

COMMENTARY

Medicare Cuts DXA to the Bone

By Chrisine Simonelli, M.D.

Availability of a cost-effective screening for osteoporosis is threatened by federal budget cuts.

Osteoporosis, a disease of low bone mass and increased risk of fracture, affects some 10 million Americans. An additional 34 million have osteopenia, low bone density that can lead to osteoporosis. At least 1.5 million people in the United States suffer an osteoporotic fracture each year, leading to more than 800,000 emergency room visits, 500,000 hospitalizations, 2.6 million physician office visits, and almost 180,000 nursing home placements. Estimates of the direct costs range from \$12.2 billion to \$17.8 billion and are projected to increase to more than \$25 billion annually by 2025; the indirect costs associated with lost productivity by both patients and family caregivers add billions more to the tab. Osteoporotic fractures are also associated with substantial mortality; more deaths occur annually from complications following hip fracture than from breast cancer.

To reduce the impact of osteoporosis and osteopenia on individuals and society, it is essential to identify persons at increased risk of fracture and initiate therapy to reduce that risk. Bone density measurement with central DXA (dual energy X-ray absorptiometry) is currently the gold standard and the only technology for diagnosing osteoporosis and osteopenia using the World Health Organization classification system. Central DXA also allows physicians to monitor patients' response to therapy. A recent enhancement of central DXA is vertebral fracture assessment (VFA), which enables better detection of vertebral fractures, two-thirds of which are asymptomatic and often go undetected. VFA, combined with DXA, has the potential to identify those at greatest risk for future fractures. However, access to these screening technologies in physicians' offices is likely to decrease because reimbursements are being reduced to levels far below the cost of performing these screenings.

Costly Cuts

Osteoporosis and osteopenia are predominantly diseases of age, and the U.S. population is aging. Today, it is estimated that half of 50-year-old women and one-quarter of 50-year-old men will suffer an osteoporotic fracture during their lives. The most frightening of these fractures, of course, is a hip fracture. One in four Americans older than 50 who suffer a hip fracture dies within a year of the incident; many never regain even limited mobility. The cost of treating a hip fracture is tens of thousands of dollars; the cost of a DXA exam in a physician's office in 2006 was approximately \$140.

Recognizing the consequences of failure to prevent fractures in the aging population and the availability of an effective diagnostic technology, Congress took action a decade ago to increase bone density screening. Specifically, it passed the Bone Mass Measurement Act of 1997, which called for education about osteoporosis, screening of women older than 65 using DXA, and prevention of the disease. A U.S. Preventive Services Task Force report affirmed the call for

more screening, and primary care physicians and specialists alike began screening more patients. As a result, Medicare claims for DXA screening exams increased from 77,000 in 1994 to more than 1.25 million in 1999. In 2004, 2.5 million claims for such tests were filed under Medicare. But even with that dramatic increase in the number of people screened for the disease, approximately 75 percent of all female Medicare beneficiaries remain unscreened.

This year, the Medicare reimbursement rate for DXA was slashed by more than 40 percent to just over \$80. By 2010, it is slated to drop to \$35 per screening. At the same time, the reimbursement rate for VFA is slated to drop 43 percent, from \$40 in 2006 to \$19.22 in 2010. The effect of such cost cutting carries over to private insurers, as they base their reimbursements on those paid by Medicare.

There are two main reasons behind the drastic cuts. The first is the Deficit Reduction Act (DRA) of 2005, which took effect January 1. Section 5102 of that act, "Adjustments in Payments for Imaging Services," was inserted into the bill at the last minute and was not debated. This reduced reimbursement for DXA screening done in physicians' offices to match the amount paid to hospitals for screenings done in outpatient departments, which is typically less than \$100.

The other factor is the mandated five-year review undertaken by the Centers for Medicare and Medicaid Services (CMS). Every five years, CMS sets reimbursement rates for thousands of medical services based on complex calculations of physician time and effort, the cost of equipment and supplies needed to perform a service, equipment utilization rates, and the cost of malpractice insurance for those who perform the service. Unfortunately, CMS used a set of flawed assumptions to create its reimbursement rates for DXA and VFA this year:

- CMS estimated physician time and effort at only two-thirds of the time actually reported by doctors who perform the tests in a survey conducted last year by the International Society for Clinical Densitometry (ISCD), the doctors' group that speaks for all practitioners who do bone screening, regardless of their medical specialty.
- CMS used as its figure for the cost of equipment that of a last-generation machine, which accounts for fewer than one in five being used today. The cost of the current technology is nearly double.
- CMS also estimated a utilization rate for the equipment used for DXA and VFA based on the utilization of imaging equipment found in radiology facilities. Only 4.3 percent of doctors who responded to the ISCD survey are radiologists. Fully 70 percent are internists, family physicians, and OB/GYN practitioners. Primary care providers have a far lower utilization rate for imaging equipment because they are busy providing their patients with more comprehensive services. Thus, primary care physicians' costs for providing these screenings in their clinics are likely higher than those of physicians working in high-volume radiology facilities.

Without adequate reimbursement, it can be expected that bone densitometers will be removed from primary care providers' offices. Consequently, osteoporosis screening rates will decline, and that will lead to an increase in the number of fractures. This is clearly a "penny-wise, pound-foolish" approach that will ultimately increase Medicare expenditures.

What Can Be Done?

At this point, the most important action physicians can take is supporting federal legislation to prevent the reduction of DXA testing for both screening and follow-up. Specifically, Rep. Carolyn McCarthy (D-NY) has introduced a bill, H.R. 1293, that will place a two-year moratorium on the

DRA's proposed imaging cuts until a study of their impact is conducted by the Government Accountability Office. McCarthy's bill would apply the DRA's reimbursement reductions only to advanced diagnostic imaging procedures, thereby excluding DXA and VFA that screen for fracture risk.

Other more important proposals are being developed by patient advocacy and clinical groups. These would establish the 2006 reimbursement for DXA and VFA as a floor for future rates. It is expected that such bills will be introduced this summer. Information on legislative developments can be found on the ISCD website, www.iscd.org.

This is a critical time for those of us who are passionate about preventing osteoporotic fractures. Combined legislative and regulatory efforts seem destined to destroy the field of osteoporosis prevention, and this will lead to unnecessary fractures with costly consequences. Physicians need to inform their elected officials about this issue and urge them to preserve access to these low-cost screenings. The time to act is now. Contact your congressional representatives and ask them to support H.R. 1293. **MM**

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