WPS Proposed Local Coverage Determination (LCD)
Open Meeting Transcript

Moderator: Dr. Joelle Vlahakis
June 25, 2025
1:00 pm CT (2:00 pm ET)

Vlahakis, Joelle
Thank you, rich.
Good afternoon, everyone. This is the proposed Local Coverage Determination, or LCD, Open Meeting conducted by WPS. Today is June 25th, 2025, and the time is now 2:03 pm Eastern Standard Time.

I am Dr. Joelle Vlahakis, and I'll turn on my camera briefly so you can see that I am real – in corporal form – and I'll be conducting this meeting, moderating.

The purpose of today's meeting is to take comments from stakeholders on proposed LCDs. Before we begin, I'll ask my colleagues at WPS to introduce themselves, starting with the Contractor Medical Directors, or CMDs who are in attendance.

Claudia Campos, MD
Good afternoon, everyone. My name is Doctor Claudia Campos. I am a dually board-certified internist and PM&R physician. I have been with WPS for over a year. Thank you for being here.

Nachodsky, Denise
Good Afternoon everyone. My name is Doctor Denise Nachodsky. I am a sub-specialist in cardiology, with certification in both internal medicine and cardiology. I have been a WPS CMD for over five years here. I live in southern Delaware and I'm not tolerating the heat wave that we're getting here very well. But I'd like to welcome everyone here and thank you for taking time out of their busy day to support this meeting. Thank you.

Schaening.Perez, Juan
Good morning. I'm Doctor Juan Schaening. I'm board-certified internal medicine. I have been a CMD for WPS for the past two years. It's a pleasure being here and thank you for attending.

Vlahakis, Joelle
Thank you all. Will the Policy Coordinators please introduce themselves?

McCary, Michelle
Hi, I'm Michelle McCary.

King, Andrea
Good aft-

McCary, Michelle
Oh, sorry, Michelle McCary. I am the clinical policy supervisor. I've been with WPS for almost 10 years.

King, Andrea
Good afternoon, everyone. My name is Andrea King and I'm one of the policy coordinators.

Schroeder, Tara
Good afternoon. My name is Tara Schroeder. I am also a policy coordinator.

Vlahakis, Joelle
Thank you. I'd like to give our other WPS staff on the line a chance to introduce themselves as well.

Oliver, Linda
Thank you, Dr. Vlahakis. Good afternoon, everyone. My name is Linda Oliver. I'm the director over our clinical services here at WPS and thank you all for joining us.

Staley, Richard
Good afternoon. My name is Richard Staley. I'm the Policy Administrative Assistant and I am doing the Webex troubleshooting issues, so if you're having an issue you can connect with me through the chat or e-mail richard.staley@wpsic.com and I will try to get your issues taken care of. Thank you.

Trivedi, Radhika
Good afternoon. My name is Radhika Trivedi. I am the policy researcher for the team. Thank you.

Vlahakis, Joelle
Thank you all. So I'll take the next several minutes just to cover some procedural matters and some ground rules. And then we can take comments on the proposed LCDs.

So this meeting is being conducted in accordance with the CMS Internet Only Manual Publication 100-08, Chapter 13, Section 13.2.4.4. Our purpose is to take public comment on the proposed LCDs, and that is the only business for today's meeting.

Today's meeting is open to the public and is being recorded and will be transcribed. Both the recording and the transcription will be posted and available on our website in a few weeks.

All callers are currently muted. I will introduce the proposed LCD up for comment and then we'll invite the comments. There are two types of comment that we'll be taking today: Formal presentations that have been submitted and registered in advance, and any public comment that we may have. Those wishing to comment may click on the raised hand icon or if calling in by phone, pressing *3. When Mr. Staley calls on you, please make sure that your microphone is on at your end and that your speakers are silent to prevent echo. Prior to commenting, please introduce yourself, state your affiliation and indicate whether you have a conflict of interest and what that conflict is. When making your comments, please be specific so that you can help us to improve the proposed LCD. If a previous speaker has already made your point, there's no need to repeat it. But if you do wish to go on record, you can simply say that you agree with the previous speaker.

Each speaker will be allotted 10 minutes to give equal time to all who wish to comment. Mr. Staley will provide a 2 minute warning and I will ask the speaker to stop at the 10 minute point. If a speaker has a slide presentation, one of our WPS team members will advance the slides to avoid technical difficulties.

Our purpose today is to listen to your comments, so we typically do not respond to questions or make comments during this meeting, but we may ask questions of any speaker. Please be aware that only comments or questions submitted to Medicarepolicycomments@wpsic.com, or our Medicare policy comments mailbox, will receive a written response. Please include the topic of the LCD on the e-mail subject line. If you have supporting scientific literature, please attach that either in a PDF or in a Word document to your e-mail. Unfortunately, WPS cannot follow e-mail

links. All responses are for educational purposes only and do not establish Medicare or WPS policy. Comments will not be addressed individually, but will be compiled and addressed in a response to comment document posted with the final LCDs.

And with that, I'd like to start with the presentation of the proposed LCDs. The open comment periods for these are from May 29th, 2025, until July 12, 2025, and May 15, 2025, until June 28, 2025.

And with that, I'll proceed. The proposed LCDs up for comment are, of course, listed in the agenda. The first one we'll be starting with is proposed LCD DL36408, which is entitled Allergy Immunotherapy with Subcutaneous Immunotherapy. This proposed LCD is a multi-MAC effort to update a policy consistent with current evidence. Allergen immunotherapy involves the administration of an allergen to which the patient is sensitive for the purpose of modulating the untoward immune response to that allergen and alleviating allergic symptoms. Allergy immunotherapy represents the only therapy capable of inducing a state of immune tolerance and provides the potential to affect a sustained clinical benefit with long standing clinical remission of the allergic condition. This LCD stresses the importance of shared decision making and the vital role allergists play in modifying factors which impact a patient's health and quality of life. In keeping with updated guidelines, atopic dermatitis due to dust mites has been added to the covered indications for allergy immunotherapy.

This policy is the responsibility of policy coordinator Andrea King and myself, CMD Dr. Joelle Vlahakis. It remains in open comment until July 12.

So we are now going to open the floor to your comments on this LCD, specifically. Raise your hand to request to speak, again, introduce yourself, state your affiliation and indicate whether you have any conflicts of interests. And with that, I'll open the floor.

Staley, Richard
Thank you. So again, you can click the “raise hand” icon or press *3 if you're calling on a touch tone phone.

I see no comments at this time.

Vlahakis, Joelle
Very good. So the next proposed LCD we will introduce is DL38682, entitled Transurethral Water Jet Ablation of the Prostate. This proposed LCD is also a multi-MAC effort to update the original coverage policy. Benign prostatic hypertrophy is a

very common condition, and its incidence increases with age, making it very, very relevant to our Medicare population. Prostatic enlargement itself can lead to bothersome lower urinary tract symptoms, which can have a significant impact on quality of life of our beneficiaries. So WPS, along with several other MACs, received reconsideration requests to revise the covered indication guidelines specific to removing the age requirement, the prostate volume specifications determined by transrectal ultrasound, the need to void at least 125 ccs of urine and the exclusion criteria of patients with known or suspected cancer, or a PSA of greater than 10, unless that patient has a negative prostate biopsy within the six months of treatment. The multi-MAC effort also considered the limitations on bladder calculi and BMI.

Based on the submitted information and searched evidence, we determined that the literature was insufficient to compel an age limitation and that's been removed. The literature also supported removing the requirement to have prostate volume determined necessarily by TRUS, although the volume requirement itself is supported. The 125 cc volume voiding requirement has been removed so as not to exclude those who cannot void even small amounts. The prostate volume criteria and elevated PSA and known or suspected prostate cancer were not revised. There was insufficient data to remove the coverage determinations on bladder calculi or BMI. So the Coverage Guidance, Summary of Evidence, and Rationale for Determination have all been revised and reformatted.

This LCD draft was the responsibility of policy coordinator Andrea King and yours truly, CMD Joelle Vlahakis. It will remain in open comment until July 12. We now open the floor to any comments on proposed LCD DL38682, specifically.

Again, raise your hand to speak and indicate your – when you introduce yourself – your affiliation and whether you have any conflict of interests.

Staley, Richard
Thank you. If anyone has any comments, raise hand or *3.

All right. And, could I just have someone click the raised hand icon because one of our CMD says that they're unable to raise their hand?

OK, Dr. Schaening, I see that it works for you. OK. Just making sure that that's an isolated incident and not an everything incident. If anyone would like to speak and they're having trouble raising their hand, connect with me through the chat and I will get you – get your mic open.

OK, there are no raised hands at this time. Nothing in the chat. You may continue.

Vlahakis, Joelle
All right. Thank you everyone for your patience. You know, technology is sometimes kind of tricky.

So now we are going to have the wonderful opportunity to hear from my colleague Dr. Juan Schaening, and he's going to moderate this section of our open meeting. And that's just my deference to his really hard work on this particular LCD.

Doctor Schaening?

Schaening.Perez, Juan
Thank you, Dr. Vlahakis.

So the last proposed LCD of today's meeting is DL40193, titled Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancers. his proposed LCD is a multi-MAC effort that has been developed to create a policy consistent with current evidence for the treatment of nonmelanoma skin cancers with superficial radiation therapy and addresses a variation of superficial radiation therapy utilizing high resolution ultrasound guidance and electronic brachytherapy for the treatment of nonmelanoma skin cancers.

The proposed Local Coverage Determination policy ensures access to superficial radiation therapy as a treatment option for nonmelanoma skin cancers in nonsurgical patients. The policy does not cover image guidance with ultrasound to perform SRT or electronic brachytherapy as there is insufficient evidence to support this modality and the evidence fails to demonstrate benefit to the patients. The position of this policy aligns with the recommendation of the American Academy of Dermatology, American College of Mohs Surgery, American Society for Radiation Oncology and the National Comprehensive Cancer Network. The LCD requires that only appropriately trained providers must perform radiation services. It does not prohibit dermatologists from performing radiation treatment. It allows performing providers with the experience and training necessary to deliver SRT in a safe manner and in compliance with all current guidelines for radiation therapy.

This LCD is the responsibility of Policy Coordinator Michelle McCary and I am the responsible CMD. This LCD will remain open for comment until June 28th and the comment period started on 5/15/20025.

OK. Let's go now to our presentations. We have five formal presentations for this proposed LCD. Our first presenter is Doctor Lio Yu of the Dermatology Association of Radiation Therapy. Doctor Yu, please state any conflict of interest and proceed with your presentation.

Yu, Lio
OK. Thank you. Can you hear me?

Schaening.Perez, Juan
Yes.

Yu, Lio
OK, Great. Thank you. Well, good afternoon everybody. Thank you for the opportunity to speak today. My name is Doctor Lio Yu. I'm a board-certified radiation oncologist for over 30 years. I'm also the chair of research for the Dermatology Association of Radiation Therapy and lead author on several of the largest contemporary studies on IGSRT. Next slide, please.

Just to briefly introduce myself for context: I trained at Yale in molecular biophysics and biochemistry, followed by radiation oncology training at major institutions including Mount Sinai, Memorial Sloan Kettering, Dina Farber and Montefiore. I currently serve as clinical director of Radiation Oncology and Chair of Research for DART, the Dermatology Association of Radiation Therapy, and I've authored or co-authored multiple peer reviewed studies in book chapters focused on head and neck cancer, skin cancer and radiation protocols. In recent years, I've led some of the largest IGSRT outcome studies in the United States with over 20,000 lesions analyzed, many of which are directly relevant to the policy we're discussing today. I also serve as a consultant to industry partners, including skin cure oncology and other – previously other entities. But I have a strong belief in transparent data-driven decision making. Next slide please.

So today I want to talk to you not just as a researcher, but as someone who treats patients every week with this technology. Seeing first-hand how Image-Guided Superficial Radiation Therapy, abbreviated IGSRT, is changing lives, but unfortunately the current LCD draft doesn't reflect that reality. This policy overlooks a large body of new data and seems to conflate older SRT methods with modern IGSRT, which uses daily ultrasound guidance. That distinction is crucial. It's the difference between guessing and knowing, between static treatment and real time response. Next slide, slide please.

So this is where the data becomes powerful. We publish results showing that IGSRT consistently delivers greater than 99% freedom from recurrence across virtually every risk group in basal cells, squamous cells, there's no meaningful difference between those two, of over 99% control rate is even better for SCCIS. There's no difference in outcomes by age, including over age, under, there's no difference by tumor location, patient sex or comorbidity burden. And importantly, there's no difference based on socioeconomic status. In other words, IGSRT provides highly reproducible success across diverse real-world populations. This isn't just theoretical. This is what we see day-to-day in practice and is reflected in the studies like by McClure, Farburg, Agha and Ma.

So let's be honest, this draft LCD leans heavily in that outdated literature. Studies that predate the era of real time dermal ultrasonography and daily adaptive therapy. Since 2020, we published over a dozen major studies including multi-institutional analysis of more than 20,000 lesions treated with IGSRT and these shows consistent cure rates exceeding 99%. Not just in ideal patients, but across all risk groups. None of that appears in the LCD and that's just not a technical omission, it's a disservice to patients and to the Medicare program itself.

CMS policy requires that local coverage decision be based on a full and up-to-date review of the evidence. That standard hasn't been met here. The omission of large contemporary IGSRT studies, including those involving frail, elderly and comorbid Medicare patients, is not just an oversight, it skews the entire risk benefit assessment. These are precisely the patients who can't undergo Mohs surgery or tolerate more aggressive interventions. When done with daily imaging, IGSRT gives them a safe, effective, non-invasive option and we have the peer reviewed data to prove it. Next slide please.

Here's the clinical bottom line. across 15 peer-reviewed publications, IGSRT consistently achieves long term local control rates above 99% at two, four, even six years of follow up. This isn’t cherry picked data from one institution. There are large multi-center studies using real world patient populations. In our large IGSRT studies, I personally authored and reviewed several of them, we track more than 20,000 lesions. And the local control and freedom from recurrence rate exceed 99%, again at two, four and six years. And some people have said that “Oh, there's so many patients. Thousands of patients lost to follow up.” That's simply not true and I can get to that a little later on. And these results is not a fluke. It's a real-world performance across institution and across risk categories. Next slide please. Next slide.

So what do they all have in common? They used the Ladd Yu Protocol, meaning image guided, superficial radiation therapy with daily high resolution dermal ultrasound. It's just not a minor tweak of an old SRT machine; It's an entirely new class of technology. We pair the high-resolution thermal ultrasound with precise image guided radiation delivery. That capability simply did not exist prior to 2016. It's like comparing a flip phone to a smartphone; sure, both make calls, but one is clearly smarter, faster and safer. So to lump IGSRT with legacy SRT approaches, the approach ignores the core innovation that makes these results possible. Daily ultrasound-based guidance and real time treatment adaptation. Every one of these studies show that when imaging is added, outcomes improve significantly. And that's not a coincidence. It's a reproducible clinical fact. And the meta-analysis and aggression studies confirm it.

Without daily ultrasound, these changes are invisible. With IGSRT, we see them in real time and adjust accordingly. That's why these cure rates are not just better, they're statistically superior. Next slide, please.

The IGSRT protocol is vital. The imaging is vital. So let's be clear: IGSRT without imaging is not IGSRT. The daily use of high-resolution dermal ultrasound is not optional; it's the foundation. This imaging accurately defines the tumor borders in depth, monitors the treatment response, and allows us to redefine the field as the tumor shrinks. So traditional SRT studies, even the best ones, don't have this capability, and that's why the cure rates top out about 90 to 95%. Every study since 2019 that includes ultrasound guidance has shown improved outcomes.

Staley, Richard
Two minutes.

Yu, Lio
And – OK, Next slide please. Next slide.

Here's what's especially troubling even ECRI, the same organization CMS often turns to for technical evaluations, issues of favorable score for IGSRT. This was an industry paid review. It was independent, evidence based and recognized both the effectiveness and safety of the technology. Yet the LCD doesn't even mention it. Next slide. Next slide.

We've contributed significantly to this evidence base. My colleagues and I have published peer reviewed papers and journals like Advances in Radiation Oncology,

BMC Cancer Dermatopathology and General Clinical Cancer Research, Clinical Oncology and these are excellent peer reviewed journals and have undergone rigorous scrutiny. So these are just some of the partial list of bibliography. Next slide. Next slide.

This is a before and after picture of a patient with nodular – was a high risk basal cell before and after, and by the way, we could treat more than one lesion in one shot. So the cost is actually quite comparable with most. Even better, we can treat up to four lesions at the same time. Next slide.

So. I want to draw attention to particularly damaging issue, the mischaracterization of IGSRT by groups like the American College of Mohs Surgery. Here is a handout to their providers comparing legacy SRT with lower cure rates, comparing them to Mohs, but they conveniently left out the IGSRT, which shows a comparable even better cure rate than most. Next slide.

Staley, Richard
All right. The ten minute mark is up.

Yu, Lio
I just have a couple - Yeah, 30 seconds. So this - It shows the – adds in the IGSRT studies with the SRT. Next slide.

So in conclusion, I want to just say that IGSRT: we have a reproducible protocol;. We have multi-year outcomes; We have independent validation by ECRI; consistent success across subtypes and patient demographics. And this LCD, this isn't experimental, unproven and somewhat comparable to technologies from 15 years ago. So the group with outdated radiation techniques is to misrepresent the science, and to do so in a way that affects real patients. It's time for policy to catch up with the evidence, and I urge this body to rewrite the LCD in consultation with clinicians, researchers and the most current data available.

Thank you.

Schaening.Perez, Juan
Thank you for your presentation. Are there any questions from the CMDs?

Hearing none, let's go then to our next presenter. Our next presenter is Doctor Laurin Council of the American College of Mohs Surgery. Dr. Council, please state any conflict of interest and proceed with your presentation.

Doctor. Counsil, you're on mute. Rich, I think Doctor Council is having an issue with the mute button.

Can you unmute doctor Council, Rich?

Staley, Richard
Oh, I'm sorry. I was on mute, I said I cannot unallow her, but it looks like she logged out and she'll log back in.

Schaening.Perez, Juan What?

Staley, Richard
OK, it says only select participants can unmute, but that's – I gave her permission to unmute. Let me just take a look and see if there's anything else I can do here.

Schaening.Perez, Juan
If doctor – OK, good, good.

Staley, Richard
All right. OK, Here we go. I think we got it now.

M. Laurin Council, FACMS
OK, thank you. Can you hear me now?

Schaening.Perez, Juan
Yes.

Vlahakis, Joelle
Yes.

M. Laurin Council, FACMS
Thank you.

Staley, Richard
Thank you. Sorry about that.

M. Laurin Council, FACMS
All right, that was - made me a little nervous.

I'm Laurin Council. I am with the American College of Mohs Surgery and I appreciate the opportunity to speak today on the LCD. So the American College of Mohs Surgery supports the LCD as written because it does put reasonable safeguards in place for patients. It's very similar to the current LCDs that we have in place for Mohs micrographic surgery, which the ACMS also supports. And skin cancer is very, very prevalent. We're currently in an epidemic. More and more skin cancers are being diagnosed each day and we're going to need LCDs to safeguard the integrity of programs and protect beneficiaries from treatments that don't have quite the evidence yet to deem them as used as they are. Next slide, please.

When you look at peer reviewed studies on image guided and superficial radiation therapy, the journals that you want to pay the most attention to are journals that are peer reviewed, unbiased, they are written by authors who don't have conflicts of interest such that they are not hired by companies that provide radiation, for example, and the highest impact studies are in the Journal of the American Academy of Dermatology. That is our highest impact journal that we have. We have very rigorous peer review standards and we are not open access, meaning authors cannot pay to publish their studies. Next slide, please.

Concerning trends, when you look at CPT codes used for radiation therapy, superficial radiation therapy in particular, and also the simulation codes and image guidance codes, these are increasing over the past several years. Next slide please.

In fact, the annual increase you can see on the second-to-last column on the right, there for delivered services, including superficial radiation therapy, has increased 93.8% annually. And then RT ultrasound guidance increased 233.7% annually. So the trends, if you look from 2016 to 2021, where in 2016 you start out on the left column with 4895 instances of using that code, we're now up to 133,000 in 2021 and the numbers continue to rise as this technology becomes more prevalent. Next slide, please.

The proposed LCD is based on a comprehensive literature review that demonstrates that superficial radiation therapy is not the first line therapy for skin cancers. Image guided superficial radiation therapy has not been shown to be better than standard superficial patient therapy in trials that are head-to-head. It simply requires documentation as to why superficial radiation therapy is utilized. It doesn't restrict superficial radiation therapy in any clinically significant way when it is indicated. If it meets all the criteria, the use of SRT is considered reasonable and necessary for the presence of a low risk cutaneous basal cell or a high risk basal cell as per the NCCN, ASTRO or AAD guidelines, with documentation that the patient is not a

surgical candidate and that is also true for squamous cell carcinoma and squamous cell carcinoma In Situ. Next, please.

These are the National Comprehensive Cancer Network guidelines for the treatment of basal cell carcinoma. So these are the guidelines that were developed by a multidisciplinary committee of radiation oncologists, dermatologists, surgeons, all who treat low risk basal cell carcinomas, higher risk basal cell carcinomas, etcetera. When you look at primary treatments, the treatments that are recommended include curettage and electrodesiccation, shave removal, standard decision and radiation therapy is certainly an option, especially for non-surgical candidates. But it's by far the most expensive. If you have multiple options for treatment, it's important that we use those treatment options as appropriately. So judiciously use radiation therapy. However, know that other less expensive modalities are in existence, particularly for lower risk basal cell. Next slide, please.

Same is true for high risk. So for high risk basal cell, Mohs micrographic surgery is considered the standard of care as per NCCN guidelines. Unless a patient is a non-surgical candidate according to the guidelines those are the patients who could be considered for definitive radiotherapy. Next slide, please.

The LCD currently states the use of high resolution ultrasound to guide SRT delivery and to assess lesion reduction during the superficial radiation treatment protocol is not considered reasonable and necessary and is not supported by literature. The ACMS supports this provision of the proposed LCD. The literature review in the LCD is comprehensive and the literature simply does not support the use of ultrasound. Next slide.

Proponents cite articles to make claims that image guidance is superior to superficial radiation or image guided superior surgery or image guidance should be first line therapy. But when you look at the literature, again, it's very important to look at high impact journals that have these meaningful articles that are not published by individuals who have conflicts. Next slide.

There have been no direct head-to-head trials that compare image guided SRT to superficial radiation therapy. Again, industry conflicts are often prevalent among authors. There are no prospective, randomized, control blinded trials comparing image guidance with standard SRT or surgery; Low quality, low impact factor, pay-to-publish journals have been publishing studies, but no publications are in flagship journals; There are comparative cohorts or either poorly, or non-matched; There's not a blinded central review of efficacy; there's very scant reporting of adverse

events; many tumors are lost to follow up. In the two studies that are touted the most frequently, 85% of tumors are lost to follow up at four years. A second paper that was cited has 98.6% of tumors lost to five years, so you have very, very little follow up for these tumors. The studies are not prospective; they're not randomized; they're not controlled; they're not blinded; they're very poorly designed studies in low quality, pay-to-publish journals. Next slide, please.

Of the 12 newest and most frequently articles of image guidance, none are randomized; none are prospective; none have control groups; none have blinded central review; 10 of 12 had industry conflicted authors; 9 of 12 had an impact factor of less than 3.5; 2 of 12 are in journals with no impact factor; 11 of 12 are in pay-to-publish journals; 1 in 12 are in a private equity controlled journal and 2 in 12 are not in journals related to oncology or dermatology. Next slide.

So the point that we're trying to make is a lot of these articles just are not scientifically sound. This article here, the treatment of nonmelanoma skin cancer with image guided superficial radiation therapy and analysis of 2,900 keratinocytic carcinomas, there's no comparison so the primary assertion is just that the tumor appears to have resolved; It's not randomized; not prospective; No control; 45% of tumors had less than 12 month follow up, so less than a year follow up. The only inclusion criteria was completion of 20 fractions, so patients with adverse events who had disease progression while undergoing treatments did not have 20 fractions and they were excluded. Next slide please.

Freedom from recurrence across age and nonmelanoma skin cancer. This is another article that is frequently cited. It's not in an oncology journal, but in a pay-to-publish journal. There are zero other individual or oncology articles in this journal. No conflicts are disclosed; not randomized; not prospective; No control as far as the loss to follow up, in two years; 60% were lost to follow up at the four year mark; 85% lost to follow up and at six years 98%.

Staley, Richard
Two minutes.

M. Laurin Council, FACMS
To follow up, next slide please. Next slide please.

All right, understanding the importance of daily imaging with treatment of nonmelanoma skin cancers. There's no evidence presented that daily alterations in the ultrasound images reflect actual tumor changes. And they, the authors don't

consider alternative explanations for the ultrasound findings. For example, it is equally plausible that changes in the ultrasound findings are a result of tumor edema generated by irradiation damage to the cells, or by mechanisms other than tumor regression or progression. There's no validated tool or study that proves that ultrasound findings correspond directly with the histologic findings of nonmelanoma skin cancer. Next please.

Ultrasound guidance considerations: High quality studies comparing superficial radiation and image guided or non-existent. The radiation fields can be set by examination. Skin cancers that are amenable to radiation are superficial without extensive derma involvement. Small measure difference makes no significant difference in the treatment of nonmelanoma skin cancer by superficial radiation therapy. The skin cancer size does not grow to date day-to-day, so there's not a need to increase the field or change it on a daily basis. There's also no published data that radiation dosing can be safely decreased if the tumor responds. No validated protocol for assessing tumor depth by ultrasound nor correlation of ultrasound with Histology or microscopic tumor invasion. The literature is purposely vague in how ultrasound is used to guide the adapted therapy. Next slide please.

At best, the image guidance is considered experimental. Ultrasound certainly is very interesting and patients may like it, but it does not make it medically necessary. Next slide please.

Despite the lack of good evidence, ultrasound guidance has exploded, as you can see in trends from 2016 to 2021, an annual growth rate of 234%. Next slide please.

Image guided radiation therapy is designed for internal cancers where external landmarks are not reliable. It's not really designed for skin.

Thank you.

Staley, Richard
And 10 minutes is up.

Schaening.Perez, Juan
But we're doing well on time. We provided an extra minute to the previous call presenter. Rich, give her one minute to finalize.

M. Laurin Council, FACMS

Next slide please.

There are also several expenses that are included in these codes that dermatologists don't use, which makes them not necessarily the most appropriate. Next, please.

And when we talk about high impact studies published in journals that have meaning, the Journal of the American Academy of Dermatology accepted a publication in May of 2025 that says the present data suggests that image guidance rarely prompts refinements to the dosimetry protocol through superficial radiation regimens. Given that common IGSRT regimens involve 20 fractions, our findings suggest that image guidance is performed at most fractions, but only prompts a dose calculation of 1.03 to 1.23 per regimen. With one mandatory calculation occurring at treatment onset, although image guidance may aid in the initial dosimetry calculation and help exclude deeper or poorly defined lesions from receiving superficial radiation therapy, it likely provides extremely limited additional value during subsequent fractions at a substantial cost. These findings are import amidst ongoing concerns regarding the over utilization of image guided services. Next slide please.

From the proposed Brachy- Based on the consensus of the literature and the recommendations of the AAD, ASTRO and ACMS, the use of EBT for the treatment of nonmelanoma skin cancers is not considered reasonable and necessary at this time. Next slide, please.

LCD will help the conscientious provider, so physicians who are providing medically necessary services and are billing appropriately should welcome this LCD, given the explosive growth in SRT and related codes partially driven by inappropriate actions, the LCD will help people to judiciously use this when appropriate. Thank you very much.

Schaening.Perez, Juan
Thank you for your presentation.

Are there any questions from the CMDs?

Thank you.

So Rich, please provide one extra minute to each presenter because we're doing well on time, OK?

Let's then go to our next presenter. Our next presenter is Doctor Kristi Hawley, of the Derm Institute of West Michigan. Please, Dr. Hawley, state any conflict of interest and proceed with your presentation.

Dr. Kristi Hawley
Hi everyone. Hi colleagues. Thank you for having me today. I'm Doctor Kristi Hawley. I'm a board certified dermatologist and a private practice owner in Grand Rapids, MI. I don't have any conflict of interest other than I currently offer IGSRT to my patients. I have to say that the PowerPoint I have provided has already been covered by Doctor Yu. So if it's OK, I'd like to just kind of pivot and discuss my experience offering IGSRT in my practice. More so, hoping to protect Dermatologist's ability to continue to offer IGSRT, and why it's been so important.

Since – I've learned a lot since starting to carry SRT in my practice from patients, I've received an influx of patients from the community who have found me because they realize that I offer this alternative treatment option for surgery. And I've gotten so many hugs and so many patients have been like, “thank you so much. 'm terrified of surgery or I've had surgery before and I've had terrible outcomes” or what have you.

And so, you know, because our Medicare patients have lower immune systems they have – they often can have more poor healing depending on their comorbidities and there's sometimes increased risk of infections or blood thinners. You know, having this alternative option has been incredible for my patient’s happiness, but also for efficacy and the safety.

Speaking to this, I actually about three to four weeks ago had a gentleman come into my office who found me because I carry IGSRT and he had had a biopsy done of a squamous cell a couple of years ago. But the only thing that was offered to him was surgery at the time, and he was terrified. So, you know, he was lost to follow up and then he discovered that I carried this and he's like, “OK, I'm ready to get my squamous cell treated.”

And on physical exam after meeting him, I palpated some lymph nodes, and you know, got him an urgent referral to oncology, and it turns out he has metastatic squamous cell now, because he had delayed treatment because he didn't have any other option and refused to do surgery.

So you know when we talk about cost to CMS in the healthcare system, you know, if SRT could have been an option, you know, maybe not only this poor guy's life is

completely changed, he has to have full surgical resection; Lymph node resection, and now he's undergoing radiation and chemotherapy. You know, I always wonder, you know, what would have happened to him in his life if things were different.

And then, you know, another thing; removing IGSRT or SRT in general from private practices. It's not a secret, and I really wish I had done my presentation different with some evidence, but it's not a secret that private practices are significantly cheaper when delivering care over hospitals or big corporations. You know, patients are aware of this as a treatment option now and they're seeking it out. And so if a hospital system is now the only one that's allowed to deliver this, that is going to come with the cost plus the facility fees and the hospital fees and all these extra costs that that we don't bill in private practice.

I also have a satellite location in a really underserved remote area. There's no Mohs surgeons; there's no ENT facial surgeons at all; and so previously before I started offering IGSRT patients who had skin cancers had to go to the hospital, they had to be put under, go to the OR and get general surgery to remove their skin cancers at an exorbitant cost and at huge risk to these patients. And so now you know, in this underserved area, patients have the opportunity to get SRT instead and hopefully have better outcomes and it is less - there's more cost effective to everyone.

And so, you know, we talked about – Doctor Yu did such a great job talking about the image guidance, you know, for me, I personally, based on the data, love that, from what I've read, the cure rate is higher. I also like that I'm able to tailor my treatment to what I'm seeing on the image guidance. So, for example, you know previously without this, patient's got a set protocol and they had to have a certain amount of treatments and we didn't have the image guidance to help us determine if the skin cancer is still there or not. So now I'm able, if I think after 12 treatments, a patient's skin cancer looks great under ultrasound, and I can actually stop treatment early.

So I really thank you guys so much for having all of us and considering allowing dermatologists to continue offering this. I can't even imagine pulling this from my patients as an opportunity. I think so many hearts would break. But, let me know if you guys have any questions or feel free to reach out. I put my camera on 'cause there's nothing to look at, so hope you don't mind. But thank you everybody.

Schaening.Perez, Juan
So thank you so much for your presentation. We really appreciate the services that you provide to our beneficiaries.

Does any of the CMDs have a question for Doctor Hawley?

OK, seeing no hands raised, please, let's go to our next presenter. Our next presenter is Doctor Jonathan Cheng and Robert Burnside of the Genesis Cancer Center and Elekta, Inc. Please state any conflict of interest and proceed with your presentation, Doctor Cheng.

Staley, Richard
And Doctor Cheng, I've made you a presenter, so you should be able to unmute your mic at will.

Doctor Cheng, are you able to unmute your microphone? How about now?

Jonathan Cheng, MD
You hear me now? Can you hear me? Hello, Hello, can you hear me?

Staley, Richard
I can hear you.

Jonathan Cheng, MD
Oh, thank God. OK.

Schaening.Perez, Juan
You're welcome. Go ahead.

Jonathan Cheng, MD
OK. Thank you guys. Thank you for the opportunity. Good afternoon, My name is Doctor Jonathan Cheng. I'm a board certified radiation oncologist at Genesis Cancer Center in Houston, TX, and I'm joined here by Mr. Rob Burnside from Elekta. Today I'm here to speak not on behalf of the industry, but as a treating physician for many Medicare patients, many of whom rely on electronic therapy, also known as EBT, here, as their only safe and effective treatment option for nonmelanoma skin cancer patients - skin cancers. next slide.

So what's at stake here? So if the proposed LCD is adopted, and EBT coverage is removed, thousands of Medicare beneficiaries, many elderly, frail or medically inoperable, will be denied access to a curative, non-invasive and highly effective treatment. EBT has actually been shown to achieve local control rates above 98% with minimal toxicity, favorable cosmesis and short treatment durations. This is not

an experimental medicine. This is evidence-based care, are utilized across the country for over a decade. Next slide please.

So what does the concern with the current draft LCD? Well, the draft LCD actually fails to consider 10 plus years of published literature on high dose rate HDR EBT. It relies heavily on a 2019 consensus guideline that was created before the long-term EBT outcome data was available. Worse yet, that guideline actually included no EBT-using physicians and was developed by individuals affiliated with a competing technology vendor, thereby representing a significant conflict of interest. There are also, over the last 10 years, there are well over 14 peer-reviewed publications that have documented EBT's safety and efficacy, none of which will reviewed or acknowledge in the current ECD – LCD, sorry. next slide.

So let me be clear: EBT is well aligned with all the major national guidelines and societies: NCCN, AAD and ASTRO have all endorsed superficial radiation therapy for nonmelanoma skin cancer in non-surgical candidates. EBT is just a modern, standardized variation of superficial radiation therapy. Compared to SRT, which is superficial radiation therapy, EBT often uses fewer fractions and has more consistent dosimetry, and it is better tolerated in frail patients. There are no randomized trials proving that SRT is actually superior, because such trials will be considered unethical in elderly cancer patients. However, there are retrospective and match-cohort studies such as the one published by Patel et al. In 2017, and Dogget et al. in 2023, which showed that EBT compared favorably with SRT and even Mohs surgery in select cases. Next slide.

Now the AMA, American Medical Association, CPT editorial panel has met in September 2024 and May 2025, and along with ASTRO, they have already reviewed a clinical data and made its judgment. In May 2025, the AMA voted not to separate SRT and EBT into different codes. Instead, it created a separate CPT code called 77X07, which is to be effective January of 2026. And this is to encompass both modalities, SRT and EBX. This actually affirms their clinical equivalency and acknowledges that both are reasonable and necessary in appropriate patients. And the fact that they both use similar photons and treat similar pathologic and anatomic indications. By deleting EBT coverage now would contradict the national coding alignment and the judgment of these leading specialty societies. Next slide please.

So here's a table that compares the difference between the high dose rate EBT versus SRT. Now, besides uniform depth dosing with the EBT, the EBT actually uses a lot less fractionation. It's called hyperfraction regimens. We generally use only about 8 to 10 fractions and this helps enhance patient compliance and lower patient

cost. This is in contrast to SRT, which uses generally in the 20 to 30 fraction range and obviously that requires more treatment and increased patient costs. Secondarily, EBT requires specialized, trained staffing for this procedure. We generally employ AART certified radiation therapists who would remain in room to treat a patient. Versus SRT, these are mostly provided by medical assistants and not necessarily AART certified radiation therapists, and they are generally outside the room while the treatment is going on. Third, EBT is always supported by board-certified radiation oncologists and medical physicists to ensure accurate and safe delivery of these high dose fractionation; generally given 400, 500 centigrade per fraction. As opposed to SRT, the radiation oncologist, like myself, is almost never involved in these treatment process. And the rationale behind that is they treat using lower daily dose of 200 to 300 centigrade per fraction. Lastly, the EBT also has stricter state and federal regulatory oversight than that of SRT. EBT is usually falling on the category of high dose rate brachytherapy. Thus the regulations are a lot more stricter. Next slide.

So here's our ask: We're respectfully asking that Section 5 of the draft LCD, which proposes to eliminate EBT coverage to be removed. This is not just about a treatment modality. This is actually about preserving patient access, honoring guideline-based care and protecting patient autonomy. By denying EBT, It disregards both the science and the human impact on elderly patients with limited options. Especially the ones who are non-surgical elderly patients with skin cancer. Next slide.

Here's a short list of the bibliography of the publications over the last 10 years. For instance, in the first study, Doggett, et al., this is our long term outcome in which they show – it show a low recurrence rate of 1.1% at 7.5 years. It was the longest EBT follow up to date. We have a study from Patel et al. in 2017, which was a match-pair cohort study in 369 patients, which compare EBT versus Mohs surgery. In elderly patients and the study showed no significant difference in recurrence or cosmesis in a 34 year follow up. You have other studies on Paravati, 2015, Goyal, 2021, Tang, 2022, and Cheng, 2024, which also show a 95 to 98% control rate with excellent cosmetic results. So these data together spend thousands of lesions across multiple continents, devices and patient population, including many Medicare beneficiaries. Next slide.

So in summary, HDR EBT is clinically effective. It is endorsed in national coding, as mentioned earlier by the AMA panel. It's also aligned with national guidelines such as NCCN and national societies such as ASTRO, ABS, AAPM, ACR and AAD. So we know this is critically important for elderly patients. So we therefore ask that you

maintain a coverage for EBT under the same standard applied to SRT. Thank you for your time and consideration. I welcome any questions.

Schaening.Perez, Juan
Thank you for your presentation.

Staley, Richard
Thank you and –

Schaening.Perez, Juan
I see that Mister Burnside has his hand raised, and you still have time on your presentation. So go ahead, Mr. Burnside.

Robert Burnside
Thank you. Again, I'll take advantage of the one minute extra we've been offered. My name is Robert Burnside, my conflict is that I am an employee of Elekta, which is one of the manufacturers of the three different machines that practitioners use to offer electronic brachytherapy to their patients. I have heard input from other clinicians through our partner and colleague manufacturers that that would also add their agreement to what Dr. Cheng just said and to clarify a couple of points very briefly.

First of all, they would like it to be known that the description of EBT electronic brachytherapy in the LCD is mostly accurate but does lack clarity and precision. Just the way that Dr. Cheng said that the significant difference between electronic therapy and Superficial Radiation Therapy (SRT) has to do with the hyper-fractionated doses. The much higher doses have everything to do with the differences. The other thing that these practitioners would like it to be known is they do not have any opinion about IGSRT because electronic brachytherapy is not inherently an image guiding technology. So we have no comment on that aspect, only on the electronic brachytherapy.

And then finally, again, as Dr. Cheng said, the practitioners that are utilizing this very valuable technology want everyone to know that both SRT are reasonable and EBT are reasonable and necessary and that we should not remove that as an option for patients because they would be denied coverage for high dose rate electronic brachytherapy which is a viable, safe and highly effective non-surgical option. As was one of the clinicians that we heard that spoke to the industry mentioned surgery should be the last intervention not the first. And if there are non-surgical options that

patients should be aware of them and electronic brachytherapy is a very viable choice. Thank you very much.

Schaening.Perez, Juan
Thank you for your comments, Mr. Burnside. I will appreciate if you could send them in writing also, so we may address them in our comment response document, to the mailbox that was mentioned previously. The - this LCD is still in the comment period, so please proceed and send those comments in writing, OK?

So, do any of our CMDs have any comments or questions regarding this LCD?

Seeing no hands up, Let's move to our next presenter. That is actually our last presenter, is Doctor Robert Durst. He's from the American Academy of Dermatology. Dr. Durst, Please state any conflict of interest and proceed with your presentation. Thank you.

Staley, Richard
And Doctor Durst, you should be able to unmute your mic.

Robert Durst
I'm doctor Robert Durst. I'm a board certified dermatologist and the Kansas alternate Representative to Dermatology, Medicare Contractor Advisory Committee for the WPS Region 5. The DermCAC is a national association of dermatologists selected by their state, and I have no, I have no conflicts to represent. The DermCAC appreciates the opportunity to provide comments on the proposed LCD – Superficial Radiation Therapy for the Treatment of Nonmelanoma Skin Cancer. In particular, I'll focus on two key messages: First we support the proposed LCD coverage and SRT as secondary treatment for non- next slide, please, as not – first of all, we support the proposed LCD coverage for SRT as a secondary treatment for the nonmelanoma skin cancer when surgical intervention is contraindicted or declined. And second, we support the inclusion of dermatologists as qualified to furnish SRT for nonmelanoma skin cancer, but we recognize changes to the requirement, to demonstrate training expertise in order to preserve patient access to qualified, appropriately trained Dermatologists.

I'll provide for the account, slide three please. Slide 4. Back to Slide 3.

So starting with the report for SRT as a secondary treatment option, this approach is consistent with the current available evidence, especially society guidelines, including the American Academy of Dermatology's clinical guidelines. These

guidelines recognize that surgery is the most effective treatment for basal cell carcinoma and squamous cell carcinoma, with very few exceptions. We note the surgical option like excision and Mohs surgery are safe and well tolerated, even among high risk populations, including the elderly, immune suppressed, or medically complex patients. As a result, non-medical candidates represent a small subset of the overall nonmelanoma skin cancer population. At the same time, the evidence reflects that SRT is reasonable and necessary in select cases. Thereby supporting coverage for SRT as a secondary treatment option.

We appreciate WPS has conducted a comprehensive review of available literature and we support these coverage decisions that reflect the current state of evidence. We also encourage reliance on the best available data that WPS has [inaudible] LCD, as well as considering potential future policy. Slide 4 please.

Recognize - we appreciate the proposed policy recognizes the importance of patient selection, clinical judgment and shared decision making in the treatment of nonmelanoma skin cancer, and it thereby allows physicians to exercise autonomous clinical decision making authority to address it and individual patient care needs.

To that, we appreciate the inclusion of [inaudible] outline examples of clinical scenario that may qualify patient as a nonsurgical candidate, such as potential functional impairment, significant morbidity or poor prognosis and the anatomy [of sensitive areas] as well as the situation in which patients declines surgery following shared decision making. We highlight the importance of decision collaboration with patients, consider such factors as cure rates, long term clinical outcomes maintenance with normal anatomy and functional medical circumstances and the patient's preference deciding on a course of treatment. We also underscore the importance of addressing potential risks and benefits for patients before moving forward with any treatment option. Finally, we appreciate the proposed policy supports SRT as an option in the treatment armamentarium against nonmelanoma skin cancer. Next slide.

OK, Before I continue, let’s first address the policy on HRUS – the High Resolution Ultrasound and Imaging guided SRT; the LCD supports the “use of HRUS to support delivery and to assess lesion reduction during the superficial radiation treatment protocol is not considered reasonable and necessary as supported by the literature.” We acknowledge this emerging area of technology. However, the current published evidence on IGSRT does not allow definitive determination of the value of image guidance during a course of SRT for nonmelanoma skin cancer. We anticipate reviewing the scientific literature as it continues to develop. We encourage the

continued reliance on the best available high-quality data when refining, implementing to diagnose future updates, next slide.

As I previously mentioned, the DermCAC supports including dermatologists as qualified physicians to perform SRT for the treatment of nonmelanoma skin cancers. Dermatologists have been responsibly using radiation for over 87 years, since the Academy of Dermatology was founded. We want to be able to continue our treating patients with radiation and use newest and best technologies when available. We believe this policy as proposed reflects dermatologist's long standing expertise in diagnosing and treating nonmelanoma skin cancer, including our comprehensive understanding of skin anatomy and oncology. [inaudible] the resident and fellowship training, as well as ongoing medical experience and continuing medical education.

Dermatologists have long extensive study, knowledge and use of superficial radiation electromagnetic energy across a variety of wavelengths to effectively treat a wide range of skin conditions. Dermatologists have a long history of furnishing SRT under the Medicare program, with a Medicare claims demonstrated the majority of SRT instances with nonmelanoma skin cancer are furnished by dermatologists. We highlight using a dermatologist as qualified for SRT for nonmelanoma skin cancer, Support patients access, continuity of care and positive outcomes. For example, this approach allows for the streamlining of diagnosis, treatment, follow-up with a single office visit under the dermatologist's management rather than requiring referrals to other stressors or coordination with treatment facilities after dermatologists diagnosed the cancer. As a result, it minimizes hands-off and opportunity for delay. Finally, allowing dermatologists to furnish SRT, the proposed policy establishes a broad pool of qualified physicians [inaudible]. Restricting dermatologists from performing SRT could create barriers to care and limit access to timely cost-effective treatment for patients with nonmelanoma skin cancer. Next slide.

At the same time, we are concerned that the proposed policy requires dermatology training and expertise to be acquired within the framework of accredited residency or fellowship program. We believe this approach is flawed for numerous reasons. To begin, it is unnecessary and it excludes qualified dermatologists, restricing patients access to medically necessary care. It does not reflect the current clinical practice as many dermatologists have completed residencies or fellowships before the emergence of newer SRT technology. Finally, it fails to recognize the alternative avenues for receiving training and developing expertise that dermatology pursue, including medical education, post-graduate training programs, hands on experience. If all medical services are limited to what physicians learn as a resident or in a

fellowship, the ability to innovate or offer advanced treatments would be severely crippled. Next slide.

For all these reasons, DermCAC recommends the WPS finalize coverage of SRT as a secondary treatment option for patients when surgery is contraindicated or declined. Finally, Finalize inclusion of dermatologist as qualified physicians eligible to furnish SRT. Dermatologists, again, have treated patients with radiation for over 87 years, since the inception of the American Academy of Dermatology. We have patients – we have physicians now, dermatologists now, who actively use SRT to treat their patients. They earned this privilege. They deserve to continue to have this privilege. And, to revise training and expertise requirements, that to a dermatologist, to acknowledge that appropriate training and practice may be obtained through multiple pathways outside of residency and fellowship, including CME, post graduate training programs and hands on experience. Thank you for considering these comments.

Schaening.Perez, Juan
Dr. Durst, thank you so much for your presentation and your comments and your service to our CAC. Do any of our CMDs have any questions for our esteemed CAC member?

OK, hearing none, are there any further comments on the proposed SRT LCD for the attendees? Please raise your hand.

I see that Doctor Yu raised his hand. Doctor Yu?

Yu, Lio
Hi, can you hear me?

Schaening.Perez, Juan
Yes, I can hear you.

Yu, Lio
Yeah. I just wanted to just follow up a little bit and address some of the issues that was brought up by the – Dr. Council from the ACMS. Interestingly, I've been to several of the LCD's and the same slides were presented by multiple different people – presenters, but unfortunately 90% of those slides are flat out wrong. Interest the- it's kind of like the pot calling the kettle black. The surgeons have the financial incentive to keep doing, in my opinion, unnecessary surgery, OK. And they're using all kinds of methods, smoke and mirrors, you know, distortion of information,

misinformation, disinformation. And one of the things I do want to point out is that there's a critique that the 20,000 lesion studies were – had thousands of cases lost to follow up. Well, this critique reflects basic misunderstanding of clinical statistics, particularly Kaplan-Meier Analysis. These studies didn't just ignore patients who dropped out or were unavailable. They used standard time-to-event methods that account for variable follow up durations and censor each patient individually based on the actual follow up data available. In fact, all the large IGSRT studies applied Kaplan-Meier methodology correctly and many also incorporated competing risk models to account for deaths as unrelated to skin cancer. So, the studies are well designed and well run. They're retrospective, but to use a commonly used phrase these days, With 20,000 cases and we have over 120,000 patients that were treated all around the country, with 99 plus percent cure rate, It's just too big to rig. You can't – It's too big to rig, OK. If the failure rate were so high, you could be sure there'd be plenty of patients and providers running to, you know, the societies and complaining about it. This is clearly a turf battle issue, OK. And you know it's technology that's here, it works well. Patients needed a non-surgical option. Thank you.

Schaening.Perez, Juan
Thank you for your comments. I have a question for you: I read the ECRI report you refer in your presentation, and just the scales is sized toward a positive review, but on the conclusions it states that “the study's too high at risk of bias to permit conclusion on IGSRT’s comparative effectiveness” and it also said “randomized control studies or prospective comparison studies with well-matched patient groups assessing IGSRT and surgery, and reporting long term outcomes are needed”. So what do you have to say regarding the statement on the ECRI report?

Yu, Lio
Well, with that regard, we have retrospective studies and prospective studies, I feel, is really unnecessary because we have so many patients, OK. But interestingly, NCCN, most of the data for their recommendation are not based on randomized control trials. OK. The vast majority, I think 80% or more of their recommendations are not based on randomized control trials. So to do a randomized control trial, randomizing someone to surgery or not surgery, that would be unethical and probably not doable. OK. So we have large scale retrospective studies that look at this. And I did a comparative study, two of them: a meta-analysis and a logistic regression analysis that compared non image guided modalities to image guided modalities and across the board, they were statistically significant better for image guidance. And when I – when – they're not talking about, you know, a small percentage. I mean, even the small percentage, like I mentioned before is a lot of

patients, OK. So it's clear that this data is mature enough at this point, OK, to have this as really the standard of the care. The standard of non-surgical care for the patients and the patients deserve this.

Schaening.Perez, Juan
Perfect.

Yu, Lio
You know, you hear that that case that the patient neglected his tumor for such a long time where he metastasized. OK, this is not necessary, you know. This is also very costly for the health system.

Schaening.Perez, Juan
Thank you for your comments.

We are here all for our beneficiaries and we just want to provide them access to the best treatment with evidence to support it. So we really appreciate your comments. And now, I don't see any further hands up. So I will go back to Dr. Joelle Vlahakis, that she will continue with the meeting. Thank you.

Vlahakis, Joelle
Thank you, Dr. Schaening. We really want to thank all of you for participating in the open meeting. I know it's been incredibly informative and helpful. Please remember that only comments or questions submitted to Medicarepolicycomments@wpsic.com, that mailbox, will receive a written response. I'm going to put that in the chat right now. Include the topic of the LCD on the e-mail subject line and if you have any supportive evidence, please attach it directly to the file, as I remind you, we can't open any e-mail links.

And then just again, thank you so much, my colleagues here at WPS for participating and all of you who took your time to put together presentations for us, be thoughtful and considerate about those. We really thank you very much and we hope that you have a wonderful afternoon. I will now adjourn the meeting at 3:23 pm Eastern Standard Time, 2:23 pm Central time.