

THE AMERICAN GERIATRICS SOCIETY

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September 29, 2008

Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Coverage and Analysis Group
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS List of Potential National Coverage Determination (NCD) Topics for Third Quarter 2008

Dear Sir or Madam:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) list of potential topics for National Coverage Determinations (NCDs). The AGS is a not-for-profit organization comprised of more than 6,700 health professionals who are specially trained in the management of care for frail, chronically ill, older patients. Our society is devoted to improving the health, independence and quality of life of all older people.

As such, we offer the following comments with respect to various items on the list. Our comments are provided in the same order that topics were listed by CMS and therefore do not represent any particular priority preference of the AGS. In addition, the AGS urges CMS, in its approach the NCD process, not to restrict coverage on the basis of age, particularly where the evidence indicates that age is not a contraindication, or where limited data on the elderly exists. Below, please find our specific comments on the potential NCD topics.

Potential NCD Topics for Third Quarter 2008

ESAs have known serious adverse effects in patients who have cancer or pre dialysis chronic kidney disease (CKD). Their long term benefits and harms in the ESRD population are unclear. ESAs are a large cost in current ESRD treatment strategies.

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CKD uses of ESAs have known adverse effects. Medicare recently implemented anemia reporting requirements that include the reporting of hemoglobin or hematocrit information on claims for ESA uses in CKD. It is unclear if ESAs are being used appropriately in this population.

AGS Response:

We have reviewed the current FDA and CMS recommendations, and we believe that the parameters for assuring the safe use of ESAs are appropriate. We therefore support the current FDA and CMS parameters for use and reimbursement of ESAs for patients with chronic kidney disease and ESRD.

Parenteral iron supplementation may be accomplished with a variety of iron containing preparations. Iron overload and hypersensitivity reactions are not uncommon.

AGS Response:

We have reviewed the current CMS recommendations and we agree that IV ferrous gluconate is safe and effective for patients with end-stage renal disease (ESRD). If CMS decides to open an NCD for parenteral iron supplementation, we do not believe that age should be a factor in reaching a coverage determination for this medication.

Bisphosphonates, particularly longer acting parenteral preparations, have been associated with osteonecrosis of the mandible (jaw) in patients who have dental procedures. Given the ready availability of oral preparations it is unclear if the convenience afforded by the less frequent administration parenteral agents outweighs the potential harms.

AGS Response:

Parenteral bisphosphonates are effective for osteoporosis while jaw necrosis is very rare. In the HORIZON Recurrent Fracture Trial (2007), the relative risk reduction of hip fracture with yearly zoledronic acid (5 mg) was 35%. The most frequent adverse events in patients receiving zoledronic acid were pyrexia, myalgia, and bone and musculoskeletal pain, but no cases of osteonecrosis of the jaw were reported.

Based on the current literature, we agree with the American Society for Bone and Mineral Research that bisphosphonates, at doses used for osteoporosis, decrease the risk of osteoporotic fractures. There is currently no conclusive evidence that parenteral bisphosphonates increase the risk of jaw necrosis compared to oral bisphosphonates when used at osteoporosis dosage. There are, however, situations where IV use is justifiable albeit with careful monitoring. These situations include, but are not limited to, presence of contraindication to oral bisphosphonates and poor tolerance to oral bisphosphonate due to gastrointestinal side effects. Use of parenteral bisphosphonates for convenience only should be discouraged.

We therefore believe that any national coverage determination should be limited to those patients who have contraindications or cannot tolerate oral preparations; coverage should not extend to patients only because they find the parenteral dosing regimen more convenient. In addition, age should not be a factor in determining coverage for parenteral bisphosphonates.

Proton beam therapy for prostate cancer: Proposed as means to concentrate radiation therapy and reduce side effects. Very high upfront cost to build these facilities and thus only at very few facilities. For prostate cancer treatment, no current comparative trials comparing to usual therapy.

AGS Response:

Proton beam therapy promises to be able to deliver higher (equivalent) dose therapy to a tumor than conventional radiation therapy with acceptable morbidity. However, the decision to invest many millions of dollars to build a proton beam center appears to be completely dependent on CMS's decision to reimbursement for proton beam therapy for the treatment of prostate cancer.

In the treatment of prostate cancer, there are no long term studies that have tested whether proton beam therapy is superior to state of the art radiation therapy in terms of mortality, long-term disease control, or long-term morbidity. Long term studies are required to determine if the promise of proton beam therapy will improve outcomes of prostate cancer.

It is premature at this time to pay for this therapy before clinical trials have shown superiority in either survival or in complications to the bladder and rectum. We believe it is appropriate for CMS to support long-term clinical trials, and to reimburse centers for proton beam therapy provided as part of these clinical trials. However, it would be premature to seek national coverage for a very expensive therapy that has not yet shown added long term benefit to patients with prostate cancer.

Hip resurfacing may be an alternative to total hip replacement that might offer an interim option to patients. Although many patients can expect to outlive the treatment's effectiveness, hip resurfacing may have the advantage of preserving enough healthy bone to allow for a future total hip implant. Is the evidence adequate to demonstrate health benefits in the patients who receive the procedure?

AGS Response:

Hip resurfacing is preferable to hip replacement because hip resurfacing conserves more bone. It uses a larger hip ball that decreases the risk of dislocation. Patients who have this procedure must have good quality bone; therefore, it is possible that a large proportion of patients who are scheduled for this procedure may actually end up having a hip replacement. After a direct examination of the bone, the surgeon may conclude that the bone quality is inadequate for a hip resurfacing. However, it is important to note that age is not a contraindication. Older patients have equal or better outcomes when compared with younger patients having the same procedure. (See McGrath, M. S., Desser, D. R., Ulrich, S. D., Seyler, T. M., Marker, D. R., & Mont, M. A. (2008). Total hip resurfacing in patients who are sixty years of age or older. *The Journal of Bone*

and Joint Surgery.American Volume, 90 Suppl 3, 27-31. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=18676933&site=ehost-live>

If CMS decides to proceed with a national coverage determination for hip resurfacing, the agency should take into consideration this and other studies indicating that age should not be a consideration with respect to coverage.

Ablation for atrial fibrillation: If medication is not effective or not tolerated for atrial fibrillation, a nonsurgical procedure called catheter ablation may be chosen. Focal and circumferential catheter ablation for atrial fibrillation is still being studied in investigational trials but may be done in selected patients to try to cure atrial fibrillation. Is the evidence adequate to demonstrate health benefits in the patients who receive the procedure?

AGS Response:

Most of the studies of this procedure have involved younger patients with paroxysmal atrial fibrillation (AF) and few comorbidities. Data on patients over the age of 75 are very limited, although one recent study (J Cardiovasc Electrophysiol 2008;19:621-6) reported favorable outcomes in 32 patients 75 years of age or older treated with AF ablation (similar efficacy to younger patients, slightly but not significantly higher complication rate). Clearly more study is needed, but in the interim, we do not believe that CMS coverage for this procedure should be restricted on the basis of age.

Off label use of drug eluting coronary stents: Limited data are available on the off-label use of drug-eluting stents (DESs) in clinical practice. Is that evidence adequate to specify groups of patients that do benefit from treatment with coronary stents or clearly do not benefit?

AGS Response:

Several recent large studies (Am J Cardiol 2008;101:293-9; Am J Cardiol 2007;100:1619-24; J Am Coll Cardiol 2008;51:607-14; NEJM 2008;358:342-52) have shown that outcomes with off-label use of DES are similar to those with on-label use and superior to outcomes with bare-metal stents (BMS), with reduced mortality and target vessel revascularization procedures at 1-2 yrs follow-up and no increase in the risk of in-stent thrombosis. The median age in all of these studies was about 64. In the JACC study, the favorable effects of off-label DES relative to BMS were at least as great in patients 64 yrs or older as in patients under the age of 64. Thus, in our opinion, CMS should consider expanding coverage for off-label use of DES, and older age should not be a criterion for either utilization or coverage of this procedure.

Vertebroplasty and kyphoplasty: Vertebroplasty and kyphoplasty are radiologic procedures for the treatment of the intense pain caused by vertebral compression fracture in patients whose pain has been refractory to medical management or other therapy. Vertebroplasty and kyphoplasty involve the intraosseous injection of acrylic cement under local anesthesia and fluoroscopic guidance to control the pain of vertebral fractures associated with osteoporosis, tumors, and trauma. Typically, vertebroplasties are performed in an outpatient setting, while kyphoplasty

typically requires hospital admission. Is the evidence adequate to demonstrate health benefits from pain reduction in selected patients?

AGS Response:

Both of these procedures have shown excellent outcomes in reducing the pain and disability associated with vertebral fractures whether of osteoporotic or oncologic etiology. Compared to kyphoplasty, vertebroplasty costs less to provide, but has increased risks of adverse events. Kyphoplasty costs more due to the cost of the device, but has less risk of adverse events. However, age should not be a factor in determining coverage for this procedure. We urge CMS to take this into consideration if it decides to pursue a national coverage determination for vertebroplasty and kyphoplasty.

Peripheral arterial stenting and vascular intervention: Angioplasty and angioplasty with vascular stenting are commonly used to treat conditions that involve a narrowing or blockage of arteries throughout the body, including 1) narrowing of large body arteries due to atherosclerosis, or hardening of the arteries, a gradual process in which cholesterol and other fatty deposits, called plaques, build up on the artery walls and 2) peripheral vascular disease (PVD) and peripheral artery disease (PAD), a narrowing of the arteries in the legs or arms. In patients with PVD or PAD, angioplasty alone or angioplasty with stenting may be used to open up a blocked artery in the pelvis, leg or arm. Is the evidence adequate to specify groups that do and do not benefit from angioplasty and stenting in the peripheral vascular system?

AGS Response:

The data on this issue are thoroughly reviewed in the American College of Cardiology/American Heart Association (ACC/AHA) guidelines for management of PAD (JACC 2006;47;1239-1312). We note that none of the recommendations mention age as a criterion for determining the appropriateness of stenting for PAD, and to our knowledge there is no evidence that the procedure is less effective in older patients as compared to younger patients (although complication rates are likely to be higher in older patients, especially women with small vessels). Therefore, age should not be a factor in determining coverage for the procedure.

Pharmacogenomic testing: Pharmacogenomic testing detects DNA variants that are associated with altered response to therapeutic drugs, in order to optimize drug selection or modify drug dosage to improve effectiveness and/or to avoid adverse drug events. As examples, testing for certain variants in *VKORC1* and *CYP2C9* genes (and possibly others) may permit more accurate calibration of warfarin dosage for individuals to prevent thrombosis or thromboembolism; testing for a certain variant in the *UDT1A1* gene may highlight greater risk of neutropenia in those receiving the drug irinotecan as part of their anti-cancer chemotherapy. However, there is a relative scarcity of high-quality published evidence from outcome-related clinical trials about the clinical utility due to pharmacogenetic testing at this time.

AGS Response:

We understand that CMS has opened a national coverage determination on pharmacogenomic testing and that the comment period is now closed. The AGS, however, believes that recommendations in favor of pharmacogenomic testing prior to initiating treatment with warfarin were premature, as there is no evidence that such testing leads to improved clinical outcomes (although it does facilitate selection of an initial warfarin dosage). Indeed, a recent RCT showed that the proportion of International Normalized Ratios (**INRs**) in the therapeutic range during the first 90 days after initiation of warfarin did not differ among patients (mean age ~ 60) who received pharmacogenomic testing compared with those who did not (Circulation 2007;116:2563-70). In addition, a recent editorial in NEJM (NEJM 2008;358:1061-63) suggested that although pharmacogenomic testing holds promise for managing patients who require anti-coagulation with warfarin, the test "is not yet ready for prime time". Based on these data, we believe that it would be reasonable for CMS to restrict coverage of this test until additional outcomes data become available. However, in any case, age should not be a factor in this decision.

Thank you for the opportunity to participate in this process. Please feel free to contact us at (212) 308-1414 if you have any questions or would like additional information.

Sincerely,



John Murphy, MD
President
American Geriatrics Society