

ISCD Members Send a Message to CMS and Congress

Below are excerpts from just a few of the hundreds of ISCD members across the country who responded to our calls to action with heartfelt letters about the effect of the DXA/VFA cuts on access to patient care. From small rural practices to large urban imaging centers, the message was the same: the cuts will be devastating for the diagnosis and treatment of osteoporosis.

From an internist in Colorado

My practice provides bone densitometry testing to assess people at risk for osteoporosis and low bone density. These problems increase risk of fracturing and are currently already under-diagnosed and under-treated. Fractures in the elderly take a great toll on individuals and society as many elderly people with fractures are not able to return to independent living after such fractures, resulting in significant suffering and cost to the health care system.

My partner and I have invested in a bone densitometry machine due to the need to identify and treat people at risk for fracture in our community. **The next nearest bone densitometer is 50 miles away;** therefore, we provide the vast majority of the bone densitometry testing in our area. We have taken time to get the necessary training and invested a considerable amount of money in order to provide this service for our community. This type of capital for two internists to invest in equipment is difficult to come by.

If the reimbursement drops, small low-volume centers like my practice will not be able to afford to invest in or maintain the equipment for bone densitometry. In turn, the problem of under-diagnosing and under-treating low bone density which already exists will become much worse as people are denied access to bone densitometry screening. The therapies for treating low bone density and preventing fracture are proven therapies. It is always a tragedy when somebody's osteoporosis is not recognized or treated until that person has already broken a hip. A hip fracture repair and the subsequent needed home health, rehabilitation stay, and long term care required for many with hip fractures is much more costly than appropriate bone densitometry testing and treatment of low bone density prior to fracture.

I continue to practice medicine in an environment where both private insurers and government funded insurers demand the highest quality care, but then cut the necessary funding needed for physicians to provide such care. Please do not allow CMS to go through with the proposed cut for bone densitometry reimbursement as my patients, and many others, will simply suffer more as a result.

From a physician in Kerrville, Texas

This proposed cut is a tragedy. If you further research, you will also learn that scanning for osteoporosis saves Medicare money unlike other image scanning.

We purchased a bone density machine to help our patients in a rural area. The machine value is \$95,000. We recently spent \$20,000 upgrading the machine to look at the entire spine. We invested our money on the upgrade to give the best care possible; although we knew at the time we would not be reimbursed additional. We pay the manufacturer \$8,000 per year for maintenance. We pay our technician \$16.00 per hour to perform scans. We see about 10 people per week. The collections on services from insurance companies are about 80%. We lose money on the service, but feel it is necessary for the health of our patients.

With the proposed cuts, we will consider having to layoff our tech and sell the machine. This is very sad for our small rural community, especially since osteoporosis is a disease attacking millions of people. Medicare does not cover men, which is discrimination since the disease affects them as well.

Please support our President in his fight of osteoporosis and retain full payment to our physicians so they can afford to have the machines and staff necessary to diagnosis this disease.

From a Board-certified Obstetrician/Gynecologist in Florida:

When we first got a DXA machine in 1998, we were one of the few places patients could be adequately tested for osteoporosis. Over the past 8 years, I have seen how our patients have been better tested and treated for this disease than patients going to other offices. Although some patients have inevitably developed the disease, most have avoided the devastating effects of hip fractures and compression spine fractures by our aggressive testing and treatment program.

We decided it was important to get a central DXA machine, since that was the “gold standard” for diagnosis of osteoporosis. If reimbursements are cut we will be unable to continue to lease the machine and pay for a radiologic technician to run it. Our patients will have to go elsewhere for their DXA tests.

Having the machine in our office has greatly increased our patients' compliance with testing. It is rare that a woman declines to walk down the hall for a DXA test after her gyn. exam, but common that she ignores the prescription to go elsewhere. Sadly, some insurance companies do not allow their subscribers to take advantage of our DXA testing, and these women have much poorer rates of testing than those who can be tested in our office. Transportation problems are often the limiting factor in compliance with ordered tests for our elderly patients.

Our machine is currently in use about 25% of the time, since the bulk of our patient care is routine gyn exams. The time the machine is idle still costs us in the lease for the machine and the space it takes up. The cost of our radiologic technician has risen over the years, adding to the expense of providing this service.

The time we spend interpreting the tests have increased, as the reports have become more complex, with previous years' results for comparison. Treatment options have multiplied, and our patients are older and sicker, with multiple other medical problems that must be taken into consideration before treatment decisions can be made. Interpreting results and providing that information to the patient has become more complex over the past 8 years.

I believe the proposed changes in funding are shortsighted. It will force many private offices, such as mine, to stop offering this critical service, due to unsustainable costs. I have seen my patient population grow, and over 35% of my patients are now on Medicare. The need for DXA testing will only increase as our population ages, and this is not the time to deprive them of such important medical care.

From a Rheumatologist and internist in Oregon:

I have practiced for the last 26 years, and serve on three state and regional boards dealing with Rheumatology. The use of DXA is critical to the diagnosis and treatment of patients with osteoporosis. The vast majority of patients with osteoporosis remain undiagnosed because they have not received DXA scans. Even in those patients with hip fractures, less than 20% are recognized to have osteoporosis and an even smaller fraction receives treatment which can increase bone density and prevent such fractures. Approximately 60% of patients with osteoporotic fractures of the spine do not know they have the disease without having had a DXA scan and therefore have not been treated.

Never in my years of diagnosing and treating osteoporosis have I encountered a regulation that would be so devastating to the health of my patients as the recent proposal by CMS to reduce reimbursement for DXA scans. Just as we are reaching a point where this epidemic of osteoporosis is finally being recognized and treated, the future of this field of medicine is being threatened by cutbacks that will set us back 20 years, cost the nation billions of dollars for hip replacements and repairs as well as kyphoplasty and vertebroplasty, and result in needless suffering of our patients from preventable fractures. Just as

millions of people are beginning to be diagnosed and treated, the availability of these services will be dealt a terrible blow.

From a board certified radiologist and certified clinical densitometrist in Texas:

When we have surveyed patients, we find almost half of those who should have had an exam have not. Cutting reimbursement is shortsighted and will make screening even less available. High caliber physicians will not be able to continue to offer DXA evaluation, or afford to become and stay certified, so quality will deteriorate. I know my facility would no longer be able to offer these exams at the proposed rate of reimbursement. The expense of medical care to treat insufficiency fractures in unscreened and inadequately screened patients will FAR outweigh the savings from cutting reimbursement. I think requiring ISCD certification for interpreting physicians and facilities and maintaining reimbursement is the answer to improve quality of life for patients and save health care dollars by preventing osteoporotic fractures.

From an MD in California:

I have had many patients for whom the most important outcome is what did NOT happen. As a result of DXA & VFA studies I performed, a large number of patients were diagnosed with osteoporosis, received treatment, and as a result did not have catastrophic fractures. A typical example is a 66 year old woman who had never had a BMD test. On the screening DXA study with VFA performed at my office she was found to have both osteoporotic T-scores & vertebral compression fractures. She was at very high risk of more fractures, including a possible disabling, or even fatal hip fracture. She was treated with an oral bisphosphonate, and upon follow-up DXA with VFA 15 months later, was found to have had a statistically significant increase in hip & lumbar spine BMD and no new fractures.

From a family physician in Arizona:

I now serve as one of just a few physicians in our area that are specially trained to read the bone densitometry reports and then give recommendations to my local colleagues. It is through such testing that two elderly female patients were discovered to have severe osteoporosis and were aggressively managed. They have had significant improvement in their bone densities and have not suffered any fractures as a result of this technology.

From a family practice doctor, with a subspecialty interest in osteoporosis, in South Carolina:

It is extremely important to realize that even though the software provides a mechanical interpretation for the scan, this information is often incorrect if the physician does not properly evaluate the information. Ms. Jones was a 75-year-old woman with osteoarthritis at the lumbar spine and osteoporotic values at the neck of the bilateral hips. Without careful history and interpretation a falsely elevated total spine would be reported as normal and the total hips would be reported as osteopenic. Coupled with her maternal history of hip fracture with the values at the neck region of her hips, the patient required treatment for osteoporosis.

From a Rheumatology and Arthritis specialist in Florida:

A large part of my practice is to treat Medicare patients with their ongoing issues related to my specialty. There are new avenues of treatment available, but without being able to perform DXA Scans as needed, the care and treatment of these patients is put in jeopardy. High quality DXA reporting requires skilled interpretation of the many results generated by the instrument. I value the care and treatment of my patients and take pride in the fact that I can analyze and treat them to the utmost level of care. But, the upcoming changes it creates risk in how to treat and care for these people in need.

From a Rheumatologist specializing in osteoporosis in California:

A 52-year-old patient of mine had an almost normal bone density test a year ago. Two months later she was diagnosed with a breast cancer and was treated surgically as well as with chemotherapy followed by potent anti-estrogen medications.

She just had a follow up annual bone density test to see how all these events that could potentially be bone toxic, have affected her. Sure enough, the follow up bone density revealed significant bone loss. [Screening] made it possible to intervene with medications and other measures to save her skeletal integrity, and prevent fractures and deterioration of her health and independence.

Over the long run, lots of cost would be saved by keeping her active and functional rather than ending up treating her for fractures in spine with cardiopulmonary consequences, or repairing a hip fracture at a huge cost with potential complications.

From an MD in Texas:

We will no longer be able to offer this service to our osteoporotic patients due to the high costs associated with providing this valuable service. Our patients are currently able to receive this service in our office at the time of their regular office visits which leads to improvement in their quality of care.

The proposed cuts in reimbursement will likely result in limitation of services nationwide. In practices where small numbers of patients are measured and treated, it will become difficult to pay for the necessary machines and skilled technicians. In large clinics like mine, it will be difficult to justify performing studies which pay so little in return for the investment in machines, personnel, expertise, and space. The standard of care for interpretation of these studies has been set by ISCD, but the meager reimbursement for interpreting these studies would prevent me or my partner from spending the time and effort it takes to meet these standards. Instead we could only devote the time to sign the computer report - which is a disservice not only to my patients, but also to the ordering physicians and their patients. And yet without these studies the entire field of osteoporosis will grind to a halt.

The estimate of the professional portion of the physician work component is barely sufficient to cover a simple signature attached to a computer readout and does not begin to address the complexities of providing a standard of care report (see ISCD guidelines 2006). The degree of work, time, and expertise exceeds that of reading a lumbar spine x-ray, for example, but interpreting a DXA is already reimbursed at a fraction of the amount (11% of the total fees whereas most x-rays are reimbursed at approximately 25%). With the proposed cuts, I could never justify putting into each report the time needed to meet the standard of care and without question will cease that aspect of my practice if these cuts are enacted.

Every day of my practice I see patients who have significant osteoporosis - often with fractures of the hip, spine, pelvis, or other areas who were never diagnosed as having osteoporosis, much less treated, until a DXA was performed. Without this technology being readily available, these people will be destined to be disabled, have surgery, live in nursing homes, or even die from complications of osteoporosis (20% mortality in the first year after hip fracture). Even my own mother went unrecognized by her physician until I insisted on a DXA scan.

From a Diagnostic Radiologist specializing in Women's Imaging, including Bone Densitometry for diagnosis of Osteoporosis, in Maine:

I have had many patients of all ages who have had the "not me" syndrome. Had they not had a bone density measurement to accurately document degree of bone loss, they would probably not have agreed to treatment. Unfortunately many individuals are still diagnosed at the time of their first fracture.

From an Endocrinologist and bone center director in Maryland:

In this capacity I evaluate multiple patients with osteoporosis. Our center also provides state-of-the-art DXA and VFA services to the community. In Maryland, VFA is not covered by Medicare at all as of 5/18/06. Decrease in reimbursement will unquestionably have a serious impact on our ability to

accommodate patients referred for DXA screening and follow-up. At this point we continue to provide VFA to referred patients *gratis* in order to optimize their diagnostic accuracy and care decisions. In order to be able to provide VFA services we upgraded our equipment last year.

I think that this situation is extremely unfair to physicians and patients, especially in view of projected costs of care for osteoporotic patients who go on to develop an osteoporotic fracture. On the other hand, proper diagnosis and care may decrease fracture rate by over 50%.

As a skilled densitometrist I am hurt and disappointed by CMS conclusion that the actual physician work of DXA interpretation is "less intense and more mechanical" than was accepted previously. High quality DXA reporting requires skilled interpretation of the multiple results generated by the instrument. Incorrect DXA reading and wrong comparisons to baseline and previous scans by poorly trained physicians may result in multiple unnecessary specialty referrals or withholding of treatment of high risk patients. Properly read VFA may uncover previously undiagnosed compression fractures and completely change care decisions. Considering the fact that this is a point-of-care service with minimal radiation exposure, the denial of coverage is just mind-boggling!

It is my sincere hope that in view of osteoporosis epidemics and sky-rocketing cost projections for care of patients with fractures, CMS will change its decision [that] penalizes patients and physicians who are trying to prevent fractures from occurring in the first place.

From a rheumatologist in Ohio:

These tests are the single best predictor of the potential for future fracture from osteoporosis. Without the utilization of these tests, our ability to diagnosis and treat osteoporosis will set us back more than ten years. The technician and I have undergone specialized training to perform and interpret these tests. My practice (as well as many other practices) will not be able to provide these tests because the time, effort and cost involved in providing this type of analysis will exceed the proposed level of reimbursements.

There is a good deal of skill involved the interpretation of these tests. Furthermore the skill to interpret these tests will intensify in the future. The World Health Organization has mandated Risk Fracture Analysis reporting worldwide that takes into account the clinical makeup of the patient in the context of the values found by DXA and VFA. This type of reporting will demand a higher level of reimbursement (not lower) because of its complexity.

From a fellowship trained and board certified Endocrinologist, with a specialty in osteoporosis and bone health, in Pennsylvania:

Approximately one of two women over age 50 will have an osteoporotic fracture in her lifetime. Therefore, this issue is of huge importance to older women. A 70 year-old female in my practice was devastated when she fractured her hip. It changed her independent life style to one of dependency. She was angered that she was never given a bone density test, so her problem could be identified BEFORE her fracture. I am certain that this change in reimbursement will lead to more undiagnosed cases like my patient and will put us many steps backwards, instead of moving forward.

From an MD and Director of an Osteoporosis prevention and treatment center in Massachusetts:

The proposed dramatically-reduced reimbursement will absolutely not be sufficient to support densitometry services, and I have no doubt that availability of these services will decline. Such decreases in services will substantially reduce our ability to serve our patients, just now when we have all sorts of good treatments that reduce the risk of fractures dramatically in patients with low bone density.

It is especially appalling that the calculation of the expenses involved in densitometry utilized outdated pencil-beam technology, and assumes that the physician input has little impact on the bone density report. I must emphasize, as a densitometrist who has carefully tracked the time I spend, that I spend an average of 10 minutes in reading and interpreting each bone density. It is crucial that each bone density be carefully reviewed by the physician, given the high incidence of pathology in the spine and hip that can falsely alter the reported bone density unless this pathology is identified and excluded. Physician

involvement is especially critical when reporting follow-up bone densities, to make sure that all aspects of positioning and placement of the region of interest is comparable to prior images to make sure that observed changes in bone density are not due to changes in technique. Reducing reimbursement to the physician component will reduce physician involvement in reporting bone density, which will dramatically adversely affect the quality of the reported results, to the detriment of our patients.

From an ob/specialist in Massachusetts:

A large portion of my practice consists of menopausal women. I anticipate that the proposed cuts would force me to surrender my central DXA machine because of an inability to afford payments on the lease. These cuts will force many practitioners and BMD testing sites to close. It is well known in both the medical community and the general population that osteoporosis is a devastating disease. It is virtually 100% preventable, if osteopenia is detected BEFORE fractures occur. Reducing patients' access to BMD screening will only serve to increase the total cost of medical care when patients with untreated and un-prevented cases of osteopenia and osteoporosis fracture their wrists, spines and hips - increasing the already tens of billions of dollars spent in caring for osteoporotic fractures and complications.

I personally treat hundreds of women with osteopenia and osteoporosis. I personally interpret every BMD that is performed in my office. When interpreted correctly, BMD evaluation is not an easy test. Particular care must be given to assure that study sites are properly positioned and designated. Follow-up studies require significantly more time and attention to assure that the images from one scan to the next are properly correlated. It is not unusual for me to spend 30 to 40 minutes per scan to make sure there is consistency between subsequent scans.

Please do not restrict patient access to an important tool in maintaining their health and quality of life. Please do not ignore the future of increased fractures, debilitation, increased nursing home admissions, and unnecessary morbidity and mortality should these cut-backs come to pass. Please do remember that medicine is striving to prevent disease, and the DXA for screening, diagnosing and treating osteoporosis is a critical tool that should not be taken away.

Thank you to these individuals and all the others who supported this effort in this and other ways.