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July 30, 2006

Roseanne M. Eagle, MPP
American Medical Association
Department of Physician Payment Policy and Systems
515 N. State Street
Chicago, IL 60610

Re: CMS-1512-PIN
Medicare Programs Five-Year Review of Relative Value Units under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology for Calendar Year 2007

Dear Ms. Eagle:

The International Society for Clinical Densitometry (ISCD) appreciates the opportunity to provide comments to the AMA regarding the Centers for Medicare Services (CMS) Five-Year Review of Relative Value Units under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology published in the June 29, 2006 Federal Register.

The ISCD is a professional society committed to excellence in the assessment of skeletal health. Our members come from a number of medical specialties represented by the AMA including, but not limited to, internal medicine, rheumatology, endocrinology and radiology. The ISCD appreciates the enormous work of the AMA/Specialty Society RVS Update Committee (RUC) and the Practice Expense Review Committee (PERC) to determine fair work and practice expense RVUs. As many of our members are involved in the daily care of patients, we too understand the importance of protecting the worth of E/M services.

The new five-year review of the Medicare Physician Fee Schedule proposes to enact drastic cuts in payment for dual energy X-ray absorptiometry (DXA; CPT code 76075) and vertebral fracture assessment (VFA; CPT code 76077). When fully realized in 2010, this would amount to a decline in payment of 71% for DXA and 37% for VFA. ISCD is concerned that this will markedly reduce the availability of high quality bone mass measurement and thus have a profound adverse impact on patient access to appropriate skeletal health care. Such an outcome is directly contrary to multiple initiatives at the Federal level including the Bone Mass Measurement Act, the US Preventive Services Task Force recommendations and the Surgeon General's Report on Osteoporosis, all of which underscore the importance of osteoporosis recognition using DXA and the value of appropriate prevention and treatment approaches to reduce the personal and societal cost of this disease. Moreover, in contrast to other imaging procedures where costs are escalating but improvements in patient outcome have not been clearly demonstrated, DXA and VFA are of relatively low cost and of proven benefit. Additionally, DXA and VFA are readily available to patients being seen by primary care physicians and specialists alike.

As the methodology used to generate Practice Expense (PE) has changed from a “top-down” to a “bottom-up” approach, a critical review of the input data is warranted. Upon doing this, we are concerned that anomalies in the data used to generate PE have played a major role in these cuts. Specific concerns include:

- **Inappropriate application of equipment costs.** While the equipment cost is appropriately listed for VFA using current fan beam densitometers at ~\$85,000, in contrast, DXA is assigned a cost of \$41,000 based on pencil beam instrumentation. Of the two largest US manufacturers of DXA instruments, one no longer produces pencil beam machines and for the other such low-end instruments comprises less than 20% of sales. As fan beam densitometers make up the vast majority of densitometers currently available in practice, the ISCD would argue that the equipment cost for DXA should be listed at \$85,000.
- **Other densitometry costs** are omitted. For example, the cost of phantoms, necessary service contracts/software upgrades and office upgrades to allow digital image transmission are not included.
- The ISCD strongly objects to the **utilization rate** of 50% that was applied to all procedures. Although some procedures have slightly higher or lower utilization, procedures used in single-disease states (e.g., DXA and VFA) have substantially lower rates estimated at 15-20%. Based on 2002 Medicare data, 70% of DXA studies are performed in-office (30% in hospital settings) and 60% are performed by non-radiologists. These settings reflect the predominant role of primary care physicians offering DXA to their patients as part of general medical care and not high volume imaging centers which are associated with significantly greater utilization rates.
- We believe that the non-physician total time allocated for performing DXA (31 minutes) and VFA (15 minutes) is overall appropriate, although additional tasks such as performing daily quality control, loading prior studies for comparison, archiving and printing copies for interpretation are not listed.

Finally, we must be candid in our disagreement with the AMA RUC which overruled the American College of Radiology’s (ACR) survey recommendation that work RVU for DXA remain at 0.3. The RUC reduced this to 0.2, which represents the 25th percentile of the ACR survey, stating that “... *the (RUC) workgroup believed that the actual work is less intense and more mechanical than the specialty society’s description of the work.*” To further evaluate this, and with the cooperation of the ACR, the ISCD is currently conducting an additional physician work survey using the same clinical vignette. This survey will be sent to clinicians including primary care physicians, rheumatologists, endocrinologists, and others. The results of this survey will be presented in our appeal to CMS by the August 18th deadline.

Moreover, the RUC recommendation to reduce the physician work RVU for DXA places DXA in a unique group of only 29 other codes out of a total of 721 which the RUC recommended for cutbacks. This cut in DXA work RVU has created a rank order anomaly, in that peripheral DXA is now assigned a greater work value (0.22) than central DXA (0.20) despite the clearly recognized greater complexity of reading a central DXA study of the spine and hip in comparison to a peripheral study of the heel.

Finally, the same process which will reduce DXA reimbursement from \$139.46 to \$39.80 and VFA from \$39.41 to \$24.64 will increase QCT from \$131.13 to \$203.14. We anticipate that market forces will dictate and result in the virtual disappearance of DXA and VFA technologies with the subsequent increase in QCT, a valuable technology, but one not intended for, nor best utilized in, widespread utilization for diagnosis and monitoring of patients with osteoporosis.

Although, we fully appreciate the necessity for unity in the medical profession, we cannot ignore the aforementioned situation, which we believe will adversely affect skeletal health assessment in this country. We appreciate the opportunity to bring this critical issue to the attention of the AMA.

Sincerely,

Neil Binkley, MD
ISCD President

Andrew Laster, MD
Chair, ISCD Public Policy Committee