June 26, 2025

Palmetto GBA
Part A Policy
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Submitted Electronically: A.Policy@PalmettoGBA.com

Re: Proposed Local Coverage Determination (LCD) DL40189 Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancers (NMSC) and Draft Local Coverage Article (LCA) DA60211 Billing and Coding: Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancers (NMSC)

Dear Palmetto GBA Contractor Medical Directors:

On behalf of the American Academy of Dermatology Association (AADA) and the Dermatologic Medicare Contractor Advisory Committee (DermCAC), thank you for the opportunity to comment on the Proposed LCD, DL40189 Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancers (NMSC), and its associated billing and coding article, DA60211: Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancers (NMSC).

The AADA is the leading society in dermatological care, representing more than 17,500 dermatologists nationwide. The AADA is committed to excellence in the medical and surgical treatment of skin disease; advocating for high standards in clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of skin disease. The DermCAC is a national coalition of dermatologist representatives selected by their state dermatology societies and represents the board-certified dermatologists in your carrier region. The DermCAC advocates for policies that prioritize patient well-being.

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As experts in skin cancer, dermatologists play a crucial role in the management of NMSC. We strongly support the development of a final policy that preserves access to superficial radiation therapy when medically appropriate and ensures that qualified dermatologists remain able to

furnish this service based on their education, training, and clinical judgment. The AADA and DermCAC respectfully submit the following comments on the Proposed LCD and LCA on SRT for the treatment of NMSC.

I. SRT as a Secondary Treatment Option for NMSC

The AADA and DermCAC support consideration of SRT as a secondary option for the treatment of basal cell carcinoma (BCC) and squamous cell carcinoma (SCC), for use in special circumstances, such as when surgical intervention is contraindicated or refused and after the benefits and risks of treatment alternatives have been discussed with the patient.[1]

We appreciate that the proposed policy reflects this position and aligns with our long-standing view that SRT may be appropriate in select cases where surgery is contraindicated or refused by the patient. We support the policy's emphasis on patient selection, clinical judgment, and shared decision-making, and we commend the Palmetto GBA Medical Directors for their careful consideration of the evidence and alignment with guidance from relevant specialty societies.

We also appreciate that the proposed policy recognizes the importance of patient selection, clinical judgement, and shared decision-making in the treatment of NMSC, and that it thereby allows physicians to exercise autonomous clinical decision-making authority to address individual patient care needs.

Based on current evidence, surgical management remains the most effective treatment for BCC and SCC.[1] Notwithstanding, physicians should have the autonomous clinical decision-making authority to deliver individualized patient care and determine the most appropriate course of treatment in consultation with each patient. Dermatologists should discuss treatment options with patients and determine the most appropriate treatment for patients based on cure rates, long term clinical outcomes, maintenance of normal anatomy and function, medical circumstances, patients' desires, and full disclosure of all the risks and benefits of each treatment modality.[1] As appropriate, this includes consideration of SRT as a secondary treatment option.

We support the proposed policy's alignment with this evidence-based approach and urge Palmetto to retain this framework in the final LCD.

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[1] American Academy of Dermatology/Association Position Statement on Superficial Radiation Therapy. American Academy of Dermatology/Association. November 6, 2021. https://server.aad.org/forms/policies/Uploads/PS/PS-Superficial%20Radiation%20Therapy.pdf

II. Dermatologists as Qualified Physicians to Perform SRT

The AADA and DermCAC strongly support the inclusion of dermatologists as professionals qualified to perform SRT in the proposed policy. We believe this policy, as proposed, reflects dermatologists' longstanding expertise in diagnosing and treating NMSC, including their comprehensive understanding of skin anatomy and oncology, which they have gained through residency and fellowship training, as well as through ongoing clinical experience and continuing medical education.

As noted in the proposed LCD, SRT has been used for over a century to treat skin cancer. Dermatologists pioneered its use and have maintained a leading role in its delivery in outpatient practice. The specialty's training and clinical experience inherently includes the management of NMSC and, when indicated, the use of SRT. In fact, superficial radiotherapy was developed within dermatology, and Medicare claims data show that dermatologists continue to furnish the majority of these services for Medicare beneficiaries.

Dermatology also has long led in the study, knowledge, and use superficial radiation—and electromagnetic energy across various wavelengths, including narrowband ultraviolet B (UVB) and lasers—to effectively treat a wide range of skin conditions. Photon-based superficial radiation uses X-rays, which fall within the electromagnetic spectrum with which dermatologists are intimately familiar.

We also highlight that including dermatologists as qualified to furnish SRT for NMSC supports patient access, continuity of care, and positive outcomes. For example, this approach allows for the streamlining of diagnosis, treatment, and follow-up within a single office under dermatologists' management, rather than requiring referrals to other specialists or coordination with other treatment facilities after a dermatologist diagnoses the cancer. By allowing dermatologists to furnish SRT, the proposed policy establishes a broader pool of qualified physicians able to deliver this service. Restricting dermatologists from performing SRT could create barriers to care and limit access to timely, cost-effective treatment for patients with NMSC.

While certain radiation devices have historically been used by dermatologists, the AADA and DermCAC agree that all physicians providing SRT must have appropriate education and training to ensure safe and effective use.[2] Notwithstanding, we affirm this education and training for dermatologists may be acquired post-residency and/or fellowship, as would be required for any new technology or therapy.

III. Evidence Supports Appropriate Use of SRT in Select Clinical Scenarios

The AADA and DermCAC appreciate Palmetto GBA's comprehensive review of the available literature on SRT. We support the effort to base coverage decisions on high-quality clinical

[2] *Id.*

evidence and encourage continued reliance on the best available data when refining or implementing future policy updates. While existing studies support the use of SRT in select clinical circumstances, we recognize the importance of continued research to inform best practices. We reiterate that dermatologists with appropriate education and training should be permitted to furnish SRT when clinically indicated, regardless of whether such training occurred during residency or through other recognized educational pathways.

IV. Proposed Policy Language May Limit Appropriately Trained Dermatologists from Performing SRT

While the proposed LCD appropriately recognizes dermatologists as qualified to furnish SRT, the AADA and DermCAC are concerned that specific language regarding provider qualifications may inadvertently limit appropriately trained dermatologists from performing this service and, in turn, limit patient access to SRT for the treatment of NMSC.

The proposed LCD states:
"A qualified physician for this service is defined as follows: training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty (i.e., Radiation Oncology OR by a qualified dermatology program of training with didactic and clinical experience in radiation treatment)."

This requirement does not fully reflect current clinical practice. Many dermatologists currently delivering SRT completed their training before the emergence of newer SRT technologies. As such, relevant training for dermatologists is often acquired post-residency and fellowship. Education and training may be obtained through multiple pathways, including accredited continuing medical education (CME), post graduate training programs, and hands-on experience, such as through collaboration with radiation oncologists or other practicing dermatologists with significant experience or training in SRT. Accredited CME hours are available that provide didactic instruction on the use of SRT for NMSC, including its application, risks, benefits, and potential side effects.

With appropriate education and training, physicians should be allowed to employ new technologies and treatments and should not be limited to only those offered in their residency and/or fellowship programs. Furthermore, federal and state laws and regulations govern the provision and billing of SRT services, and many states establish specific requirements for those administering superficial radiation.[3] In addition, the AADA and DermCAC support the requirement that SRT services be delivered under the direct supervision of a qualified physician

[3] For state radiation safety agency contact information and/or regulations, refer to the Conference of Radiation Control Program Directors website (https://crcpd.org/) and/or the American Society of Radiologic Technologists website (https://www.asrt.org/main/standards-and-regulations/legislation-regulations-and-advocacy/states-that-regulate).

(MD or DO) to ensure patient safety and high standards of care. Accordingly, dermatologists should be permitted to perform procedures consistent with their education, training, and individual competency, and in accordance with applicable federal or state law.

As written, the policy could restrict appropriately trained dermatologists and limit access to a medically appropriate service for Medicare beneficiaries. Dermatologists should have the right to use all treatments, including SRT, in their armamentarium and determine the most appropriate treatment for their patients. **The AADA and DermCAC urge Palmetto to revise the "Provider Qualifications" section to remove the limiting requirement that training and expertise "must have been acquired within the framework of an accredited residency and/or fellowship program," as this may exclude qualified dermatologists who have obtained the necessary training through other recognized educational pathways.** We support ensuring physician competency, but recommend a revision that maintains flexibility for alternative, yet appropriate, training routes for dermatologists performing SRT**.**

V. Nonsurgical Candidates Constitute a Small Patient Subset

The AADA and DermCAC support the inclusion of language outlining examples of clinical scenarios that may qualify a patient as a nonsurgical candidate. We appreciate that the proposed LCD references specific factors—such as potential functional impairment, significant morbidity, or poor cosmesis in anatomically sensitive areas—as well as situations in which patients decline surgery following shared decision-making. This language helps clarify the parameters of coverage and reflects current clinical considerations.

To reiterate, we believe SRT should be considered a secondary treatment option for NMSC, used when surgery is contraindicated or declined and after the risks and benefits of available treatment options have been discussed with the patient.[4]

Nonsurgical candidates represent a relatively small subset of patients. From a dermatologist's perspective—shaped by decades of clinical experience—surgical treatment options such as excision, Mohs micrographic surgery, and other minor destructive procedures are generally safe and well tolerated across patient populations, including the elderly, immunosuppressed, and those on anticoagulant therapy. These procedures are typically performed under local anesthesia, obviating risks associated with general anesthesia. Furthermore, dermatologic surgeons routinely manage patients with anxiety, phobias, or other behavioral challenges that may impact treatment decisions.

We support the inclusion of language outlining specific examples of nonsurgical candidacy; however, we emphasize that such patients constitute a small subset of the overall NMSC population. The final policy should preserve flexibility for clinical judgment

[4] American Academy of Dermatology/Association Position Statement on Superficial Radiation Therapy. American Academy of Dermatology/Association. November 6, 2021. https://server.aad.org/forms/policies/Uploads/PS/PS-Superficial%20Radiation%20Therapy.pdf

while ensuring medical necessity is clearly documented when SRT is selected over surgery.

VI. High Resolution Ultrasound (HRUS) and Image-Guided SRT (IGSRT)

The AADA and DermCAC acknowledge that the use high-resolution ultrasound (HRUS) and image-guided SRT (IGSRT) are emerging areas in the treatment of NMSC and anticipate reviewing the scientific literature as it continues to develop.

The draft LCD states:
"Use of HRUS to guide SRT delivery and to assess lesion reduction during the superficial radiation treatment protocol is not considered reasonable and necessary and is not supported by literature."

The overall body of current evidence on IGSRT does not allow definitive determination of the value of image guidance for planning, ongoing evaluation, nor final determination of treatment status during a course of SRT for nonmelanoma skin cancer. We encourage continued reliance on the best available, high-quality data when evaluating and/or refining future policy updates.

VII. Future Coding Updates for SRT Services

The AADA and DermCAC note that the coding structure for superficial radiation therapy is expected to change as part of the CPT© 2026 code set. We encourage Palmetto to consider these coding changes when finalizing the billing and coding article associated with the local coverage policy on SRT for the treatment of NMSC.

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The AADA and DermCAC appreciate the opportunity to provide feedback on the proposed LCD and draft billing and coding article on SRT for the treatment of NMSC. Thank you for your consideration of these comments. On behalf of dermatologists in the Palmetto region and nationwide, the AADA and DermCAC remain committed to ensuring patients have access to high-quality, medically necessary dermatologic care. We value continued collaboration with Medicare administrative contractors on all policies impacting the specialty.

If you have any questions or would like more information about the comments in this letter, please contact Cameron Huff, MHA, Manager, Payment Policy at chuff@aad.org. We welcome the opportunity to discuss this further.

Sincerely,

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