

DXA:
**Appropriate Utilization, Standard of
Care and Potential Threats to Federal
Initiatives**

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Key Talking Points

- Patient access to osteoporosis care is threatened
- DXA is a preventive service that saves money
- DXA is underutilized
- Current financials undermine efficient health care delivery
- DXA reimbursement cuts are unique. Combination of DRA and MPFS:
 - No other CPT code was cut 75% by changes to MPFS
 - Incorrect inputs in physician work and practice expense
 - Complexity and intensity of service
 - Machine cost
 - DXA tech time
 - Utilization rate

Is Diagnostic Imaging Overused ?

- From 2000-2005, imaging has seen the highest cumulative growth (61%) per Medicare beneficiary of all physician service categories.
- Concerns have been raised about potential over use, inappropriate use and quality.
- DXA is included along with CT, MRI, PET scans and other advanced diagnostic imaging in DRA cuts (Section 5102).
 - Mammography is exempt

CMS Claims for 76075/77080: Non-facility and Hospital

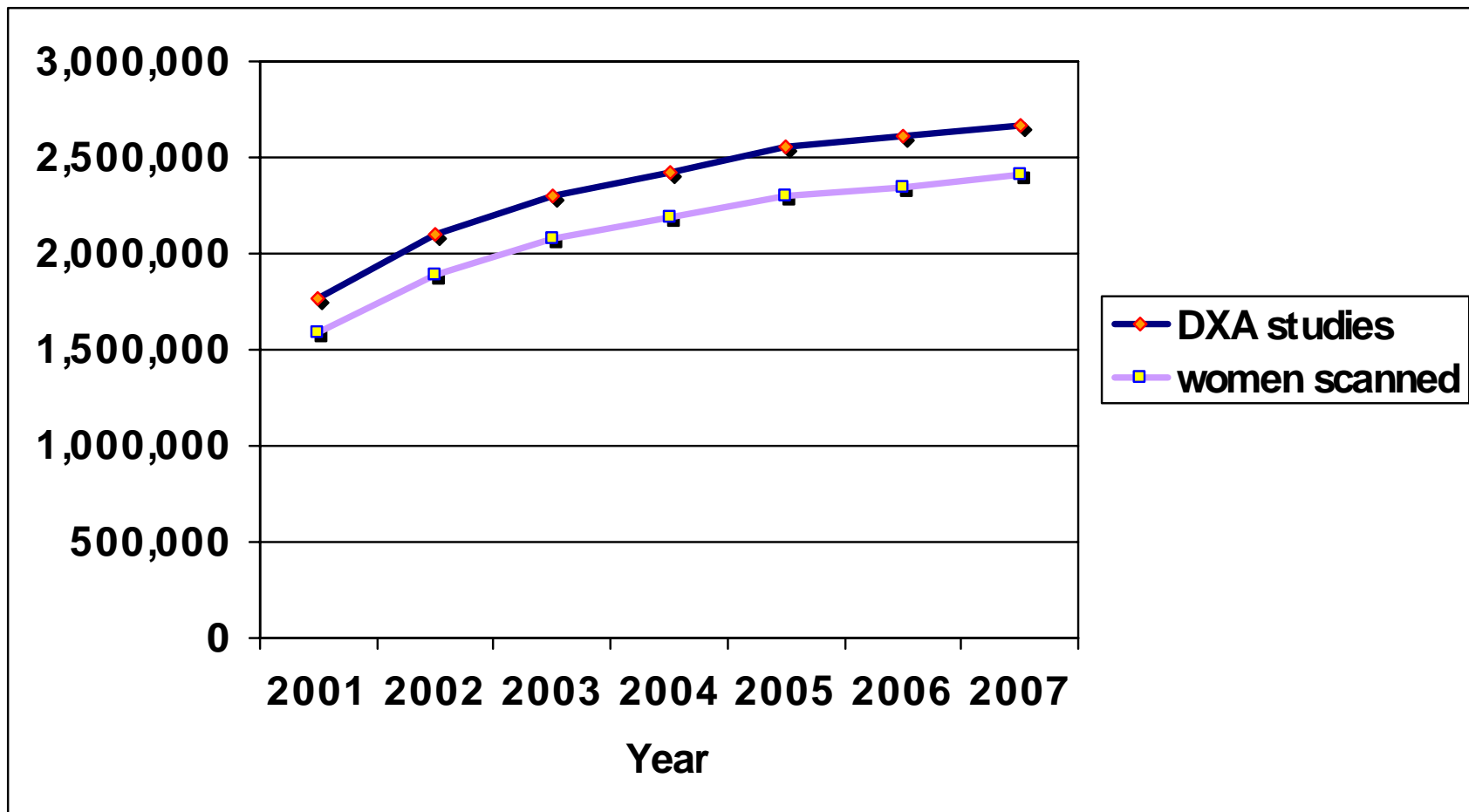
Year	Central DXA
1994	77,122
1998	1,013,362
1999	1,332,393
2000	1,582,552
2001	1,767,503
2002	2,099,912
2003	2,302,449
2004	2,424,895
2005	2,554,651
2006	2,608,897
2007	2,670,290

2/3rds of DXA claims are
from the non-facility
setting

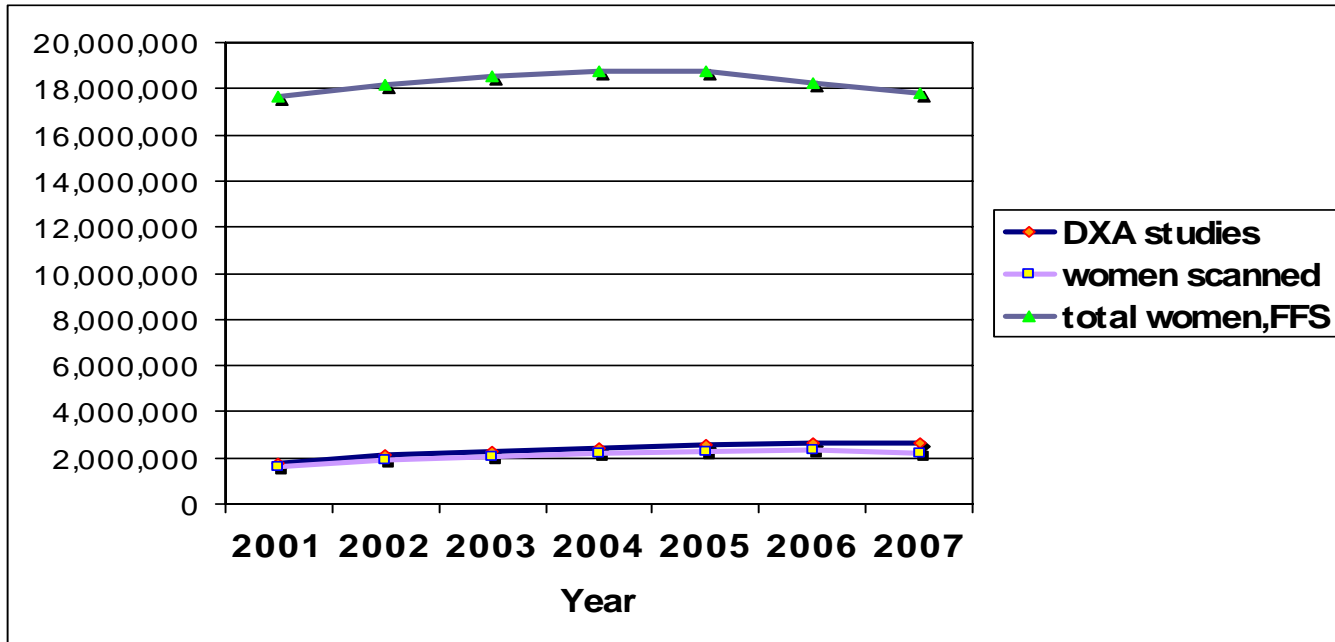
Federal Initiatives to Increase DXA Testing

- 1997 **Balanced Budget Act (Bone Mass Measurement Act)**
- 2002 **US Preventive Services Task Force**
 - DXA testing for all women 65 and older
 - DXA testing for all women 60 and older if specific risk factors
- 2004 **Surgeon General's Report on Osteoporosis**
 - Bone mass measurement: "one of the most significant advances in the last quarter century"
- 2005 **Welcome to Medicare Exam**
 - Osteoporosis evaluation with DXA part of key preventive services
- 2007 **PQRI: Pay for Performance; 4 osteoporosis measures**

Trends in Medicare Fee-for-Service DXA studies 2001-2007



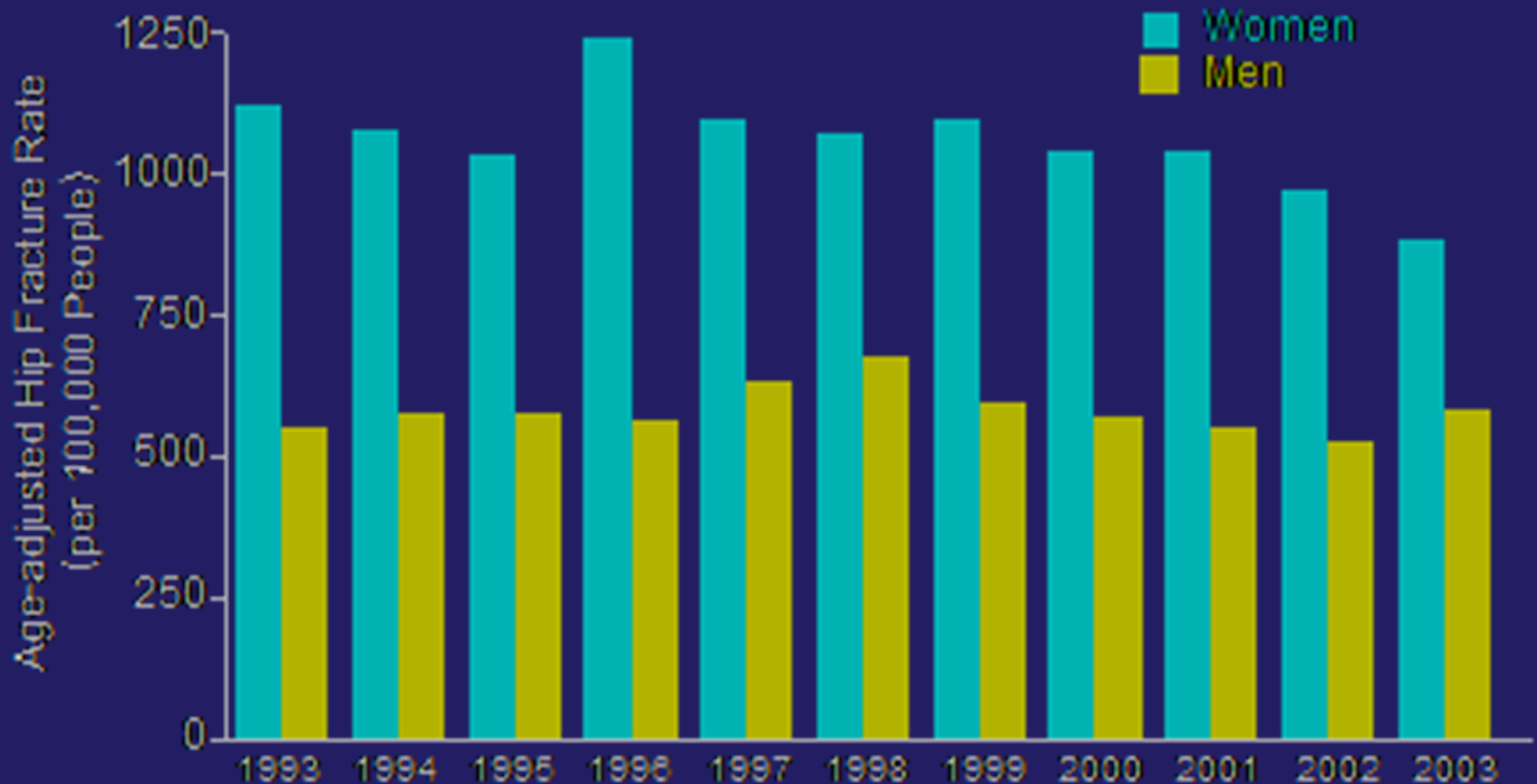
DXA Remains Underutilized: Trends in Medicare Fee-for-Service DXA studies 2001-2007



year	2001	2002	2003	2004	2005	2006	2007
% women tested	7.9%	9.1%	9.8%	10.2%	10.8%	11.3%	11.8%

Though Progress is Being Made...

Hip Fracture Hospitalization Rates Have Declined ~21% for Women

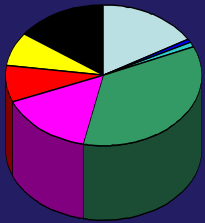


Adapted from; Stevens, et. al., MMWR, Nov 17,2006

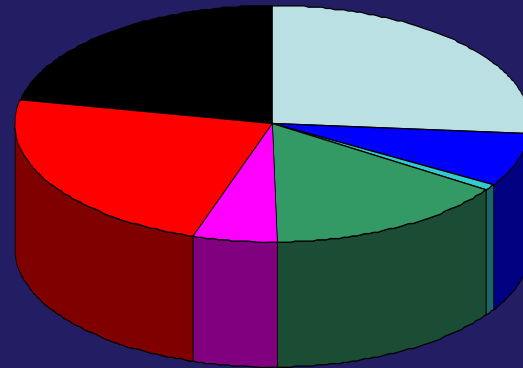
DXA Growth: Who Are the Drivers?

- Concern has been raised that the marked increase in volume of a number of diagnostic imaging services are due in part to:
 - Interventional specialists purchasing imaging technologies for their own practice
 - Free standing imaging centers
 - Ancillary revenues to supplement income
- Significant geographic variations in use of imaging with largest volume seen in areas with large number of specialists (Fisher et al).
- In contrast, the growth in DXA volume has been driven by primary care and non-interventional specialists (endocrinologists and rheumatologists).

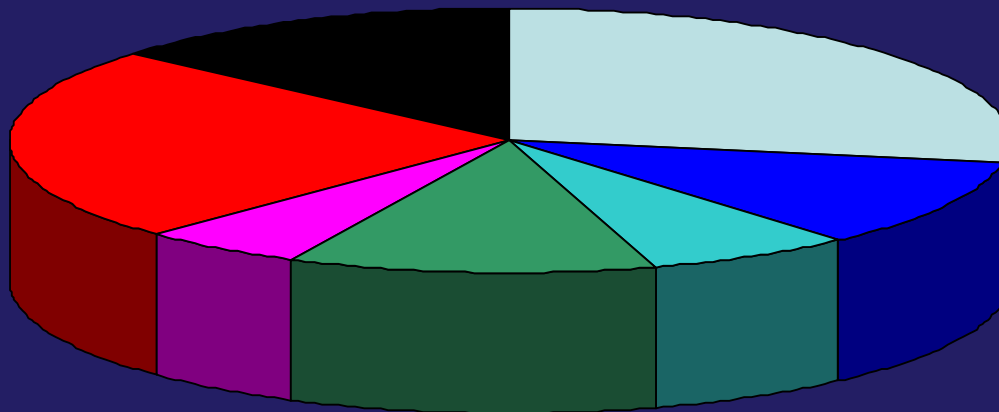
Non-facility: DXA Volume Increases Driven by Primary Care



1994: N = 61,862



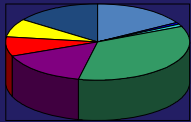
1999: N = 853,144



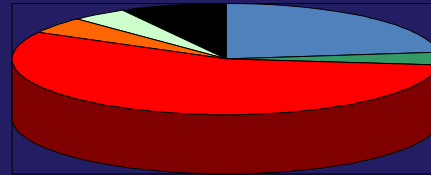
2004: N = 1,593,796

- IM
- FP
- OB-GYN
- Rheum
- Endocrinology
- radiology
- other

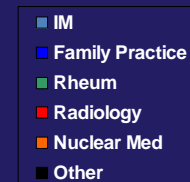
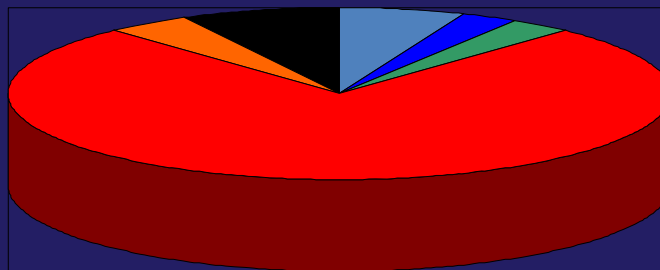
Facility: DXA Volume Increases Driven by Radiology



1994: N = 11,865



1999: N = 320,397



2004: N = 704,349

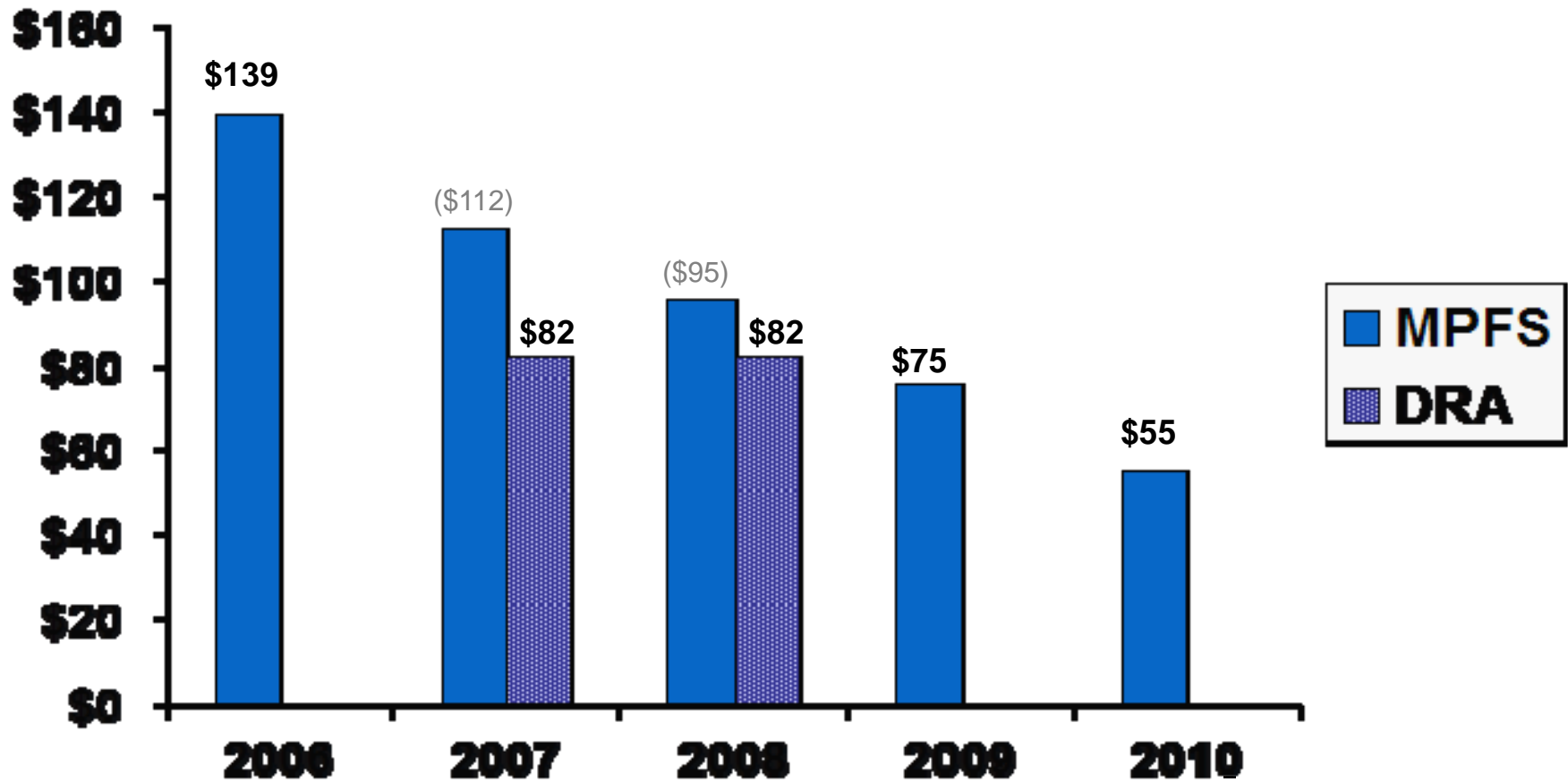
DXA: Low Potential for Inappropriate Use

- Reimbursement for DXA is based on well defined criteria (“qualified individual”) legislated by the Bone Mass Measurement Act of 1997. Applies to all Medicare beneficiaries.
 - Estrogen deficient woman (surgical or natural)
 - Osteoporosis, osteopenia, vertebral fracture
 - Hyperparathyroidism
 - Use of corticosteroids (prednisone dose of ≥ 7.5 mg/d for ≥ 3 mos.)
 - Monitoring response to medical therapy
- Modifications to coverage introduced by CMS in November 2006 (CMS-1321-FC)
 - Steroid dose reduced to ≥ 5 mg/d
 - Central DXA the only technology that will be reimbursed when monitoring response to medical therapy

DXA: Low Potential for Overuse

- Bone Mass Measurement Act of 1997 also codifies frequency of testing:
 - No more often than every 24 months
 - Exceptions include:
 - glucocorticoid use
 - hyperparathyroidism

DXA Reimbursement Overview: Non-Facility (Office) Setting



Federal Register: CMS 1321-FC: 971(November 2006); CMS 1385-FC (November 2007)

Dollar amount for 2009 and 2010 Conversion Factor is frozen at \$38.08.

Summary of PFS Changes for Bone Mass Measurement Reimbursement

Procedure	CPT	2006	2010	change
DXA	77080 76075	\$139.46	\$55.44	60% decline
VFA	77082 76077	\$39.41	\$28.18	28% decline
pDXA	77081 76076	\$42.07	\$32.95	22% decline
QCT	77078 76070	\$131.13	\$203.14	55% increase

Deficit Reduction Act of 2005 (Section 5102: Adjustments in Payments for Imaging Services)

- A mechanism to pay for the freeze in payment cuts for the Medicare Physician Fee Schedule.
- Took effect January 1, 2007.
- Medicare payment for technical component of an imaging service is set at the Hospital Outpatient Department (HOPD) payment rate, if the HOPD rate is lower than the Physician Fee Service (PFS) payment rate.
- Imaging service affected include DXA, ultrasound, CT and MRI but not mammography

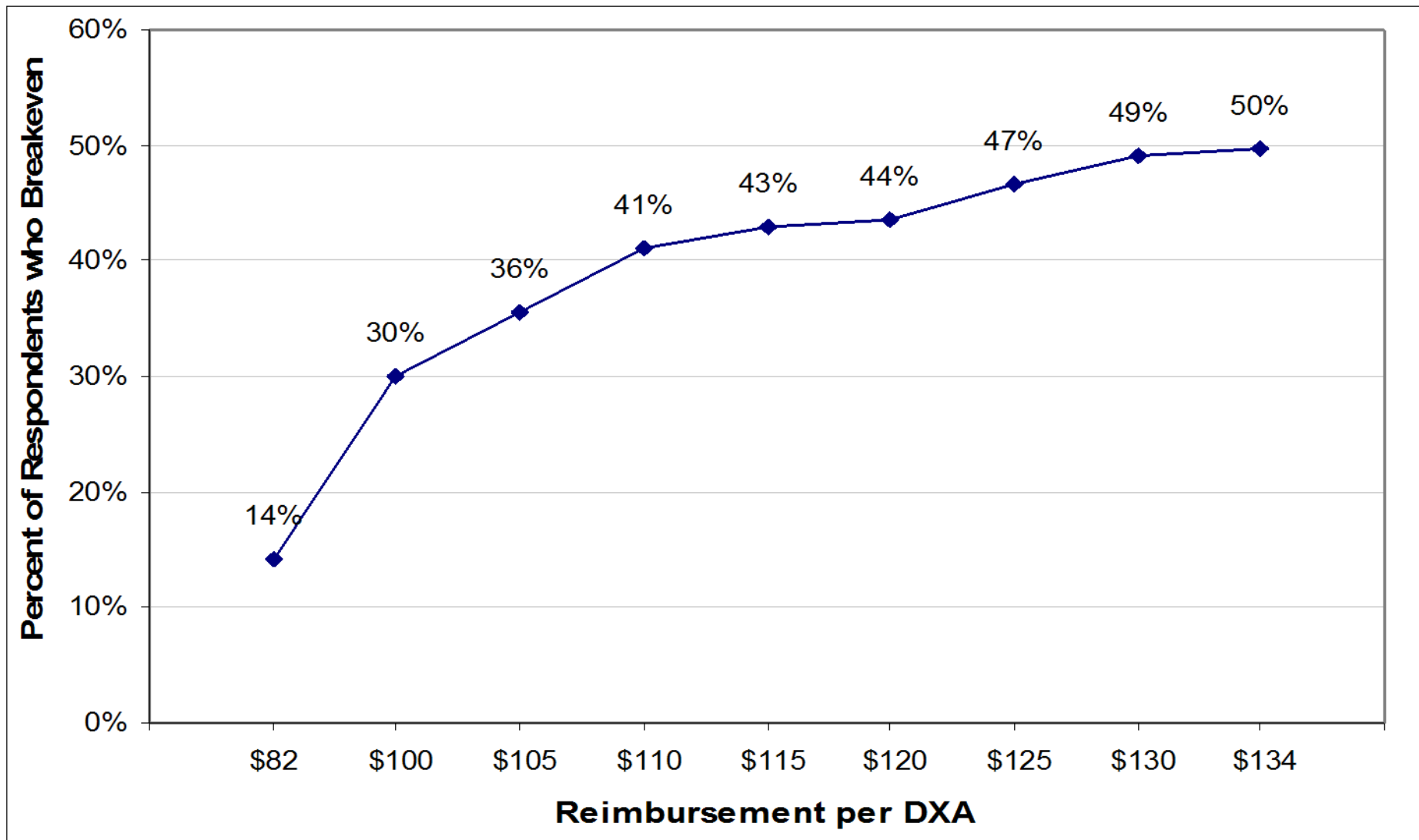
Why Non-Facility DXA Costs Are Different from Hospital

- DXA purchase may represent the single largest purchase for office based practice
- DXA costs as % of overhead are significantly greater for the non-facility (office) setting
- Utilization rate is usually lower for non-facility practice
- Medicare co-pay is ~20% for non-facility vs ~ 40% for hospital based practice

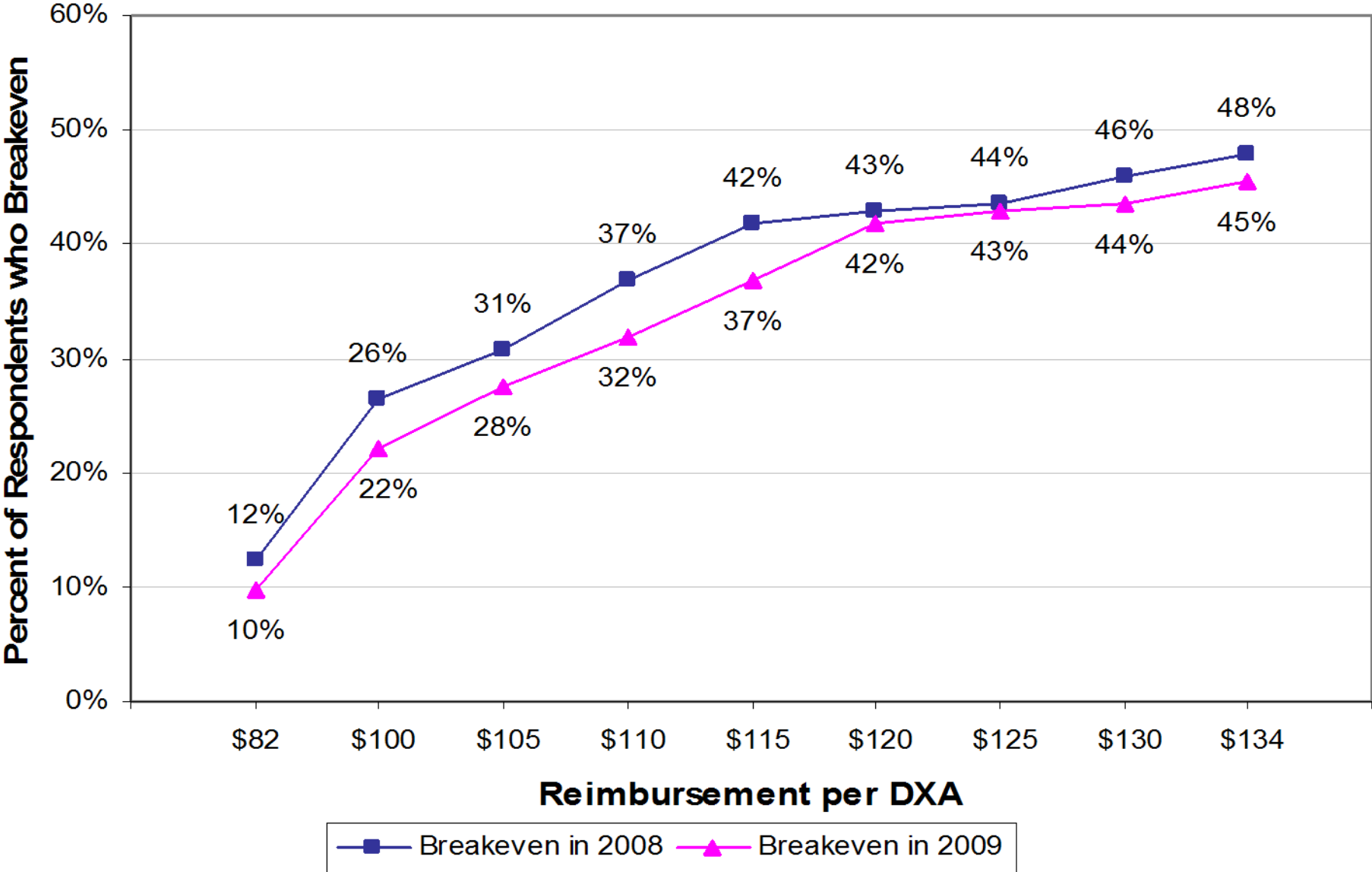
DXA Cost Analysis

- ISCD, ACR, AACE, TES commissioned the Lewin Group to survey office-based providers of DXA to develop estimates of costs a/w providing DXA services in office setting
- The Lewin Group is a recognized leader in health care reform analysis and modeling
 - independent analysis of financial impacts of health coverage policy at both national and state level
 - often provides data to CMS and Congress
- 161 respondents:
 - 39% primary care (IM, FP, GYN)

Distribution of Providers' Breakeven Reimbursement per DXA 2007



Distribution of Providers' Breakeven Reimbursement per DXA 2008 - 2009



Physician Responses to Central DXA Reimbursement Cuts

- 4/26/2007 Survey distributed electronically to members of ISCD, AACE, ACR, TES
- 757 respondents: 30% primary care, 30% endocrinologists and rheumatologist, 4% radiologists
- 7% indicated they had already stopped performing DXA studies
- Based on 2007 MPFS:
 - 37% indicated they would stop performing DXA by year end
 - 73% to curtail professional development activities (CME, courses, facility accreditation) in the field osteoporosis.
- Based on 2010 MPFS: 93% would stop performing DXA studies

DXA Closures & Cutbacks

- Reimbursement cuts are already impacting patient access
- Across locations: practices serving urban, rural and suburban patients
- Across practice type: primary care and specialists
- Across practice size: not limited to smaller groups. Includes practices performing large numbers of scans (over 6,000 / year)

DXA Reimbursement Cuts Are Already Impacting Patient Access

- The largest osteoporosis center in NJ, which performs > 6,000 DXA studies yearly has ceased to perform comprehensive osteoporosis care.
- A clinic in the FL panhandle that served a rural area with mobile vans closed in March.
- A multi-site clinic in AZ shut down its most rural DXA; staff at other locations has been reduced.
- A mobile van program serving the lower peninsula of MI performing approximately 1,600 scans per year closed in June.

DXA Reimbursement Cuts Are Already Impacting Patient Access

- A **mobile clinic** in **Michigan** serving ~ 4,000 rural patients/yr ceased operation.
- A **small community hospital** in **Massachusetts** refuses offer a free DXA machine because of reimbursement cuts.
- A **50 physician OB/GYN** practice in **Pennsylvania** stops offering DXA services and osteoporosis counseling.
- A **clinic** in **Boston** that performed nearly 7,000 studies at 3 locations has cancelled purchase of a new DXA machine.

Why Not Shift DXA Testing to the Hospital Setting?

- **Increased complexity of care**
 - Another provider, another location, a different DXA
 - Forwarding of medical records which must be reviewed
 - Results of study need to be forwarded back to primary MD
 - Patient needs to make another visit with primary MD
- **Reduced access to care**
 - Vulnerable populations at increased risk (poor, rural)

Why Not Shift DXA Testing to the Hospital Setting?

- **Discontinuity**

- Unable to measure response to treatment since switching machines; can't determine least significant change
- New baseline measurement must be made
- Shift care from primary physician to radiologist

- **Additional costs**

- Transportation for patient
- Transfer of medical records
- Patient co-pay is now 40% instead of 20%

Why Not Shift DXA Testing to the Hospital Setting?

- Screening efforts are sub-optimal now, decline further with increased **barriers to care**.
- Fracture rates increase with increased global health care costs

DXA & Osteoporosis: A Perfect Model for Disease Prevention

- Osteoporosis is a silent disease until fractures occur
- DXA is the best predictor of fracture risk and can identify those at risk before fractures occur
- DXA testing is relatively inexpensive
- FDA-approved medications are available with documented efficacy that lower fracture risk, reduce health care costs and save lives

Are There Savings to Restore DXA Reimbursement to 2006 levels?

- Savings a/w avoiding fractures (5 yrs): \$2.1 billion
- Increase direct DXA payments: \$648 million
- Cost of treating at-risk individuals: - \$294 million
- Savings over five years \$1.145 billion

Legislation

HR 4206 “Medicare Fracture Prevention and Osteoporosis Testing Act of 2007”

- HR 4206 introduced by Rep. Berkley (D- Nevada) 11.15.2007
- Bi-partisan support with 52 co-sponsors
- Companion Senate bill: Salazar (D-CO) and Snowe (R-ME)
- Supported by NOF, AACE, ISCD, ACR, TES, ACOG and ASBMR
- Freezes DXA and VFA at 2006 reimbursement levels— national average of \$139 for DXA and \$39 for VFA.
- Institute of Medicine performs study of ramifications of the cuts for DXA and VFA on beneficiary access to BMM .
- Study must be submitted to Congress within one year of effective date of the bill and include recommendations to insure access to BMM.

Senate Finance Committee Proposal

- Chair: Senator Max Baucus (D-MT)
- Supported by Hologic, GE, P&G
- Covers screening mammography, CAD and BMM
- Limits cuts to Practice Expense for BMM under the MPFS to 20%
 - (Imposes moratorium on Practice Expense cuts for mammography and CAD)
- Shields DXA procedures from the DRA cuts
- Requires study by Comptroller General of access to screening mammography and DXA services including utilization rates, adequacy of payment, increasing screening rates
- Results in ~\$115 reimbursement for DXA

Senate Finance Committee

Democrats (11)

Max Baucus, MT, Chair

John D Rockefeller IV, WV

Kent Conrad, ND

Jeff Bingaman, NM

John Kerry, MA

Blanche Lincoln, AR

Ron Wyden, OR

Charles Schumer, NY

Debbie Stabenow, MI

Maria Cantwell, WA

Ken Salazar, CO

Republicans (10)

Charles Grassley, IA , Ranking Member

Orrin Hatch, UT

Trent Lott, MS

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Comparison of Proposals

	HR 4206	Senate Finance
Cost analysis	Lewin Group	CBO
Amount	\$645 million over 5 years	\$200 million over 2 years (BMM)
Reimbursement	~ \$139	~ \$115
When	2009	before July 2008
Other	Stand alone bill	Part of the Medicare fix for MPFS

Changes to VFA Reimbursement: Non-facility (Office) Setting



Federal Register: CMS 1321-FC: 971 (November 2006); CMS 1385-FC (November 2007)

For CMS 11.2006: Conversion Factor for 2006 is \$37.90. Assumed CF dropped by 5% per year. PE in 2010 = 0.41

For CMS 11.2007: Conversion Factor for 2008 is \$38.08. Assume CF is frozen at \$38.08 for 2009 and 2010. PE in 2010 = 0.53

Likely Outcomes of Undervalued DXA

- A **vital preventive service is in jeopardy** of disappearing from the primary care, non-facility setting
 - Women's health care particularly hard hit
- Patient **access to care is threatened** and the current low screening rates are likely to decline further
- **Quality and continuity of care is being undermined**
- Opportunity to prevent serious morbidity and premature mortality from fractures will be reduced
- Projected 5 year **cost due to increased fractures of \$2.2 billion¹**

1. The Lewin Group. Assessing the Total Cost of Providing DXA in the Office-Based Setting and Scoring a Reimbursement Alternative. Presented to CMS on August 28, 2007.

Appendix

Conclusions: DXA is Different From Other Imaging Services

- DXA is a **low cost** procedure (median cost \$134) with a **proven benefit** in identifying individuals at increased risk for fracture.
 - Treatments are proven to reduce fractures, lower costs, save lives.
- **Indications** for DXA are **well defined** and legislated by Bone Mass Measurement Act of 1997.
- **Volume increases** in CMS DXA claims are an **appropriate** response to Federal initiatives.
 - Drivers are primary care /principal care providers (rheumatology and endocrinology)
- Despite these increases, **screening rates remain very low** with less than 20% of qualified Medicare beneficiaries tested.¹

1. Medicare Claims Data. Medicare claims data are derived from 100% RIC O Line Items from the Part B Extract and Summarization System (BESS) and 100% Outpatient SAF file for CY 2005. The beneficiary enrollment information is derived from 2004 and 2005 Denominator files