AAVBC
AMERICAN ACADEMY OF VALUE BASED CARE

Melanoma

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: **Melanoma** is a malignant neoplasm arising from melanocytes, most commonly in the skin (**cutaneous melanoma**) but also in the uveal tract and mucosal surfaces.[1] Cutaneous melanoma develops through **ultraviolet-induced DNA damage** with **activation of the MAPK/ERK and PI3K/AKT** pathways; a **BRAF V600** mutation is present in roughly **50%** of cutaneous tumors and determines eligibility for targeted therapy.[2] Four histologic subtypes are recognized: **superficial spreading** (most common), **nodular** (most aggressive, disproportionately lethal), **lentigo maligna**, and **acral lentiginous**.[2] In the Medicare population melanoma is predominantly a disease of older adults — the mean age at diagnosis is **65** and **65.7%** of cases occur between ages **55 and 84**.[3] Almost **90%** of cases are attributable to ultraviolet exposure.[4]

ICD-10 Codes:

Invasive cutaneous melanoma is reported with the **C43** series, subdivided by anatomic site and laterality to the 5th–6th character — for example **C43.4** (scalp and neck), **C43.62** (left upper limb), and **C43.72** (left lower limb). **C43.9** (melanoma of skin, unspecified) should be reserved for genuinely undocumentable sites. Melanoma in situ (Stage 0) is reported with the **D03** series and does not map to any HCC. Confirmed distant metastases are coded at each site in addition to the primary: **C78.0-** (lung), **C78.7** (liver), **C79.31** (brain), **C79.51** (bone). **Z85.820** (personal history of melanoma) is used only after treatment is complete and the patient is in documented remission.[5]

Prevalence: An estimated **100,640** new invasive melanomas and **99,700** new in-situ melanomas were projected in the United States in 2024, with about **8,510 deaths**.[6] The rate of new invasive cases is **22.3 per 100,000 per year**, and incidence rose roughly **1.1%** per year over 2014–2023.[7,8] Mortality fell about 2.2% per year, and approximately **2.2%** of Americans will be diagnosed in their lifetime.[9,10] Melanoma of the skin represents **5.3%** of all new cancer cases in the U.S.[7]

CLINICAL PEARL - RECOGNITION GAPS IN OLDER ADULTS

The classic **ABCDE** rule (Asymmetry, Border, Color, Diameter >6 mm, Evolution) was derived from superficial spreading melanoma and is **less reliable in older adults**, who more often present with nodular, amelanotic, or ulcerated tumors on the head, neck, and scalp that do not meet classic criteria.[11] AAVBC supports dermoscopy, as recommended in all skin-cancer practice guidelines, to raise detection sensitivity. Patients aged 80 and older present with significantly thicker tumors (median Breslow 0.80 mm)[12] and far worse 2-year survival once distant metastases are present (10.9% vs. 34.8% in patients under 40).[7] Because no Medicare-covered standalone screening benefit exists, and the **USPSTF** assigned visual skin-cancer screening an 'I' (insufficient evidence) rating in 2023, primary care remains the default setting for detection. However, the **American Cancer Society (ACS)** and **American Academy of Dermatology (AAD)** recommend that adults aged **40 and older** undergo a professional skin examination annually as part of routine cancer-related care — a position AAVBC supports. Early detection depends on the primary care total-body skin examination at the annual wellness visit and at problem-oriented encounters.[3]