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

Meeting Date & Time: October 20, 2026, 4 pm ET (3 pm CT)
Topics:

- Real-Time Fluorescence Wound Imaging for Bacterial Presence (Moleculight) (DL40468)
- Near Infrared Spectroscopy (NIRS) in Wound and Flap Management (DL40466)

CURTIS MCFADDEN 0:06

Good afternoon, everyone. This is Curtis McFadden with Provider Outreach and Education. I am the producer for today's session.

We will begin promptly at 4:00 p.m.

Good afternoon again. This is Curtis McFadden with Provider Outreach and Education. I am the producer for today's open meeting.

At this time, I will turn the floor over to our Chief Medical Officer, Dr. Earl Berman, who will lead today's meeting.

Dr. Berman, the floor is yours.

EARL BERMAN 3:58

Thank you so much, Curtis. I appreciate it.

I would like to welcome everyone to our October 20 Open Meeting. We have two policies that we will be discussing today.

Curtis, there you go. Thank you.

First, I would like to mention the disclaimer. As we all know, Medicare policies can change frequently. However, at the time this PowerPoint presentation was prepared, all information was current and accurate. This disclaimer simply acknowledges that changes may occur after publication.

Next slide, please.

Today, there are two LCDs for discussion, and we have a large number of presenters. Therefore, I will keep my remarks brief, as the primary purpose of this Open Meeting is for the CGS team to hear the presentations and discussion in advance of receiving your formal written comments.

I want to ensure that everyone presenting understands that we look forward to receiving written comments through the designated comment process. We have already received a number of comments over the past several days. I have noticed that some appear to be AI- or bot-generated. The reason I say this is that several comments referenced a procedure as an "AD junk," which appears to be an incorrect rendering of the word "adjunct." I do not believe that any presenter today, or anyone authoring an independent comment, would have intended that wording.

We appreciate all comments and will address them in the required Response to Comments article, as outlined in the Program Integrity Manual (PIM). Similar comments may be grouped together and addressed collectively in the response document.

I also want to emphasize that we read every comment that is submitted. Organized comment-writing campaigns are appreciated, as they demonstrate the level of interest and importance stakeholders place on these issues. However, AI-generated or bot-generated comments can sometimes appear less professional than comments that are individually authored.

I simply wanted to offer that observation as a topic for consideration.

Today, we have two proposed LCDs for discussion. The first is Real-Time Fluorescence Wound Imaging for Bacterial Presence. This is a National Workgroup policy.

To be clear, this is not an NCD. An NCD originates from CMS and follows an entirely different

© 2026 Copyright CGS Administrators, LLC.

process for development, research, review, and implementation.

This policy is an LCD. Each MAC maintains an independent decision-making process regarding whether to participate in, adopt, and implement LCDs developed through the National Workgroup process.

The National Workgroup process allows subject matter experts to present information to a group of medical directors representing multiple MAC jurisdictions, rather than presenting separately to each individual MAC.

The two policies under discussion today are:

Real-Time Fluorescence Wound Imaging for Bacterial Presence

Near-Infrared Spectroscopy in Wound and Flap Management

Both are National Workgroup policies, and both currently propose noncoverage for the services represented by these policies.

Next slide, please.

The comment period for these policies runs from October 1, 2026, through November 14, 2026.

We strongly encourage you to submit comments using the designated email address listed on the slide: CMDInquiry@cgsadmin.com.

Some comments have been sent directly to my email address because it is listed within the policy documents. That is perfectly acceptable. When I receive those comments, I forward them to the CMD Inquiry mailbox so they can be processed through the official draft LCD comment process.

Either method is acceptable. However, when I am traveling for work, it may take several days before I can review my inbox. For that reason, the most efficient option is to send comments directly to the CMD Inquiry mailbox.

The submission form provided on the website makes the process straightforward, and that mailbox is actively monitored by both primary and secondary staff members on a regular basis.

If you wish to submit supporting literature, please provide it in the form of a full-text PDF. We can only accept published literature. Presentations, unpublished abstracts, and similar materials cannot be considered under the LCD development process established by CMS and adopted by the MACs.

Next slide, please.

This slide provides additional information. We will remain here briefly while I review the presentation process.

We have eight presentations scheduled today. Presentation time is allocated by dividing the total time available for presentations by the number of presenters. As a result, each presenter has been allotted five minutes.

Curtis has copies of the presentations that were submitted and approved for today's meeting. He will control the slides. Presenters simply need to indicate when they are ready to move to the next slide.

Curtis is very experienced in managing these presentations, and we will closely adhere to the schedule. A timer will be displayed on the screen, and we ask that all presenters respect the allotted time in consideration of the other speakers.

For informational purposes, the presentation order will be:

- Dr. Wendy Cole
- Dr. Brock Liden
- Dr. Jeffrey Niezgoda
- Dr. Marlene O'Brien
- Ms. Crea Pinto
- Maura Sixtus
- Stephanie Waffle
- Dr. Julie Wright

I wanted to review this sequence so everyone is prepared. When Curtis displays your presentation, we will ask you to begin promptly, and we will adhere to the allotted time.

Next slide, please.

© 2026 Copyright CGS Administrators, LLC.

This summary page provides information about how to access the Draft LCD Comment Form and where to submit it.

Our preferred method is submission through the CMD Inquiry mailbox. However, comments may also be submitted by fax using the designated cover sheet referenced on this slide, or by regular mail.

Yes, we do still receive postal mail at our office.

Next slide, please.

We will now begin the presentations.

Our first presenter is Dr. Wendy Cole from Kent State University College of Podiatric Medicine.

Curtis, if you would please display Dr. Cole's presentation, we will ensure she has speaking privileges and then get started.

CURTIS MCFADDEN 13:04

Okay, not a problem.

Give me one second while I pull that information up.

Also, let me give Dr. Cole speaking privileges.

Dr. Cole, I have enabled your microphone privileges. You should now be able to speak from your end.

Could you please test your microphone for me so we can make sure everyone can hear you?

You may need to unmute yourself.

EARL BERMAN 13:44

While that is being set up, I'd like to remind everyone that all speakers were required to submit a Conflict of Interest Disclosure Form.

Rather than reading those disclosures myself, I ask that each presenter briefly state any conflicts of interest they may have. If you have no conflicts to disclose, please simply state that you have no conflicts of interest.

Okay, Dr. Cole, we can hear you.

Windy Cole DPM 14:06

Can you hear me now?

Yes. Can you hear me now? OK.

EARL BERMAN 14:08

Yes, ma'am.

Windy Cole DPM 14:09

Excellent. Can you bring up my slides please?

CURTIS MCFADDEN 14:12

Yes, I am in the process of doing it right now.

Windy Cole DPM 14:15

Thanks.

CURTIS MCFADDEN 14:16

Okay, one second.

Let me close that and start the slideshow from the beginning.

Oh, that's the wrong presentation. I apologize.

There we go.

Starting the slideshow from the beginning.

Give me one moment while I bring up the timer.

Unfortunately, the timer will need to remain as a floating window. I wish there were an easier way

© 2026 Copyright CGS Administrators, LLC.

to integrate it into the Teams display, but it will float on the screen so that everyone can see it as we proceed.

Windy Cole DPM 14:54

Okay, I'll get started.

My name is Dr. Wendy Cole, and I am a podiatrist. I have practiced in Northeast Ohio for nearly 25 years and currently serve as the Director of Wound Care Research at Kent State University College of Podiatric Medicine.

I was an early adopter of both of these imaging technologies and have extensive experience using them. I will briefly discuss that experience today.

Next slide, please.

We face many clinical challenges when caring for patients with hard-to-heal and chronic wounds. To support better outcomes, we need improved diagnostic tools that help us tailor treatment plans to individual patients.

Chronic wounds often fail to heal for a variety of reasons, including inadequate tissue perfusion, excessive biofilm formation, and high bacterial burden. Unfortunately, clinicians do not always recognize these factors as causes of delayed healing or clinical deterioration, which can ultimately lead to infection, hospitalization, or amputation.

Advanced imaging technologies provide valuable visual cues that may reveal early signs of hypoxia, chronic limb-threatening ischemia (CLTI), and elevated bacterial burden. As a result, clinicians can adjust treatment plans sooner, avoid unnecessary therapies, such as inappropriate use of oral antibiotics, reduce the risk of antimicrobial resistance, and hopefully prevent serious complications.

These technologies can significantly affect patient management and clinical decision-making.

Next slide, please.

I would like to share a few patient cases from my practice.

I have been using these technologies for nearly a decade in both my research clinic and private practice.

First, regarding fluorescence imaging, I participated in the pivotal FLAAG trial that supported FDA clearance of this device. After serving as a principal investigator in that trial, I began incorporating the technology into routine clinical practice because it helps detect bacterial burden at clinically significant levels, generally at 10^4 colony-forming units or greater.

My goal is to identify bacterial contamination before patients develop infections, require systemic antibiotics, are hospitalized, or need surgical intervention or amputation.

The cases shown on the screen illustrate this point.

The first case involved a patient with a lower-extremity wound that had been progressing well toward healing. However, the wound suddenly stalled and began increasing in size. There were no obvious clinical signs or symptoms of infection on examination. When fluorescence imaging was performed, a characteristic starburst pattern revealed bacterial presence within the wound and surrounding periwound tissue.

This finding allowed me to promptly treat the patient with a short course of oral antibiotics and antimicrobial dressings, helping to prevent more serious complications.

The second case involved a patient whose wound had failed to progress despite regular debridement. Fluorescence imaging identified substantial bacterial burden in the periwound area, which required targeted treatment before the wound could proceed toward complete healing.

Next slide, please.

I also conducted a case study demonstrating that fluorescence imaging can effectively guide wound hygiene and debridement.

The key finding from that publication, which is cited on the slide, was that wounds did not enter a healing trajectory while significant fluorescent bacterial signal remained.

The study showed that using fluorescence imaging to guide debridement was a critical component of successful wound management.

Next slide, please.

© 2026 Copyright CGS Administrators, LLC.

I also use near-infrared spectroscopy extensively to assess local tissue oxygenation and perfusion in patients. This technology assists with surgical planning, treatment selection, and ongoing monitoring.

In addition, it can identify microcirculatory abnormalities in patients with diabetes, which was the focus of the published case study referenced on this slide.

Next slide, please.

This case demonstrates a situation in which traditional noninvasive vascular studies were not particularly helpful in guiding treatment decisions.

However, near-infrared spectroscopy provided valuable information regarding tissue perfusion and showed that the patient's treatment plan was producing positive results. Continued monitoring supported clinical decision-making, and we were ultimately able to salvage the limb, despite initial consideration of amputation by vascular surgery.

This case was also published.

I believe I am out of time. Thank you.

CURTIS MCFADDEN 20:08

Yes, ma'am. You are out of time.

EARL BERMAN 20:10

That is very interesting. Thank you so much for that presentation.

Curtis, our next presenter is Dr. Brock Liden. I hope I am pronouncing your name correctly.

CURTIS MCFADDEN 20:24

Okay, one moment while I enable his microphone.

Dr. Liden, let's see

EARL BERMAN 20:45

About this under attendees, he's by the 6th one down.

CURTIS MCFADDEN 20:50

I have just enabled your microphone.

Dr. Liden, you will need to unmute yourself on your end so that we can hear you. Your microphone privileges have been enabled.

Brock Liden DPM 20:58

Hello, thank you very much.

No conflicts of interest.

CURTIS MCFADDEN 21:02

OK.

Brock Liden DPM 21:03

These aren't my slides.

CURTIS MCFADDEN 21:05

Give me one second.

Brock Liden DPM 21:09

Good afternoon. My name is Dr. Brock Liden. I have been a practicing podiatrist for 27 years and have been involved in limb-salvage clinical research for most of that time.

Like Dr. Cole, I have been an early adopter of these technologies and began incorporating them into clinical practice soon after they became available.

Next slide, please.

We recently published what I consider a premier algorithm for integrating point-of-care technologies into the treatment framework for patients with chronic wounds.

The algorithm helps clinicians identify barriers to healing, evaluate wound response over time

© 2026 Copyright CGS Administrators, LLC.

through serial imaging, modify treatment plans when appropriate, and support objective clinical decision-making at the point of care.

The publication, known as the PRISM framework, illustrates how near-infrared spectroscopy, bacterial autofluorescence imaging, and thermal imaging can be integrated into clinical decision-making pathways for wound treatment.

Next slide, please.

This publication was recently published in the Journal of Wound Care.

Next slide, please.

One important aspect of wound bed preparation is the ability to use point-of-care technologies to visualize bacterial burden in real time. Clinicians can identify bacterial levels at or above 10^4 colony-forming units and make informed decisions regarding debridement using the Dr. Abdo Scale, which I will discuss shortly.

These technologies also support decisions regarding antibiotic selection and vascular assessment pathways. Bacterial fluorescence imaging provides a clear and immediate pathway for clinical decision-making.

Under traditional models, providers often wait days or even weeks for culture results, depending on institutional processes. With point-of-care technologies, we can observe wound changes immediately and respond much more quickly.

I believe point-of-care diagnostics are becoming the standard of care in wound management. These technologies help prevent progression to complications ranging from digital amputations to major limb loss.

Next slide, please.

The PRISM framework focuses on several key areas.

First is perfusion. Using near-infrared spectroscopy, we can assess tissue oxygenation and quickly determine whether a patient has impaired vascular flow.

Depending on the findings, patients may require anything from additional vascular testing to immediate referral for vascular intervention if significant ischemia is identified.

Second is regional bacterial status. Bacterial autofluorescence imaging can immediately identify clinically significant bacterial burden and help guide treatment decisions.

In addition, serial imaging allows clinicians to assess whether bacterial burden persists following debridement. If fluorescence remains present after treatment, the clinician can continue intervention or modify the treatment plan accordingly.

This level of real-time assessment is not readily achievable through other methods, making these technologies valuable tools in limb-salvage efforts.

Another component is infection staging, which incorporates the Dr. Abdo Scale. This recently published scale helps determine appropriate clinical actions based on the severity of bacterial burden and infection risk.

The framework also addresses structural correction. A related publication, known as the VISTA study, highlights the importance of correcting biomechanical deformities. Without addressing underlying structural issues, wounds often recur, reopen, and may ultimately lead to amputation.

Finally, the framework emphasizes maintenance and monitoring. Long-term surveillance using spectroscopy and thermal imaging can identify changes, such as temperature increases of approximately 2.5 degrees, that may signal impending wound recurrence or breakdown.

Next slide, please.

This slide shows a poster presentation that was presented at the Journal of Wound Care meeting in St. Louis. The images demonstrate tissue oxygenation measurements obtained through near-infrared spectroscopy and illustrate areas of reduced perfusion within the wound bed.

Next slide, please.

This slide provides an overview of the complete PRISM framework and incorporates the Abdo Scoring System.

For optimized wounds, clinicians can continue the current treatment pathway. When increased bioburden is detected, interventions such as cleansing, debridement, and antimicrobial therapies

© 2026 Copyright CGS Administrators, LLC.

may be initiated.

If perfusion deficits are identified, revascularization may be necessary. Patients with the highest severity scores require urgent intervention, including hospitalization and involvement of vascular surgery, infectious disease specialists, and other members of the multidisciplinary team.

This approach represents the standard clinical pathway for managing high-risk patients.

Next slide, please.

In closing, we believe these point-of-care technologies should remain covered services.

These tools are critical to advancing wound care and limb-salvage efforts. Loss of access or reimbursement for these technologies would significantly hinder our ability to provide optimal care for these patients.

I believe I am out of time. Thank you.

EARL BERMAN 26:39

Thank you very much for that presentation.

Please make sure that all of these comments, observations, and supporting information are included in your written comments and submitted to us. This is very important information, and we appreciate your input.

Thank you again.

Curtis, our next presenter is Dr. Jeffrey Niezgoda.

CURTIS MCFADDEN 27:07

Dr. Jeffrey, I have just enabled your microphone.

You should now be able to speak. Please unmute yourself on your end so that we can hear you.

Jeffrey Niezgoda MD 27:10

I'm on. Can you hear me?

CURTIS MCFADDEN 27:12

Yes, Sir, we hear you.

Jeffrey Niezgoda MD 27:14

Right. I appreciate.

CURTIS MCFADDEN 27:15

Give me. Give me one second while I pull up your slides.

Jeffrey Niezgoda MD 27:18

Thank you. I appreciate the opportunity to speak before this panel today.

There is my PowerPoint. Great.

My name is Dr. Jeffrey Niezgoda, and I serve as the Chief Medical Officer for Kent Imaging. That is my disclosure. I am also a past president of both the American College of Hyperbaric Medicine and the American Professional Wound Care Association.

Like Dr. Cole and Dr. Liden, I have used these imaging technologies for many years. These devices have fundamentally changed my practice and are now an integral part of how I manage patients. I would like to speak to that experience today.

Next slide, please.

I would like to call everyone's attention to the following request.

Next slide, please.

We respectfully request the withdrawal of both proposed noncoverage LCDs, as well as the continuation and expansion of current coverage policies. The policies in question are listed on this slide.

Next slide, please.

I would also like to bring the following matter to the attention of CMS.

© 2026 Copyright CGS Administrators, LLC.

I was surprised to see the rationale presented on the website in support of these proposed noncoverage determinations. As shown here, the requester identified in the document appears to be me.

In my opinion, the information submitted has been misunderstood and misinterpreted. I would like to show the panel the letter that has been cited as part of the basis for these proposed noncoverage policies.

Next slide, please.

Next slide, please.

This is a copy of the letter we sent to Palmetto in August 2025. If you review the letter, you will see that we were not requesting the removal of coverage. Rather, we were requesting that Palmetto retire its existing noncoverage LCD.

At the time, Palmetto maintained a noncoverage policy, and following discussions with them, we submitted this letter requesting that the noncoverage determination be withdrawn.

Next slide, please.

During that meeting, we specifically requested that Palmetto retire its noncoverage LCD for near-infrared spectroscopy (NIRS).

There was no mention of bacterial autofluorescence imaging or real-time fluorescence wound imaging (RTFWI) in that letter.

We explained to Palmetto that it was the only MAC with a noncoverage LCD for NIRS. Other MACs, including First Coast, Novitas, and Meridian, had adopted temporary T-codes and established pathways recognizing its use.

We also noted that CGS and NGS had assigned contractor pricing rates and pointed out that several MACs had expressly recognized NIRS as an acceptable alternative to ankle-brachial index (ABI) testing in appropriate circumstances.

That is what was contained in the letter, and it is the document that appears to be cited in support of these proposed noncoverage policies.

Next slide, please.

As shown here, multiple MACs have issued statements acknowledging exceptions to ABI testing requirements and permitting alternative methods, including NIRS, in appropriate clinical circumstances.

These statements reflect recognition of the role NIRS can play in patient management.

Next slide, please.

When discussing perfusion assessment, MACs have also recognized the importance of evaluating vascular status, detecting infection, and addressing factors that affect wound healing and patient outcomes.

These concepts have been reflected in previous policy discussions across multiple MACs.

Next slide, please.

I would also like to reference recent publications.

This article, published in the International Journal of Tissue Repair and Regeneration, discusses the role of NIRS and the identification of infection as important components of patient management.

Next slide, please.

We know that assessing vascular status, improving tissue oxygenation whenever possible, and managing bioburden are critical components of successful wound healing.

Next slide, please.

It would be difficult to manage a patient with a fracture without obtaining an X-ray.

Similarly, limiting access to imaging technologies that support clinical decision-making can restrict a clinician’s ability to fully evaluate and manage a patient.

These technologies provide information that cannot otherwise be directly visualized. NIRS helps clinicians assess tissue oxygenation, while bacterial fluorescence imaging helps identify clinically

© 2026 Copyright CGS Administrators, LLC.

significant bacterial burden.

Both technologies contribute valuable information to the clinical decision-making process.

Next slide, please.

NIRS and bacterial fluorescence imaging have applications throughout the continuum of wound care management.

Next slide, please.

This is the PRISM algorithm that Dr. Liden discussed earlier.

The framework was recently published, and we intend to submit a copy as part of our written comments.

Next slide, please.

The PRISM framework helps clinicians understand how both NIRS and bacterial autofluorescence imaging can be incorporated into a structured approach for managing patients with complex wounds.

These technologies provide objective information that can assist in assessment, treatment planning, and ongoing patient management.

Next slide, please.

CURTIS MCFADDEN 32:42

Unfortunately, doctor, that is your time.

EARL BERMAN 32:47

Thank you, Dr. Niezgoda. Again, I appreciate your presentation.

I also appreciate your commitment to submitting the PRISM study, and I note that you are one of the co-authors. We look forward to reviewing both the study and your written comments.

The next presenter will be Dr. Marlene O'Brien.

Once your presentation has been pulled up, Curtis will provide you with speaking access.

CURTIS MCFADDEN 33:45

Doctor O'Brien, you should be able to unmute yourself from your end now.

Marlene OBrien MD 33:47

OK.

Great. Thank you so much.

CURTIS MCFADDEN 33:49

There you go.

Marlene OBrien MD 33:50

Thank you for the opportunity to present today.

My name is Dr. Marlene O'Brien, and I serve as the Chief Medical Officer for Vohra Wound Physicians, the largest wound care practice serving skilled nursing and long-term care facilities in the country.

I would like to briefly discuss our experience with this technology. We have more than 300 providers nationwide using it in clinical practice, and we have found it to be extremely valuable for our patients, many of whom have limited treatment options.

I believe this technology is particularly important in the nursing facility setting because of antimicrobial stewardship efforts. Real-time fluorescence imaging has helped reduce the number of antibiotics we prescribe by allowing us to make more informed treatment decisions.

Next slide, please.

This is how we incorporate real-time fluorescence imaging into our wound care workflow.

When patients are admitted from the hospital, we image their wounds to establish a baseline assessment. This allows us to identify bacterial burden that may not be visible during a standard clinical examination.

© 2026 Copyright CGS Administrators, LLC.

Understanding whether bacterial burden is present helps us determine the most appropriate intervention, whether that involves targeted cleansing, debridement, or modifying the treatment plan. In the long-term care environment, this information can help prevent wound deterioration and improve outcomes.

When fluorescence imaging identifies bacterial burden, we can monitor it over time through serial imaging and determine which wounds are at increased risk. In some cases, cultures may still be obtained, but more often than not, imaging provides sufficient information to avoid unnecessary cultures and antibiotic prescriptions.

For that reason, I have found this technology particularly valuable in the nursing home setting.

Next slide, please.

Diabetic wounds, in particular, are a key area of focus.

The earlier we identify bacterial burden, the earlier we can intervene. As we know, diabetic wounds can deteriorate rapidly in nursing home populations if left untreated, leading to hospitalization, sepsis, and limb loss.

In our experience, bacterial fluorescence imaging has led to fewer wound cultures, reduced antibiotic prescribing, and fewer hospitalizations for wound infections. By identifying bacterial colonization earlier, we can intervene before the wound progresses to clinical infection.

Next slide, please.

One of the most valuable aspects of this technology is identifying what may be missed through visual assessment alone.

Advance slide.

Specifically, it helps identify hidden bioburden.

Understanding where bacterial burden is located also improves debridement planning. Rather than debriding an entire wound, which may be painful for the patient, I can target treatment toward the specific areas demonstrating bacterial fluorescence.

This allows for a more focused and patient-centered approach.

Advance slide.

Another benefit is avoiding the wrong treatment at the wrong time.

I do not want to apply advanced wound care products to a wound that is not yet adequately prepared. If fluorescence imaging is positive, I would first address the local wound environment before initiating treatments such as collagen dressings, negative pressure wound therapy (VAC therapy), or skin substitute applications.

It is important to ensure that the wound bed is properly prepared, and that cannot always be determined through visual examination alone.

In addition, changes in imaging patterns provide objective data that help guide decisions about culturing wounds, escalating care, or modifying treatment plans.

Next slide, please.

When imaging is positive, we can respond with targeted cleansing and debridement.

If imaging is negative...

Advance slide.

...we gain confidence that the current treatment plan remains appropriate.

A negative image provides reassurance that the wound is progressing as expected and allows us to continue with the existing treatment strategy.

Next slide, please.

This case involves a patient with longstanding lymphedema who was admitted from the hospital.

Although the wound appeared to be progressing slowly toward healing, the initial assessment revealed important findings. To the naked eye, the wound did not appear overtly infected. There was minimal inflammation and limited drainage.

However, fluorescence imaging demonstrated substantial colonization with Pseudomonas.

© 2026 Copyright CGS Administrators, LLC.

The patient was treated with ciprofloxacin, and significant improvement was observed within one week. This intervention helped prevent infection and hospitalization while also reducing overall treatment costs by shortening the duration of care.

Next slide, please.

This case involves a patient with a Stage II wound that initially appeared relatively benign.

However, the small areas of fluorescence indicated significant bacterial colonization. The patient was treated with an antiseptic cleansing regimen, and the wound healed within one week.

In conclusion, a blanket noncoverage determination for real-time fluorescence imaging would be detrimental to patients, providers, and the Medicare program.

CURTIS MCFADDEN 39:02

Thank you, doctor.

EARL BERMAN 39:02

Thank you

CURTIS MCFADDEN 39:03

That is your time.

Go ahead, doctor Berman. I'm sorry.

EARL BERMAN 39:04

Thank you. Sorry about that.

Thank you very much for your presentation. Again, please make sure that all of these comments and supporting materials are submitted in writing. The information you have presented is very important for our evaluation process.

Our next speaker is Ms. Priya Pinto. I see that she was finally able to join us, and I'm glad she was successful in getting connected.

Curtis, if you would please grant Ms. Pinto speaking privileges and pull up her presentation, we will proceed with the next presentation.

CURTIS MCFADDEN 39:40

Dr. Pinto, you should now be able to unmute yourself on your end.

Once you are unmuted, we should be able to hear you.

EARL BERMAN 39:44

She's a jurist, Dr.

CURTIS MCFADDEN 39:46

Wow.

EARL BERMAN 39:46

She's a jurist, Dr.

So I guess that's appropriate.

CURTIS MCFADDEN 39:52

I am pulling up your slides now.

Dr. Pinto, the floor is yours. You should now be able to speak, and your microphone has been enabled.

I can see that your microphone is active, but I am not able to hear you at the moment.

Could you please check that you are unmuted and that the correct microphone is selected?

EARL BERMAN 40:24

Miss Pinto?

CURTIS MCFADDEN 40:35

At the moment, I am sharing your presentation, and your microphone has been enabled.

© 2026 Copyright CGS Administrators, LLC.

You should be able to speak, but I am not sure why we are unable to hear you.

Dr. Berman, we can move on to the next presenter.

EARL BERMAN 40:53

And what does...?

Yes, that's fine.

Ms. Pinto, if you're unable to speak, you may enter your comments in the chat.

CURTIS MCFADDEN 40:56

And.

EARL BERMAN 41:00

Ms. Pinto, could you please confirm in the chat that you are present?

Okay.

Our next speaker is Moira Sykstus.

Curtis, please activate her microphone and pull up her presentation slides.

CURTIS MCFADDEN 41:15

Give me one second.

EARL BERMAN 41:20

Hey, Miss, Pinto said.

CURTIS MCFADDEN 41:20

Yep.

EARL BERMAN 41:21

"I'm speaking, but I can't hear very well."

Ms. Pinto, are you using a headset, or are you connected by phone?

Yes, perfect. That would be great.

Curtis, do we have a call-in phone number available?

CURTIS MCFADDEN 41:40

Yes, Sir. I will put that in the chat in a moment.

EARL BERMAN 41:42

That's okay.

Jessica, please post the call-in number in the chat.

Ms. Pinto, if you are able, please dial in using the phone number. We will have Moira Sykstus present next, and then we will return to your presentation immediately afterward.

Curtis, please pull up Ms. Sykstus's presentation and activate her microphone.

CURTIS MCFADDEN 42:06

Her microphone is now active.

Let me pull up her slides.

I believe these are the correct slides. Yes, they are.

Starting the slideshow from the beginning.

Ms. Sykstus, you will need to unmute yourself, but you should now be able to speak.

B. Moira Sykstus 42:29

OK. Can you hear me?

CURTIS MCFADDEN 42:31

Yes, we can.

© 2026 Copyright CGS Administrators, LLC.

EARL BERMAN 42:31

Yes, ma'am.

B. Moira Sykstus 42:32

Perfect.

Thank you very much for the opportunity to speak today.

My name is Moira Sykstus, and I have been practicing wound care since 1992, so I have been doing this for quite some time.

Next slide, please.

The fundamental question before us today is whether these technologies provide value as bedside diagnostic tools.

From my perspective, they absolutely do.

Preeya Noronha Pinto 43:02

And.

B. Moira Sykstus 43:03

The same.

So you are looking at oxygenation and perfusion and also bacterial burden and these are oh, I'm echoing.

Preeya Noronha Pinto 43:10

Serial burden and.

B. Moira Sykstus 43:16

Anyway, next slide.

EARL BERMAN 43:16

If if everybody if I'm sorry if everybody could please mute their microphones.

So we don't have that echo.

Thank you.

B. Moira Sykstus 43:29

Next slide, please.

These technologies are extremely important to the physician and qualified healthcare provider decision-making process.

I own a physician billing, coding, and compliance consulting firm. I am a Certified Professional Compliance Officer (CPCO) as well as certified in healthcare compliance. I have participated in multiple audits this year involving wound care providers.

As a result, establishing and documenting the standard of care is incredibly important for wound care providers today, and these technologies have helped us achieve that.

Next slide, please.

Timely assessment and reassessment, including evaluation at the initial patient visit, are essential to ensuring that patients receive appropriate care.

Even initial debridement should generally not be performed until adequate blood flow has been established. While the ankle-brachial index (ABI) is often considered the "gold standard," many patients with diabetes have inaccurate ABI results due to significant microvascular disease.

In those situations, debridement may need to be deferred until additional vascular assessment is completed.

Infection control and management of bioburden are also critical components of the wound care continuum and conservative treatment approaches.

Next slide, please.

I am not going to review all of the evidence presented here today, as it is included in the

© 2026 Copyright CGS Administrators, LLC.

presentation materials.

I will ensure that the studies referenced are submitted for your review and consideration.

However, I would like to emphasize that these bedside, point-of-care, noncontact imaging modalities make it possible to evaluate and manage patients in the settings where they receive care. Without these technologies, providers may have to refer patients elsewhere for testing or delay care while waiting for additional diagnostic evaluations that may not be readily accessible.

Next slide, please.

One of the most important advantages of these technologies is that they provide actionable information.

When clinicians have access to bedside diagnostic tools that support clinical decision-making in real time, they can make immediate treatment decisions rather than delaying care for days, weeks, or, in some long-term care settings, even longer.

This ability allows providers to intervene earlier and potentially prevent more serious outcomes.

Next slide, please.

One topic that is receiving significant attention today is utilization and potential overutilization of healthcare services and technologies.

I believe there should be clear coverage guidelines governing the use of these modalities. Developing such guidelines is both reasonable and achievable.

Coverage should be tied to situations in which there is a specific clinical question to be answered, a clinical decision to be made, and the potential for the patient's treatment plan to be impacted by the information obtained through these technologies.

It is interesting to reflect on my training years. I remember participating in surgical rounds when one of the attending physicians asked a fellow how he could assess blood flow in a patient's lower extremity.

The fellow replied that he could see that the limb appeared perfused, but he could not determine whether bacteria were present, whether collateral circulation existed, or whether blood flow was compromised within the microvasculature.

These technologies allow clinicians to visualize and assess those factors directly at the bedside.

Next slide, please.

I believe both of these proposed LCDs should either be withdrawn or amended to reflect appropriate utilization and appropriate clinical indications.

Next slide, please.

It is also important that the use of these technologies be properly documented.

During audit and compliance reviews, we have seen instances in which these technologies have played a significant role in demonstrating the quality of care being provided and supporting clinical decision-making.

In many cases, they have been important differentiators for providers delivering high-quality wound care.

EARL BERMAN 48:16

Okay. I'm not sure what happened there, but thank you very much for your presentation.

You mentioned that the literature and supporting evidence are readily available. If so, please submit those materials with your written comments.

As I mentioned during my opening remarks, it is very helpful if supporting literature is submitted as full-text PDF documents along with your comments. Doing so will greatly assist us in our review and evaluation process.

Curtis, I believe Ms. Priya Pinto is up next. If you could please pull up her presentation and activate her microphone.

Ms. Pinto called in because she was having difficulty with the online connection. She has now joined by phone.

© 2026 Copyright CGS Administrators, LLC.

CURTIS MCFADDEN 49:00

I have enabled the microphone for the participant calling from the phone number beginning with 610.

The microphone is enabled on our end, but it appears that she still needs to unmute herself on her phone.

Ms. Pinto, if that is the phone number you are calling from, please unmute your phone. You should then be able to speak.

61****51 49:28**

This is Priya Pinto.

Can you hear me now?

CURTIS MCFADDEN 49:30

Yes.

61****51 49:32**

Oh, perfect.

CURTIS MCFADDEN 49:32

We can hear you no problem.

61****51 49:32**

Thank you.

CURTIS MCFADDEN 49:35

Give me one second while I get your slides up.

PowerPoint.

Here we go.

61****51 49:46**

Okay, great. Thank you so much.

I appreciate your patience and courtesy as we work through these technical issues.

My name is Priya Pinto, and I am with DLA Piper. We serve as counsel to MolecuLight.

Next slide, please.

We are here today to discuss the proposed LCD on Real-Time Fluorescence Wound Imaging for Bacterial Presence.

We believe this LCD, along with the substantially similar LCDs proposed in other MAC jurisdictions, should be withdrawn for several reasons.

First, the MACs have issued nearly identical proposed LCDs that effectively operate as a national coverage determination (NCD), yet they have not followed the NCD process. I will explain why that is problematic in a moment.

Second, the proposed LCDs are inconsistent with the Medicare Program Integrity Manual's definition of "reasonable and necessary."

There is a substantial body of clinical evidence supporting the use of fluorescence imaging as reasonable and necessary, and we do not believe that evidence was adequately evaluated or interpreted in the draft LCD.

Finally, these proposed LCDs would restrict patient access to an important imaging technology, which appears inconsistent with recent coding and payment decisions by both the AMA and CMS.

Next slide, please.

To begin, I would like to discuss the MACs' efforts to establish what is effectively a national policy without following the required NCD process.

All of the MACs issued substantially identical proposed LCDs in early October.

As a practical matter, these policies function similarly to a national coverage determination.

© 2026 Copyright CGS Administrators, LLC.

However, Congress has assigned responsibility for issuing NCDs to CMS, not to the MACs.

CMS determines whether coverage policies should be implemented nationally through the NCD process, which is established by federal statute.

In addition, the NCD process includes opportunities for public participation before a draft determination is issued. In this case, the MACs did not seek stakeholder input through a Carrier Advisory Committee (CAC) process or similar public engagement prior to issuing the proposed LCDs.

Next slide, please.

The proposed LCDs are also inconsistent with the Program Integrity Manual's definition of "reasonable and necessary."

The Program Integrity Manual establishes the framework that MACs use when determining whether services are appropriate for Medicare coverage.

Services must be safe and effective and cannot be experimental or investigational.

MolecuLight is an FDA-cleared device and therefore satisfies those criteria.

The service must also be appropriate, furnished in accordance with accepted standards of medical practice, provided in an appropriate clinical setting, ordered and furnished by qualified personnel, and used to address a patient's medical needs.

The MolecuLight device has been used widely for nearly five years. There have been more than 500,000 claims submitted by hundreds of wound care clinicians in appropriate medical settings and for patients with documented clinical needs.

For these reasons, we believe the service satisfies the Program Integrity Manual definition of "reasonable and necessary."

Next slide, please.

There is substantial clinical evidence supporting the use of MolecuLight technology.

In addition to five FDA clearances, there are more than 100 peer-reviewed publications involving over 3,500 patients.

These include randomized controlled trials, systematic reviews, meta-analyses, real-world evidence studies, and prospective clinical research.

Taken together, this represents a significant body of scientific evidence.

On the next slide, I would like to explain why we believe the draft LCD mischaracterizes some aspects of that evidence.

Next slide, please.

The MACs commented on the issue of independent infection diagnosis.

We believe that standard is not the appropriate benchmark for evaluating an adjunctive technology that provides information about bacterial presence and location.

Fluorescence imaging is designed to provide additional clinical information. Confirming bacterial species identification and establishing a definitive infection diagnosis may still require additional clinical evaluation and testing.

We believe the FLAAG trial demonstrated that fluorescence imaging provides greater sensitivity for detecting clinically significant bacterial burden than signs and symptoms alone.

We also believe there is demonstrated clinical utility because clinicians modify treatment plans based on fluorescence imaging findings.

Finally, there are meaningful clinical outcomes associated with the technology. For example, the FLAAG and Raman clinical studies reported improved healing outcomes when fluorescence imaging was incorporated into patient management.

Next slide, please.

The draft LCDs also appear inconsistent with recent actions by both the AMA and CMS.

The AMA concluded that utilization of fluorescence imaging had become sufficiently widespread to support the establishment of a Category I CPT code, which is scheduled to become effective on January 1, 2027.

© 2026 Copyright CGS Administrators, LLC.

CMS subsequently proposed a national payment rate for this imaging service under the new Category I code.

At the same time, however, the proposed MAC LCDs would eliminate coverage for the procedure within the affected jurisdictions, potentially limiting patient access to the technology.

As a result, we believe there is a significant inconsistency between these policy positions.

Final slide, please.

In conclusion, we support withdrawal of the proposed LCDs.

We believe there are concerns regarding both the policy development process and the interpretation of the clinical evidence. We also believe the proposed determinations are inconsistent with recent actions taken by CMS and the AMA.

For those reasons, we respectfully request reconsideration and withdrawal of the proposed LCDs.

Thank you very much for your consideration.

EARL BERMAN 55:05

Thank you very much for your presentation.

As always, we appreciate the information and perspective that you have provided today.

Our next presenter is Stephanie Woelfel.

Curtis, if you would please activate her microphone and pull up her presentation slides.

There we go.

CURTIS MCFADDEN 55:40

Your mic is now enabled.

You should be able to unmute.

Stephanie Woelfel - APTA 55:44

Perfect. Are you all able to hear me?

CURTIS MCFADDEN 55:45

Yes, ma'am.

Stephanie Woelfel - APTA 55:47

Okay, great. Thank you so much.

Good afternoon. My name is Stephanie Woelfel. I am a Doctor of Physical Therapy and a Board-Certified Wound Management Clinical Specialist.

Next slide, please.

I have no conflicts of interest related to these topics.

Next slide, please.

On behalf of the American Physical Therapy Association (APTA), I urge CGS to withdraw the proposed noncoverage policies for both near-infrared spectroscopy (NIRS) and real-time fluorescence imaging (RTFI).

For physical therapists practicing in the specialty area of wound management, both NIRS and RTFI provide significant adjunctive assessment information that cannot be reliably determined through visual inspection of a wound alone.

My remarks today will focus on three specific areas in which NIRS and RTFI have a meaningful clinical impact for physical therapists.

Next slide, please.

The first area is increased clinical efficiency.

NIRS allows for point-of-care assessment of tissue oxygenation and temperature during a patient treatment session. This information directly guides clinical decision-making without the prolonged delays associated with vascular laboratory testing.

Because we know that tissue temperature often increases before tissue breakdown occurs in the

© 2026 Copyright CGS Administrators, LLC.

diabetic foot, real-time assessment of tissue response to orthotics and offloading devices allows immediate modification to prevent pressure points that may lead to tissue breakdown or infection.

RTFI also improves the specificity of wound culture collection.

Because tissue biopsy is outside the scope of practice for physical therapists, fluorescence-guided wound assessment increases the likelihood of obtaining an adequate swab specimen to guide subsequent intervention.

Fluorescence-guided debridement also helps therapists more accurately target areas of necrotic tissue for removal, which can assist with pain management and facilitate identification of wounds requiring deeper debridement and referral to another provider.

Next slide, please.

The second area is reducing unnecessary healthcare spending.

NIRS allows for point-of-care screening of lower-extremity tissue oxygenation and perfusion, helping identify which patients truly require additional, more costly vascular testing. This helps ensure that the right care is provided to the right patient at the right time.

RTFI also supports antimicrobial and antibiotic stewardship by providing real-time information regarding bacterial burden within a wound.

Wounds without evidence of fluorescent signal may be appropriate candidates for discontinuation of costly antimicrobial dressings and transition to alternative treatment options.

Similarly, wounds without evidence of bacterial fluorescence may be ruled out as a source of infection, helping guide or reduce antibiotic utilization.

In addition, fluorescence imaging can be used before initiating advanced therapies such as collagen dressings to help ensure those products are not used prematurely or inappropriately.

Next slide, please.

The third area is preventing delays and improving patient care.

Physical therapy is often a patient's point of entry into the healthcare system, and access to these adjunctive assessment tools provides objective information that helps patients navigate their care more effectively.

NIRS provides an opportunity for early identification of high-risk areas, or "hot spots," in the diabetic foot, allowing interventions to occur before a wound develops.

Patients can also visualize the areas of concern themselves, which provides valuable feedback, particularly for individuals with sensory deficits, and may improve adherence to treatment recommendations.

NIRS can also help identify the need for additional vascular testing or referral for vascular surgery consultation.

RTFI provides the ability to identify subclinical bacterial burden and potential infection, which is especially important for patients with diabetes or autoimmune conditions.

This allows for more timely intervention and referral to other healthcare providers, often days or even weeks earlier than would be possible when relying solely on clinical signs and symptoms.

In closing, the American Physical Therapy Association urges CGS to withdraw the proposed blanket noncoverage policies for both NIRS and RTFI.

We will be submitting detailed written comments expanding upon these issues and providing additional supporting information.

Thank you for your time and consideration.

EARL BERMAN 59:55

Thank you very much for your presentation.

At the end of your remarks, you mentioned that you would be submitting written comments, and we certainly appreciate that. We encourage you to submit them through the email address I mentioned earlier today: CMD.Inquiry@cgsadmin.com.

Our final presenter will be Dr. Julie Wright.

Curtis, if you would please pull up Dr. Wright's presentation and activate her microphone, I would

© 2026 Copyright CGS Administrators, LLC.

appreciate it.

There we go.

Thank you.

CURTIS MCFADDEN 1:00:34

Not right. You should be able to unmute this earning.

Julia Wright MD 1:00:35

Yes, thank you so much.

Are you able to hear me at this point?

CURTIS MCFADDEN 1:00:39

Yes, ma'am.

Julia Wright MD 1:00:39

Okay, very good.

First, I would like to thank everyone for the opportunity to speak with you today.

My name is Dr. Julie Wright, and I serve as the Chief Medical Officer for MolecuLight.

Dr. Berman, I would especially like to thank you. Having previously served as a Chief Medical Officer for Medicare plans and having been involved in clinical practice, I understand the importance of the work being done here and appreciate the opportunity to participate in this process.

Next slide, please.

I would like to begin by reiterating the strength of the available evidence.

There is a broad and substantial body of clinical evidence demonstrating that fluorescence wound imaging improves the detection of elevated bacterial burden. As others have noted today, bacterial burden itself is detrimental to wound healing. Even in the absence of overt infection, elevated bacterial burden can delay healing and interfere with successful treatment outcomes, including graft success.

Therefore, identifying bacterial burden is an important component of clinical care. The ability to detect it, assess it at the point of care, and provide clinicians with actionable information at the bedside is what creates value for patients and providers.

For that reason, we respectfully request withdrawal of the proposed LCD.

Next slide, please.

I will not have time to review every slide in detail, but I would like to briefly summarize the available clinical evidence.

The evidence addresses three interrelated questions:

Whether elevated bacterial burden can be identified more effectively than through clinical assessment alone.

Whether that information adds value when combined with clinician judgment, signs, symptoms, and standard clinical evaluation.

Whether treatment decisions informed by that information improve patient outcomes.

While individual studies have limitations, the overall body of evidence points in a consistent direction and demonstrates favorable clinical outcomes and meaningful clinical value.

Next slide, please.

We would like this slide included in the record.

The FDA clearances referenced in the proposed LCD were discussed, and we wish to clarify those regulatory details for the record.

Next slide, please.

Bacterial localization is at the core of this technology's value.

The ability for a clinician to identify areas of elevated bacterial burden at the point of care and

© 2026 Copyright CGS Administrators, LLC.

incorporate that information into the overall clinical assessment often leads to different treatment decisions.

Those decisions may involve wound cleansing, debridement, determining where to obtain cultures, or selecting other treatment strategies.

As someone who strongly supports population health approaches, I believe early identification and early intervention are what truly change patient outcomes. That is one reason so many clinicians report that they would not want to practice without this technology.

The value of fluorescence imaging comes from the clinical decisions that result from the imaging findings.

Next slide, please.

The FLAAG study has already been discussed today, and it was helpful to have one of the investigators present.

The study demonstrated a fourfold improvement in the detection of elevated bacterial burden when compared with traditional clinical assessment alone.

That detection capability forms the foundation of fluorescence-guided care.

The study was cited in the proposed LCD, while the management and outcomes data demonstrate the clinical relevance of those findings.

Next slide, please.

The next study is a randomized controlled trial, summarized here in the Xu study.

This study included 200 patients who required debridement. Half of the patients were randomized to receive care guided by fluorescence imaging technology.

The use of fluorescence-guided imaging informed treatment decisions that were associated with:

Faster wound healing

Reduced hospitalizations

Shorter hospital stays

Reduced antibiotic duration

Fewer invasive procedures

Lower rates of recurrent infection

These findings help demonstrate how the technology can influence clinical decision-making and ultimately improve patient outcomes.

Next slide, please.

The remaining slides provide supporting information and additional evidence related to these findings.

If time permits, I would like to briefly review Slides 10 and 11, as they contain additional supporting data relevant to today's discussion.

EARL BERMAN 1:05:34

We can't.

We can't hear you.

Sorry not to write to you, Curtis.

Could you reactivate her microphone or she?

CURTIS MCFADDEN 1:05:41

I never turned it off.

EARL BERMAN 1:05:43

Did she mute?

CURTIS MCFADDEN 1:05:45

Yeah. I I never touched her connection.

© 2026 Copyright CGS Administrators, LLC.

EARL BERMAN 1:05:47

OK,

CURTIS MCFADDEN 1:05:47

It's still, it still says open on my end.

I'm not sure what happened. It's almost.

EARL BERMAN 1:05:53

Doctor Wright. You still there?

Oh.

CURTIS MCFADDEN 1:05:56

He may have lost connection or self connection became weak, but yeah, I never turned her off.

EARL BERMAN 1:06:02

Can you go to her last slide for me?

I'd just like to see what it is.

Oh, never mind. Okay.

Dr. Wright, I apologize. It appears that somehow we got disconnected. However, we look forward to receiving your written comments.

Curtis, could you please go to my last slide?

Let's pull up my final slide.

CURTIS MCFADDEN 1:06:32

Give me just a moment, and I'll pull up your slide.

EARL BERMAN 1:06:33

That's.

I think it's you can remove the clock.

CURTIS MCFADDEN 1:06:40

One moment.

EARL BERMAN 1:06:40

Still have it? Yeah.

CURTIS MCFADDEN 1:06:43

Remove clock.

EARL BERMAN 1:06:43

That's if you can sleep it right there. That's fine.

So I appreciate the presentation that they were very, very informative, Dr. Wright back.

Julia Wright MD 1:06:49

OK.

EARL BERMAN 1:06:56

That right?

Julia Wright MD 1:06:56

I'm trying T.

I'm certainly trying to be.

EARL BERMAN 1:06:59

OK. So we should out of respect for technology out of respect for technology. I'll, I'll if you want to make like a closing statement, I'll give you a moment a minute or two to do that.

© 2026 Copyright CGS Administrators, LLC.

CURTIS MCFADDEN 1:07:00

We hear you now.

Julia Wright MD 1:07:03

Are you OK?

Yes.

Yes.

EARL BERMAN 1:07:14

Go ahead.

Julia Wright MD 1:07:17

Well, thank you very much.

I was simply noting that the evidence presented demonstrates that fluorescence imaging provides clinically relevant information that clinicians can use to inform patient care.

There are studies showing that this information can influence treatment decisions and that those decisions may contribute to improved clinical outcomes. Taken together, we believe this supports the clinical utility and medical necessity of the technology.

On that basis, we respectfully request that the proposed LCD be withdrawn.

I apologize that we became disconnected near the end of my presentation.

Thank you for allowing me to make that final comment.

EARL BERMAN 1:07:40

That's all right.

I mean technology is technology and.

I always had to give people the benefit of the doubt if possible, so I wanted to give you a chance since you came back on to give your closing comments.

Julia Wright MD 1:07:47

Yeah.

Yeah.

EARL BERMAN 1:07:54

I appreciate you getting back in.

Julia Wright MD 1:07:54

Yeah.

EARL BERMAN 1:07:57

I was saying thanks for everybody.

Julia Wright MD 1:07:58

Thank you.

EARL BERMAN 1:07:59

The presentations were very informative, and that is the purpose of these Open Meetings: to provide the MAC, in this case CGS, with additional information for consideration.

The public comment period remains open, so please submit your written comments. As I mentioned in my opening remarks, I would appreciate comments that are personally written and professionally submitted.

We have received an overwhelming number of submissions through organized writing campaigns, including comments that appear to be AI- or bot-generated. However, I am confident that the participants on this call will submit relevant evidence, full-text literature, and thoughtful written comments. We greatly appreciate your contributions.

Thank you for taking the time to educate and inform us today. Your participation and input are always appreciated.

© 2026 Copyright CGS Administrators, LLC.

Have a wonderful rest of your evening.

Thank you again. We will now close the meeting.

© 2026 Copyright CGS Administrators, LLC.