and local chemotherapy.

Surveillance for Metastatic Disease
It is unusual for patients with uveal melanoma to have distant metastases at presentation, with less than 1% presenting with metastases when they are treated for their intraocular disease, but they are at risk for distant metastases, particularly to the liver, for years after presentation.⁵ The prospective, longitudinal Collaborative Ocular Melanoma Study (COMS) study followed 2320 patients with choroidal melanoma with no melanoma metastasis at baseline who were enrolled in RCTs to evaluate forms of radiotherapy
for choroidal melanoma for 5 to 10 years. During follow-up, 739 patients were diagnosed with at least 1 site of metastasis, of which 660 (89%) were liver. Kaplan-Meier estimates of 2-, 5-, and 10-year metastasis rates were 10% (95% confidence interval [CI], 9% to 12%), 25% (95% CI, 23% to 27%), and 34% (95% CI, 32% to 37%), respectively.

The optimal method and interval for surveillance are not well-defined, and it has not been established in prospective trials whether surveillance identifies metastatic disease earlier. Potential methods for metastases include magnetic resonance imaging, ultrasound, liver function testing, and positron emission tomography scans. One 2016 retrospective study of 262 patients estimated that use of hepatic ultrasound and liver function testing every 6 months in individuals with treated local uveal melanoma would yield a sensitivity and specificity for a diagnosis of metastasis of 83% (95% CI, 44% to 97%) and 100% (95% CI, 99% to 100%), respectively.

Identifying patients at high risk for metastatic disease might assist in selecting patients for adjuvant treatment and more intensive surveillance for metastatic disease, if such changes lead to improved outcomes. Adjuvant treatment for metastatic disease consists of radiotherapy or systemic therapy, such as chemotherapy, immunotherapy, hormone therapy, biological therapy, or targeted therapy. Randomized trials of patients with high risk for uveal melanoma recurrence have shown no differences in survival rates between patients treated with and without adjuvant therapy. However, these trials were reported in 1998 and 1990, and may not be representative of current treatment and risk-stratification methods.

**Prognosis**

Metastatic disease is the leading cause of death in patients with uveal melanoma, and approximately 50% of patients will develop distant metastasis. A number of factors may be used to determine prognosis, but the optimal approach is uncertain. The most important clinical factors that predict metastatic disease are tumor size (measured in diameter or in thickness), ciliary body involvement, and transscleral extension. Clinical staging using the American Joint Committee on Cancer (AJCC) recommendations allows risk stratification for metastatic disease. In a 2015 retrospective study of 3377 patients with uveal melanoma, in which staging was performed using AJCC classifications, the rate of metastases-free survival at 5 years was 97% for stage I, 89% for stage IIA, 79% for stage IIB, 67% for stage IIIA, 50% for stage IIIB, and 25% for stage IIIB.

**Genetic Analysis**

Genetic analysis of uveal melanoma can provide prognostic information for the risk of developing metastatic disease. In 1996, Prescher et al showed that monosomy of chromosome 3 correlated strongly with metastatic death, with a 5-year survival reduction from 100% to 50%. Subsequent studies have reported that, based on genetic analysis, there were 2 distinct types of uveal melanomas—those with monosomy chromosome 3 associated with a very poor prognosis and those with disomy 3 and 6p gain associated with a better prognosis. The BAP1 gene has been identified as an important marker of disease type. In 1 study (2016), 89% of tumors with monosomy 3 had a BAP1 variant, and no tumors without monosomy 3 had a BAP1 variant.

Gene expression profiling (GEP) determines the expression of multiple genes in a tumor and has been proposed as an additional method to stratify patients into prognostic risk groups.

**Commercially Available Testing**

DecisionDx-UM is a GEP test intended to assess 5-year metastatic risk in uveal melanoma. The test was introduced in 2009, and claims to identify the molecular signature of a tumor and its likelihood of metastasis within 5 years. The assay determines the expression of 15 genes, which stratify a patient’s individual risk of metastasis into 3 classes. The 15-gene signature was originally developed based on a hybridization-based microarray platform; the current commercially available version of the DecisionDx-UM test is a polymerase chain reaction-based test that can be performed on fine-needle aspirate samples.

Based on the clinical outcomes from the prospective, 5-year multicenter Collaborative Ocular Oncology Group study, the DecisionDx-UM test reports class 1A, class 1B, and class 2 phenotypes:
Class 1A: Very low risk, with a 2% chance of the eye cancer spreading over the next 5 years;  
Class 1B: Low risk, with a 21% chance of metastasis over 5 years;  
Class 2: High risk, with 72% odds of metastasis within 5 years.

Summary

Uveal melanoma is associated with a high rate of metastatic disease, and survival after the development of metastatic disease is poor. Prognosis following treatment of local disease can be assessed using various factors, including clinical and demographic markers, tumor stage, tumor characteristics, and tumor cytogenetics. Gene expression profiling (GEP) can be used to determine prognosis.

For individuals who have localized uveal melanoma who receive a GEP test for uveal melanoma (DecisionDx-UM), the evidence includes cross-sectional studies of assay validation and clinical validity. Relevant outcomes are overall survival, disease-specific survival, test accuracy and validity, other test performance measures, functional outcomes, health status measures, and quality of life. One commercially available test identified (DecisionDx-UM) has published data related to its clinical validity, and is the focus of this review. There is limited published data on the analytic validity of GEP testing. Three studies of clinical validity identified used the GEP score to predict melanoma metastases and melanoma-specific survival. All 3 reported that GEP classification correlated strongly with metastatic disease and melanoma mortality. Two studies compared GEP classification to other prognostic markers, and GEP class had the strongest association among the markers tested. GEP classification appears to be a strong predictor of metastatic disease and melanoma death. There are no studies directly showing clinical utility. Absent direct evidence, a chain of evidence can be constructed to determine whether using the results of GEP testing for management decisions improves the net health outcome of patients with uveal melanoma. Aaberg et al (2014) have shown an association between GEP classification and treatment, reporting that patients classified as low risk were managed with less frequent and intensive surveillance and were not referred for adjuvant therapy. It is uncertain whether stratification of patients into higher risk categories has the potential to improve outcomes by allowing patients to receive adjuvant therapies through detection of metastases earlier. However, classification into the low-risk group would support reduction in the burden of surveillance without apparent harm. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Policy History

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<td>8/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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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