# J15 Kentucky & Ohio Open Meeting:
# Draft or Revised LCD Public Discussion

**Meeting Date & Time:** August 27, 2025, 5 pm ET
**Topic:** MolDX Program

**MEREDITH LOVELESS 0:09**

Welcome, everyone. Thank you for joining us for CGS's Open Draft LCD meeting.

I'm Dr. Meredith Loveless. I'm the medical director in the area of policy, and I welcome you today to our meeting. I'm going to um begin with our disclaimer that everything we're presenting is accurate as of today, but as Medicare rules and regulations change.

The content of today's presentation may also change.

Today we will be discussing 2 proposed LC DS, both coming from the Moldex program. The comment period for these LC DS is currently open and will close on August 31st, 2025. I'll go over how to submit comments at the conclusion of the presentation.

We do ask that all attendees joining us today.

That all attendees, you should be able to see the slides now. That all attendees joining us today remain on mute unless you're A. registered presenter, at which time you'll be able to present after your.

For introduction and we ask that all of our presenters please disclose their conflicts of interest prior to beginning their presentation.

Without further ado, I'm going to move into the discussion of today's policies. The first policy, we have no presenters for this policy, so I'm just going to review the the policy and then we'll move into the second one in which we have 3 presenters.

The first one is Moldex molecular testing for solid organ allograft rejection. Allograft solid organ transplantation has become A. standard of care in patients with end stage organ disease.

And in some patients, these treatments have transformed otherwise fatal disease into treatable and preventable ones. Molecular diagnostic has emerged as an option to attempt to address limitations of current diagnostic modalities.

For for organ transplant rejection, they are not intended to be used in isolation, but part of A. constellation of clinical and laboratory data to evaluate the patient.

The policy is A. limited coverage policy for molecular diagnostic test used in the evaluation and management of those who undergoing solid organ transplantation to aid in informing decisions with standard clinical assessments in evaluation of organ.

Injury for active rejection. They must be ordered by qualified physician or provider within their scope of practice, and the goal is to rule in or out the condition and assess the need for diagnostic biopsy.

The tests that are covered are tests that inform one of the following clinical status. They need to inform of A. active rejection status or cellular anti mediated rejection status.

They're intended to inform clinical decisions to assist in evaluation of adequate immunosuppression or response to treatment in lieu of tissue biopsy, or as A. rule out test in A. validated population with suspected clinical rejection.

As A. noninvasive or minimally invasive way to to make clinical decisions regarding obtaining A biopsy.

Further evaluation of our graph status for the probability of injection after physician assume pretest review and clinical and biological factors concerning risk for rejection or the biopsy is in inclusive or unexpected or limited or insufficient material.

And at this time, current evidence supports A. maximum number of surveillance time points for evaluation in the first year post post transplantation of four for kidney, 12 for heart and 12 for lungs.

After the first year, surveillance time points may continue to decrease. Further research is being done on on the optimal frequency.

The test must demonstrate analytic and clinical validity, be used in the population for which it was designed, must be demonstrate superior additive benefit compared to single analytes if A. multi analyte test is being used.

Provide benefit profile of the molecular test more favorable than the profile of the tissue biopsy or if the biopsy is difficult to obtain and the test must meet the requirements of the Moldex program.

And A. test and biopsy cannot be performed simultaneously, except for in exceptionally ordinary circumstances.

And so that concludes the molecular diagnostic testing for solid organ allograft rejection. I'm now going to introduce the second policy, which is Moldex biomarker testing for wrist stratification in DCIS or ductal carcinoma in situ.

This is A. non coverage policy for the biomarker test, molecular or proteanomic that enables risk stratification of DCIS in patients into sufficiently low risk patients who may safely forego the use of adjunctive radiation therapy.

Or should not forgo the use of radiation therapy or receive higher intensity intervention. For the purpose of the policy, sufficiently low risk is defined as stratification of patients when the absolute risk of ipsilateral breast tumor recurrence.

From radiation therapy is estimated to be 5% or less when compared to breast conservation surgery alone, regardless of individualization factors.

There was A. CAC meeting for this policy on July 15th, 2024.

The policy framework for what is necessary for coverage is evidence. So this is placed into the policies so that tests that are in the research and development phase have A. clear expectation of what the test must meet in order to achieve coverage.

And so this is defined within the policy that and it defines the - Patient criteria that they have A. diagnosis of DCIS, not invasive tumor, not being considered for mastectomy, have not received previous radiation therapy.

Formulated treatment plan that includes radiation therapy and the - Patient already consents to use or the intent to forego radiation, not have not have had A. previously similar test and and the test being used.

In the appropriate population, the test also must meet the criteria of Moldex, including technical assessment, demonstrating accuracy and identification of sufficiently low risk patients compared to existing risk stratification methods and equal or superior performance and risk stratification.

Medication to other biomarker tests that test that already met the criteria. So this is referring to future tests to clarify what what the is being sought for coverage.

At this point, DCI risk stratification has been controversial and evidence is difficult to evaluate given several major challenges. The most notable of these is there's no clear definition or standardization of the term low risk. It is possible the ambiguous nature of the term may have contributed to.

Radiation therapy overutilization, especially when highly individualized factors are included.

So it is important to identify A. population of patients for which there is no reasonable benefit for radiation therapy and are sufficiently low risk to safely preclude radiation use regardless of other factors. At this time, based on the current evidence, it is concluded.

That any test that can identify A. - Patient who would not be that there is no convincing evidence that there is A. test that would identify patients who would not reasonably benefit from radiation therapy beyond clinical pathological factors already demonstrated to the risk stratifying patient.

If absolute risk reduction is 5% or less, most practitioners should conclude the benefit is not meaningful and should advocate for radiation therapy avoidance. Therefore, patients should not get such A. test unless it is clear they could safely forego radiation therapy.

Use if placed into that group. Additionally, other - Patient factors such as age and comorbidities must be considered before test is ordered and assist in making A. decision regarding performance of such test.

The open comment period for both of these policies is currently open and closes August 31st. The recommended way to submit comments is to utilize the form that's on the CGS website and and send that to cmd.inquiry@cgsadmin.com.

But comments can also be mailed or faxed.

And please ignore the the date there. It is due August 31st 25 and submitted comments. This is on our website, the link to the form and the address for CMD dot inquiry.

At this time, I'm going to conclude my portion of today's presentation and we're going to turn the floor over to our speakers.

So just a moment, we will get the speakers. The first speaker is going to be Doctor Forche. I hope I pronounced that correctly.

Please correct me if I'm wrong.

**Dan Forche 11:08**

Yeah, it's it's actually pronounced Forky, but thank you.

**MEREDITH LOVELESS 11:11**

OK. I apologize. Um.

**Dan Forche 11:14**

That's OK. It's, you know, it's a Midwest name from Michigan and where I originate. So yeah.

**MEREDITH LOVELESS 11:20**

Well, thank you for being with us today. Your slides are now up and we can hear you just fine. So I will turn the floor to you and just a reminder to disclose any COIS beginning the presentation.

**Dan Forche 11:28**

Perfect.

Yeah. So again, so my name is Dan Forkey. I'm the President, CEO, Prelude DX. Oops.

I think it's back. Sorry. I'm the president and CEO of Prelude DX. I've been here since 2016. The journey with Decision RT and Prelude, by the way, just so everybody understands, was really formed back in 2009.

Uh, from a license of the UCSF.

UCSF found some markers that were prognostic for DCIS that was funded by a grant from NCI, by the way, of about $10 million that was between them and Yale. We also had a fast track grant at the company through the NCI as well.

To help forward and do a number of the studies that we did. So and of course we'll talk a little bit later today about an NCI study of the decision Rd. test that's moving forward. Next slide please.

So.

So the one thing and you could just, I don't know why it's doing this. If you could just go to the next one even. I'm sorry it's doesn't look like the whole slides pulling up. There we go. Thank you. So so the first thing is when you we were sort of surprised to be honest when we we saw that you know there was this non coverage policy being built up.

For decision P, because first and foremost, what I will share today is this is not an experimental test in any way, shape or form, and the test changes physicians and patients decisions 38% of the time.

Now what I'm showing you here is a study in 2007 patients covering 63 sites, academic sites, you know, community sites, sites like Dana-farber, Cleveland Clinic, Baylor, like I was involved.

And if you can click one more so I don't know why it got goofy on this animation. I mean there's animation in there. I apologize. Can you go to the next slide?

There we go. Thank you. Oops.

Actually need to go back now. It wasn't all pulling up.

Apologize. There we go. So what we saw here in this large study we did, and this is perspective by the way, and so we did surveys before.

The the patient had the test and then afterwards and after getting the results of this is in our T.

It changed the radiation decision 38% of the time.

So what did that mean? Well, some patients that were going to be radiated after finding out they were at a low risk decided not to be radiated. There was less radiation given, which is great because they don't need it if they're in a low risk group because there's not benefit to radiation in our lowest group, which we've shown in numerous studies.

The other thing that we found out of this study was that the strongest predictor, OK here and looking at the odds ratios and this is looking at Clinpath and this is looking at patients and what they think and it's looking at the result. Decision RT was the strongest predictor.

First and foremost, right there, as you can see here, odd ratio 22. The second most important thing, impactful factor was patient preference. Now I bring that up because the way that this LCD is constructed.

It's basically taking away the patient's choice in their voice, stating that, well, you can't be considering a mastectomy. If you're low, you don't get radiated. If you're or elevated, you must be radiated. That's not.

How our system works in America.

Patients have choice and our women have choice to decide what is best for them, and these tools help them to do that. Also, we started working through Mol DX 2018, but then it was decided in early twenty-one that they weren't going to review.

Proteins.

So we were kicked over to Noridian. Now we were kicked over, by the way, after Mobile DX accepted our technical assessment as valid and said we're going to the next meeting. There's emails for that. We have those to share. So we get kicked over, we go to Noridian, we send them the dossier, we send, we do our tech assessment.

All of our pubs are over there. That was it. That was in February. They go on and look at everything for a few months, three of the different medical directors and they came back and they covered us.

Through an e-mail stating that they're going to cover us through 21st Century Cures Act and that was effective May 1st of 2021 right now. Also there's other Macs that we sent information to that have reviewed the data to.

And we've had meetings with the medical directors and they move forward and they've paid for the test, right. So we think that's important. So everybody knows that also we did have to go to administrative law judge with some of these over 200 claims and we won a majority of those cases about almost 65% of the.

The cases were overturned in favor of the test being reasonable and necessary for Medicare beneficiaries. Now the normal rate of change is about 5 to 8%. So this was really high, again showing the test is not experimental.

Next slide please.

Thank you so much. The LCD ignores statistical significant data right in multiple publications. What you see here is 4 separate studies, 4 separate publications, 474 patients, 455, five or 4926.

Now there was mentioned that, well, there just weren't enough events, but you know, you can look at the size of the studies going from 400 up to 926. We think that's a pretty good number. Now in the low risk group, they're not a lot of events, but there's not supposed to be.

Because it's a low risk group, otherwise it wouldn't be. But what you see here is significant hazard ratios. This is what physicians look at, and this is looking at the low risk versus the high risk group and seeing that, you know, hey, there's a difference of 3.72.71.53.4.

A look across those studies, the one thing that you can look at is fairly similar right now. Sweet DCS has a little bit higher, you know, risk. You look at that. That's also because nobody got Tamoxifen during those days, which would lower those down a little bit from a risk standpoint, but very significant.

And this is static data. This is what the positions look at. This is what the publishers look at when they decide to publish this type of information. Next slide, please.

Thank you. Also the reason physicians are using the tests out there is it can predict radiation therapy benefit and if you look here at the low risk group, you see 1%.

And it's NS and 1% NS and 0.6 NS. That's non significant benefit. What does it mean? That group

does not benefit from radiation therapy. Oh, by the way, the 926 group is 5% risk with or without radiation therapy.

Right. Since people were mentioning ranges of 5 to 50% as a low risk group, you can look at and again, this is for invasive. The reason to put invasive up here, this is what docs are trying to do. So half of the recurrences for DCS will come back and half of those.

Will be either a DCIS or half will be invasive. So the docs are trying to manage to that invasive coming back, but you can see here 1% percent, less than 1% versus 6-9 and nine, right? All of these things have been published.

Right. And that is stat sig. You can look at the P values. So just to to look and sort of throw that data aside to say that, Oh well, you know there's just not enough numbers. Look, you're either stat sig or not.

And again, this has been published in peer-reviewed articles, totaling over 10 publications now. Next slide please.

So the other thing here is that was frankly is a little and I can't quite understand it, but the consensus of the cap is ignored and misrepresented in the draft. Now I'm going to read something out out of the LCD and it says some but not all the committees stated they rely on current biomarker testing.

This is out of the transcript and it was like, is there sufficient clinical evidence? And you'll notice here it's yes, John Williams says. How about everybody answer? Yes. Doctor Alistair Thompson from Baylor, who's the chair? Eileen Conaty, Columbia. Yes. Brian Srnicki, the chair.

Moffitt and Pellett, who's in San Francisco, right? Doctor Kim Vanzee said no from Morris and Kettering.

Doctor Atif Khan said yes as well, who's also from Morris Sloan. Now one thing is that wasn't mentioned that needs to be known is that Doctor Vanzee somehow ended up on the cap right as the inventor of the Nomogram.

Let that sink in for just a second, right? And and it's it's I'm good type didn't get invited and they're inventors and we didn't get invited as as an inventor. 94 criteria with people look at the PII wasn't invited. So I think it's important to note.

That there was no mention that there is sufficient clinical evidence support DCS biomarker testing that is not in the LCD in any way, shape or form. And this is what the member said. And these are the experts here. These are the treating physicians.

So I think that's why that was done that way. I have no idea, but I think that's unfortunate in bringing somebody on as an inventor. I think we would all call that pretty bias. Next slide please.

Oops, is it stuck? There we go. Thank you. Now one thing is this LCD came out this draft on July 17th and on July 18th we have a new publication that came out.

And one of the things in the LCD, they kept going to MSKCC, Nomo grant and VMPI, by the way, which are the only two things we hadn't published. Now we've chaired them at Astro and other big meetings and we looked at all the different clean factors. But a couple things when you look at this.

People have been using Clin Factor in 1997, VMPI in 2003, MSKCC. All this stuff is really old. No one really uses these things because they don't work.

So the reason the study was put together is that the Radox wanted to know, and it's mostly Radox that are on this publication going oops.

Thank you. We're back. Thank you. That's much better. But they wanted to know going, can you look at all of the stuff that's very old like this, right? I'm going to show you the data on the publication that came out in just on the next slide in a second, but these are very old tools.

And I'm assuming people here today are still not using a flip phone, right? We've we've moved on. And while these were good attempts and we've shown in multivariant analysis, by the way, in every publication that this stuff doesn't work and nothing works better than the decision RT test.

Next slide please.

So this is the data. This was published in the Red Journal. Now the Red Journal, just so everybody understands, is the International Journal of Radiation Oncology. This is the Radon Journal. By the way, for those that aren't super familiar with radiation oncologists, they're Maddock and physicist.

These are some of the smartest individuals from a medical standpoint that you will ever meet because they radiate people with the power of the sun and you really have to know what you're doing. And what we showed here is when you're when you're looking at this to, first of all, a lot of authors from NCCN centers.

But can you click one more button please? I think it should come up.

Thank you. So what we did is we looked at all of the criterias out there, 9804 criteria. We looked at MSKCC, we looked at Van Nuys, we looked at age over 50 in grade one or two. We looked at ECOG criteria, all of these.

Are so-called low risk criterias.

Now after we run decision RT, what we found is more than half of those patients and MSKCC at 63%, V MBI is 57% are actually elevated risk by the test.

Also very importantly, if you look at that line where it says .25 and if you just look up from that.

Up and down that that's showing that that has like about a 70% relative benefit from radiation therapy. What does it mean? They have statistical significant that radiation therapy benefits them, hence.

These tools, while interesting, everybody still benefits and if you're using these tools, essentially you you would under treat patients, right? Next slide please.

The slides are going really slow.

Oops.

Meredith, is this frozen?

**MEREDITH LOVELESS 26:46**

Cannot see it. Let's.

**Dan Forche 26:47**

Dad doesn't seem to be want to change right now.

Modern technology.

**Rakesh Patel MD 26:55**

It's working for me, Dan.

**MEREDITH LOVELESS 26:58**

Yeah, I can see it on my end, so that's why I'm trying to figure out what.

**Dan Forche 27:08**

Oh wow, this is weird. Yeah, I don't see it, which is hold on. It may be on my side. I apologize. Hold one second here. I know, I know, I know what slide it is. I can pull it up myself. I had it readily available. So on the next slide, as long as you guys can see, it says are there breast cancer physicians?

**MEREDITH LOVELESS 27:13**

If you have that information in front of you.

OK.

**Dan Forche 27:28**

You know, all wrong. Hopefully that's what you guys are seeing right now. I bring this up because it's important to know that 200 breast cancer treating physicians order decision are over 40,000 patients. Again, these are breast surgeons that are dedicated to breast surgery for breast cancer and radiation oncologists.

**MEREDITH LOVELESS 27:32**

Yes.

**Dan Forche 27:46**

And most of these radiation oncologists we work with are dedicated to breast. You know, obviously only the treating physician can order. Now what do they do? Well, every physician that's orders the test reviews our data. They read the publications.

Right. The multiple publications, the independent publications, they read them all, they research it, they look at it, right. This stuff's talked about a lot of conferences, right? And we've shown that we have significant power for that test.

Right. So, you know, one thing is, is to look at this and say, and there's a lot of surgeons and people are on Moldy X on Monday that we're talking, including Atif Con, about the need for these medicals and how they've evaluated. And by the way, I think, you know, again, at the end of the day, we respect everything that you all do as medical directors.

But boy, these treating physicians are pretty damn smart people and they're the one that treat the patient. So we think it's important that they, you know, again, their voice is heard here. Again, 10 publications, high-impact journals, right? Amazing amount of publications that we've had.

It's really hard to get stuff published, by the way. It's not easy. There's reviewers, they're from top centers, there's editors. Yet we've been able to do that.

**MEREDITH LOVELESS 29:06**

And we are at time. So if you can just summarize, do your final summary remarks, that would be wonderful.

**Dan Forche 29:06**

Now it's also important to know that is it?

Yeah, I'll do that. You guys have this. So. So in summary, the last thing that we're not seeing here is that one is this is all about patients. And I also think that again, patient preference must be considered when making shared decisions ratio therapy that's in the guidelines, NCZN guidelines.

This draft really ignores that.

And the last thing I'll just sort of read you here and we can move on to the presenters and I appreciate that. But I'm going to read a quote here from a patient. Decision RT was nothing short of a game changer for me. When I was first diagnosed with BCS, I was overwhelmed with fear and certainly and confusion.

Didn't fully understand what what my diagnosis mad or what my treatment path would be for me. That all changed with the help of decision RT. That's one of the patients that we've taken care of. Hannah Storm, who's a ESPN sports journalist.

Right. And it gave her her power back. So the last I will say is the disease biomarker LCD we believe is flawed on multiple levels. We suggest it be pulled, rewritten in a fair and equable way with clinical input from the subject matter experts.

And we appreciate the time today and I want to thank all of you for your time and consideration. And again, we believe that these type of tests are super important for patients and especially when we're talking about our Medicare population, which is about 40%.

of all DCS that's diagnosed annually. Thank you again for your time.

**MEREDITH LOVELESS 30:56**

Thank you very much.

And now I'm going to give the floor to Doctor Pelicani. Is it Pelicani or Pelicane?

And I'll be bringing up your slides.

Just a moment.

All right.

Are you on mute?

**Pellicane, James 31:46**

I think I'm off mute now.

**MEREDITH LOVELESS 31:47**

Oh, you're off. We can hear you. I'm going to turn the floor over.

**Pellicane, James 31:50**

OK.

All right, very good. Thank you very much for having me today and I will try to be and and to the

point and and make some valid points specifically around risk. Next slide.

Just as a matter of introduction, I am a breast surgeon. I run the Breast Cancer program at the Bioscore Mercy Cancer Institute in Richmond, VA, which is a large Community Cancer Center with four hospitals in central Virginia. So we.

Personally, I have been using Decision RT for a while now since it's been commercialized because I feel like it has been a great benefit to all of our our DCI. When I read the LCDI was struck.

By the agony over risk and where this sufficiently low risk definition came in like the committee has in the and the LCD has conflated low risk with risk.

Assessment with risk reduction and risk is a very individualized characteristic, as is evidenced by NCCN and other guidelines in the system in.

You see the proposed definition by by Mold X contractors for sufficiently low risk appears very arbitrary, very inconsistent with not just guidelines, but what we do as practicing physicians every day.

Again, we we in all our decisions, what's low risk for one patient may not be low risk for another and it's not necessarily about age or life expectancy. Some 40 year olds have various tolerance and don't have the time energy.

Or the desire to undergo radiation therapy for not just a high risk disease and vice versa. People that don't have any risk tolerance for low risk disease may choose to have radiation to lower their risk when I look at.

You can go to the next slide please. When I look at the coverage indications on the LCD, I'm struck by how we are taking and I think Dan touched on this taking decision making power away from the patients to think that.

In order to run a test that provides risk assessment and provides radiation therapy benefit or lack thereof to ask those patients make a decision to not be in consideration of a mastectomy or to have formulated a treatment plan and consented.

To use prior to having all the information that they need to make those decisions to me is just ludicrous. It takes the decision away from the patient and makes it someone authoritarian and bring just back really the dark days of medicine where physicians are telling patients what they should.

To do and what they shouldn't do, need to do X in order to get Y or they need to agree to this treatment in order to run this test regardless of the results. It just seems very ludicrous to me. When you look at this slide, you see that this decision RT is being used.

In clinical practice, there is clinical utility. The continuum of the results is very important as we make decisions with our patients. For instance, when you see patients or in the low risk group or in your just above low risk and the decision score maybe a little over 3, maybe between.

Three and five, they get benefit from radiation therapy, but they don't get a huge benefit and so that that comes into play with decisions. Also you see that almost 30% of patients are still getting radiation therapy in the low risk group. This is part of shared decision making.

For certain patients who want to give themselves every opportunity to lower their risk as low as they can get it, I was struck by listening to some people on in the CAC still keep commenting on 5050% benefit overall for radiation therapy in in doctor carcinoma.

To when for big groups that's not everyone benefits 50 and these genomic tests have been enabled us to tease out which patients are going to get a huge benefit, which patients are not going to get that big benefit. And this is parallel to what we've seen in invasive breast cancer.

With genomic testing and chemotherapy, there was some pretty strong comments about the harm we've done to patients with chemotherapy for a 3% benefit prior to genomic testing. And I think the same thing for as a physician and a surgeon who sees these radiation complications.

There is no reason to be radiating some of these patients for a disease that really is a high risk marker. These patients would never progress to invasive breast cancer. Many of them would never recur and when we get a low risk result.

And we have an invasive recurrence risk of three or 5%. We don't radiate patients on the street who are walking around with a recurrent with a breast cancer risk of 12%. We're not pulling everyone in and radiating them. So this test has had great clinical utility for us as practice.

Physicians has enabled us to give our friends more precise information about what their recurrence risk is, what their invasive recurrence risk is, and what the benefit of radiation therapy is to them. Next slide.

So again, just to to go through this cut off and risk stratification and identification of quote low risk DCIS just ignores all the evidence that's out there and furthermore it ignores what we utilize as as physicians who see these patients every single day.

And I would just like the, you know, the contractors to to explain how they came up with this definition of sufficiently low risk, how they created this definition of sufficiently low risk in in.

And ignored really all the other that's out there. There is no clear definition of low risk because low risk means different things to different people, but when you can put numbers to a risk recurrence.

Recurrence risk. You can get some input from the patients. You can not just use clinical factors with that, but you can use life expectancy, comorbidities, et cetera, et cetera, in order to make proper decisions for patients.

So just to to finish, I think if we're going to use clinical pathologic factors like we see in the Sloan Kettering nomogram, like we see in Van Nuys criterion, this is basically a throwback to the 1980s and 1990.

And the way we use CIS, we are necessarily going to be radiating people that don't need it. It's unfortunate for the doctors. It's unfortunate for the system that's going to spend way more money than we have to. We can pick out patients that don't require radiation therapy and it's most unfortunate for the.

We're going to suffer some of them long-term complications from the radiation therapy, sometimes barbaric complications when we see burning and moon breakdown and et cetera, et cetera. And this leads essentially and historically to massive.

Massive overtreatment of a disease that doesn't kill anyone in the long run. Again, not every DCIS patient is going to progress to breast cancer. What we've learned from these genomic studies.

Is that DCIS is not necessarily an early invasive breast cancer. It's a different disease that needs to be treated differently with a different set of biomarkers and a different attitude. We cannot conflate invasive breast cancer in DCIS.

We have to treat it differently. We have to approach it differently and we have to use these these new biomarker tests, these new genomic studies, just like we did in invasive breast cancer. There was this pushback back then 20 or 25 years ago. We need to avoid that.

We need to get with the program here and and make sure we're not over treating all these women. I think all I really have to say at this point.

**MEREDITH LOVELESS 40:48**

Thank you very much. We appreciate your presentation.

And we'll be moving to our final presentation.

Doctor Patel.

**Rakesh Patel MD 41:08**

Yeah. Hi, everybody. Can you hear me OK?

**MEREDITH LOVELESS 41:12**

I can hear you well.

**Rakesh Patel MD 41:14**

OK, awesome. Thank you. My name is Rakesh Patel. I'm the chair of the Radiation Oncology program at Good Samaritan Hospital in Los Gatos, CA. I also am the chair of the NAPBC program, the high-risk program, as well as the Multidisciplinary Breast Tumor Board.

With many of my providers at Stanford and UCSF and other places, and I think this question really boils down to one of an incredibly common tumor board case. Few of the principles that need to be considered is many of the physicians and I think many patients are subject to.

Biases of guidelines, of algorithms, of nomograms, essentially rules of thumb that allow us to treat most of the patients along a certain pathway. And I think that the whole concept of staging, which largely looked at tumors, nodes, metastasis, anatomic clin path factors.

Including an individual's age is hard to shake because it gave us a nice boundary condition of how

most patients should be treated. The challenge in today in 2025, and has been this way for two decades, is that we don't treat cancer, we treat people. In fact, age 70 in many parts.

Of the world and certainly my neighborhood is the new 55. Age 80 is the new 65. And frankly, even the NCCN staging guideline itself discounts TNM as the only way to stage a patients. We know patients that biology matters. It has impacted every aspect.

The multidisciplinary oncologic care. We do not give chemotherapy typically without looking at the genomic profile and the biosignature. We do this at core biopsy even to plan surgical planning nowadays, whether we give chemotherapy prior to surgery or not.

The bottom line is treating on based on nomograms that are largely based on clinical factors alone or TNM stage is frankly old fashioned. Patients deserve better and clinicians have to use biology in order to make decisions and patients deserve it and it just.

We're good. I'm going to show you that we're wrong half the time and so we can't rest on these kind of classic factors. It's really pre Internet medicine in my opinion. Let's go to the next slide. Here's the scope of the problem. The challenge as a radiation oncologist and I think as a community is that.

Even when you look at these traditional factors that we utilize in the in the statement talks about which enomograms roll up, things like a patient's age where 70 was considered elderly, things like grade looking at lower grade patients, smaller lesions and wide margins.

We see that radiation continue to decrease the risk of local recurrence. This is RTOG 9804. This was done a long time ago and this kind of the gavel kind of struck saying that hey, all patients with these guys are going to have some local recurrence.

Advantage. And again, this is statistically significant, but clinically not super useful. And the reason is we don't look at an individual's clin path factors alone to make these decisions. Oftentimes we don't even see these patients and there are patients that we're going to overtreat and patients that we're going to undertreat.

And patients life expectancy is way beyond, you know, what used to be a few years for elderly patients and so on. So I'm going to walk you through the data. One of the challenges that I think I as I read the LCD and listen to all the debate commit and the jump ball decisions here is the LCD.

OCD it when I read it, it feels as a radiation oncologist as if there was only partial amount of information available at the time that this report was driven. And it's clear based on even dates of kind of July 15th, July 17th that a very important study that addresses a very issue.

That the current statement undermines was published a day or two afterwards, and so my ask is to reconsider. Look at all the information now available, which unequivocally talks about the fact that if you apply your experience, apply guidelines, apply nomograms, you're going to get it wrong.

Patient.

Are going to be underserved, overtreated or undertreated, which is the goal of our, you know, not just shared decision-making, but personalized treatment approaches oncologists today. Next slide. So here's the study. I ask you to consider this in your data. This is a hot topic around multidisciplinary cancer care today. This will be.

Featured at our upcoming meeting, as you know, Dan mentioned, this was dropped just days after the current version of the LCD. It actually addresses exactly the thing that the statement says around the value of nomograms, that there's no compelling data that's no longer true.

And this has to be considered. Red Journal is the top journal within my field of radiation oncology. It is also a multidisciplinary journal and this will be the context of our upcoming national meeting in my neighborhood in the next couple months around leveraging biology and how it Trump's TNM staging.

Everyone, the authors are here are kind of the leaders around multidisciplinary. Many of them are recognized names. They write the textbooks. It draws water. This incredibly well conducted study in my opinion. Next slide. So here's what we know. 9804 actually, if you look across the board, we have nomograms.

We have cooperative group studies in 9804 and we have these biologic signatures and the goal I think for all of us is appropriate treatment. It's not undertreatment and de-escalation or overtreatment unnecessarily leaning into fear. It's about giving the right patient the right treatment at the right time based on.

Measure that we could collectively come up with in systemic therapy. That's freedom of distant metastasis and survival. In local therapy, it's not having to deal with it again or having to go

through additional surgery or radiation. It's local control.

All of these methodologies talk about a quote, low risk cohort. Dr. Pelicane and others have talked about the threshold requirement of absolute risk reduction or what low risk means. Low risk. Actually, I'll tell you what it means when I sit with patients in consultation.

It means that the patient trusts the clinician to be able to claim it is to avoid radiotherapy to meet the highest level of control and quality of life. In order for me able to say that I need all the tools in my toolbox to fully understand if the patient's going to have.

Have a likelihood of recurring or not, and I can't point to nomograms that were developed over 20 years ago. And so from my perspective, I feel like I need all of the information to be a steward and help patients make the right decision for them today.

Biology. I would never incorporate A multidisciplinary high-quality plan for either systemic or local therapy without understanding the biologic likelihood of benefit or the safety of ignoring treatment. And so as we delve into this, yeah, nomograms identify a low risk, but they don't tell you who's going to benefit.

And not benefit. And I think that's really the crux of the argument today and some of the challenging challenge that you're having from many experts around the around the country around the way it's currently written today. It has to do with the threshold of what you're calling low risk and does that really matter and is that clinically useful and why it may be wrong in certain cases.

Cases as well as the criteria of qualifying for this to be a useful test and some of the words that were utilized. So again, next slide, as you think about this, this paper, which again I think has to be considered, it took a look at the patients in this study that we look at around patients.

Patients that did not get radiation followed them over time, the ones that we deem at low risk and all of us agree based on clinical pathologic features, these are the most favorable patients. And then what we did is we ran the biologic signature, the decision RT test in the 51% of patients that were truly low risk and compared them whether they.

They had radiation or not. OK. And so again in 9804, they said all patients had a 50% reduction of radiotherapy and I can see why that would be, you know, utilized as kind of the standard of care, which was for a long period of time.

Next slide. But if you take these low risk patients and you look at the biology, what you find is that we get it wrong. And in fact if you over half of the patients that are low risk were actually reclassified to molecular high risk.

And what that means, again, half the time patients are biologically higher risk than any of us would have predicted, including the patient. They're walking around thinking, oh, it's safe, I can avoid something. I can avoid this completion of my definitive treatment course of radiation because I'm low risk.

I don't have any of those bad factors that we use that we grew up on. Well, it turns out it's untrue. Now the second round of questions is So what? You have a higher your higher molecular profile. Does it translate to any difference if you go to the next slide?

Well, it turns out this study looked at that. And So what it shows that these patients actually did benefit from radiotherapy. If you look at the patients that had a high biologic signature despite being deemed low risk where a physician or a patient may walk.

Away thinking that radiation can be safely avoided, it turns out that's not true. These patients that have a high molecular risk profile continue to have a statistical and more importantly A clinical benefit of radiotherapy and it's a one that lasts over time. And so from my perspective, you can this is not a test.

Only for de-escalation and avoiding radiation, which I agree with is appropriate, but it's also for making sure that patients are appropriately risk stratified when they have all the information on whether to pursue the benefit of radiotherapy or not. You're going to be leaving at least half these patients in the low-risk category out from potential.

Radiation that will have a meaningful impact in their outcome. Next slide. So as you continue this journey and look across the board, you're also going to identify a patient, half the patients that are appropriately low risk and these patients don't have any benefit from radiotherapy.

That helps us as well because if many in many institutions or protocols that we're going to treat all DCIS patients and we're only going to look at the data that's convenient for us, we're going to ignore the data that doesn't matter. The harm of policies like these is they end them finding their way in the mainstream and.

We want to have this information to let the biology drive decisions for even patients that we want to safely de-escalate and give Peace of Mind to the patient as well as comfort to the physician and the multi-d team saying that molecular low risk is actually a low risk cohort unlike the low risk.

Defined by nomograms or Van Nuys, memoriso cladding or other kind of clin path factors that we grew up on. Next slide. So as you kind of think through this and you look, Dan already showed this data, but again we have whether no matter what you're looking for in terms of.

Classifying this low risk, you now have patients that would be undertreated without this decision RT. So that's one summary statement. If you ignore biology, you are going to undertreat patients. Next slide. The flip is also true. This is not just about avoiding radiation. It's a fact is that in patients that have clin path.

High risk, whether it be by nomogram or standard worry like a young patient, close margin, high grade, actually some of those patients can safely avoid radiotherapy. And so you're having a large number of patients that get risk stratified down shifted from high risk clin path to decision.

Low risk. So the punch line of this is that if you try to come up with a treatment plan as a clinician team or as an individual, a patient or together, and you don't use biology, there's a high likelihood you're going to get it wrong.

If you apply Clin Pat factors, you're using old fashioned rules of thumb and there are not relevant in 2025. I carry this argument to post mastectomy radiotherapy. I carry this argument to neoadjuvant.

Radiation after neoadjuvant radiotherapy, even after lumpectomy. We know that patients that were shoe-ins for chemotherapy, meaning no positive disease, can now safely avoid chemo, the cost of chemotherapy, the toxicity of chemotherapy, the burden of chemotherapy despite having no positive disease.

The same thing can happen here with radiotherapy. We can avoid the cost of radiation, the toxicity of radiation and frankly any clinical benefit of radiation by by doing this test and therefore it is a cost effective test. It's a clinically useful test.

From my perspective, those should be the metrics of approval. It's medically necessary in our decision making. We do not treat DCIS or invasive disease without looking at the biology of a multidisciplinary team. And so I'm a little surprised and unfortunately disappointed this is going.

To result in patients not receiving the information to make a smart decision for their best outcome.

Thank you.

**MEREDITH LOVELESS 55:23**

Thank you for your thorough presentation and I I just want to thank all of our presenters for taking their time today to to be on the call with us and I just want to.

**Rakesh Patel MD 55:26**

Sure.

**MEREDITH LOVELESS 55:39**

Remind everyone that we do need the written comments. I I understand there was some folks in the attendees that were interested in presenting and presenters in for any future meeting. It's all outlined on the CGS website.

With how to submit a presentation and the deadlines for that, we cannot have any presentations.

On the call without that pre-approval because we need to have conflicts of interest forms in advance, but the written comments are equally important, so we encourage anyone who has additional comments to submit the written comments. Again, the preferred method is to submit them to cmd.inquiry@cgsadmin.com.

And they we can accept comments up until August 31st at and so we'll look forward to receiving those comments as well. And I thank everyone who joined us and for your attention today and.

Now that we've concluded our presentations, we will conclude our.

Our open meeting.

Thank you everyone for joining us.