**Submitter :** Dr. William Coughlin **Date:** 07/31/2006

**Organization :** Dr. William Coughlin

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

In the calculation of the RVU on CPT 93701, the equipment disposables and price for the technician are always increasing. The malpractice is obviously increasing in Illinois. Therefore a decrease in reimbursement is unreasonable and in the end limits access to care.

**Submitter :** **Dr. Phillip Foley** **Date: 07/31/2006**

**Organization :** **Dr. Phillip Foley**

**Category :** **Physician**

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

The proposed RVU amount of 0.91 practice expense is not commensurate with the costs of administering this test. The device costs over $40,000 in 2006, CMS must be using old data. Additionally, while the change in office visit RVUs is encouraging, the change in method to calculate the practice expense for diagnostic test RVUs is flawed. Please cancel the proposed changes in how the RVUs are determined.

**Submitter :** Dr. Stewart Grote **Date:** 07/31/2006

**Organization :** Dr. Stewart Grote

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

Impedence with CPT 93701 has been an excellent and effective modulity for our practices for 3-4 years now. It is helpful with heart HTW and values related to CHF. Cutting reimbursement is unfair both because of our investment and relevance of this modulity. We paid more than the outdated surveys have outlined for the equipment. The new methodology for calculating the RVU amount for practice expense is flawed. Please delay implementation until a more fair method is developed.

**Submitter :** Dr. Anil Sharma **Date:** 07/31/2006

**Organization :** Dr. Anil Sharma

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

Regarding CPT 93701, Technician and overhead are increasing in my practice. The RVU amount should absolutely not be decreased from previous year. I use this technology every day in my practice and if the RVUs are decreased to 2007 and 2010 levels, I will no longer be able to provide this service.

**Submitter :** Dr. Randy Watkins **Date:** 07/31/2006

**Organization :** Cook Children's Medical Center

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Radiology, Pathology, and Other
Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

Please re-evaluate your anticipated changes in Medicare reimbursement for Anesthesia, as overhead costs are somewhat difficult to calculate but are already underestimated. CMS should gather new data rather than relying on older, out-of-date information before making a rule change which will impact thousands of physicians, and thus, their patients. There is already a shortage of qualified anesthesiologists, and it appears this will only worsen as our physician population ages. More governmental cuts in income will only weaken the workforce and recruiting efforts.
Thank you,
Randy Watkins, MD

**Submitter :** Dr. Noel Lopez **Date:** 07/31/2006

**Organization :** Palm Valley Medical Clinic

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

The proposed RVU amount for CPT code 93701 is not acceptable. The new methodology used to calculate the RVU amounts for practice expense for CPT 93701 results in a significant decrease in the reimbursable amount that is not compatible with increasing practice expenses for the procedure because the disposable prices are increasing and the equipment was very expensive. The technician costs and overhead are increasing. The cost of my BioZ equipment was $38,000 which is a significant difference from the cost estimate used by CMS at $28,000 that is based on discontinued or used equipment.

In summary, I am requesting that the RVU amounts be changed to accurately compensate us for use of this equipment that is extremely helpful in treating and controlling congestive heart failure.

**Submitter :** Dr. Ninette Hart **Date:** 07/31/2006

**Organization :** Hilo Medical Center Department of Anesthesiology

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

I have serious concerns about the current formula for payment to anesthesiologists. The formula does not adequately take into account all practice expenses and level of care that is being provided to patients. CMS must address anesthesia work undervaluation before a crisis is reached in our ability to care for these patients. As chairman of an understaffed deparment in a medicare heavy area I am unable to recruit anesthesiologists primarily because of inadequate reimbursement.

**Submitter :** Dr. Mindi Garner **Date:** 07/31/2006

**Organization :** Mindi S. Garner, DO

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Evaluation and Management
Services**

Discussion of Comments- Evaluation and Management Services

I am a Board-Certified Internist, Solo Independent, Small Business Owner that is involved in EVERY aspect of my clinic's financial and clinical duties. I practice in Pittsburg, KS, a rural Kansas town, that serves a large percentage of Medicare patients. I have been in practice almost 3 years and I assure CMS that the current RVU system for E&M services is inadequate to support the services rendered at the current reimbursement level. I urge CMS to finalize the recommended increase payment level for the valuable services I provide to Pittsburg area senior citizens. My patients have become more complex, in regards to multiple medical problems that are diagnosed during clinic visits and hospital admissions. Many more imaging and lab tests are available than years ago that increase the amount of time and energy that it takes to adequately assess my patient's illnesses and build plans that prevent further morbidity and mortality and improve their quality of life. Primary care doctors in my community would have difficulty, like me, to continue to treat Medicare patients if the current system is not overhauled.

**Submitter :** **Ben McCallister, Jr.** **Date: 07/31/2006**

**Organization :** **Michigan Heart**

**Category :** **Physician**

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8017
Baltimore, MD 21244-8018

Re: CMS 1512-PN; PRACTICE EXPENSE

Dear Dr. McClellan:

I am a cardiologist who performs echocardiography in a large single specialty cardiology practice in Ann Arbor, MI. I am delighted to have the opportunity to comment on the Proposed Notice published by CMS in the Federal Register of June 29, 2006, which sets forth proposed changes to the relative value units used to establish payment for services to Medicare patients under the Physician Fee Schedule.

I am extremely concerned about the possible impact of these changes on Medicare payment for cardiac ultrasound and other cardiac imaging services performed in the office setting. While the Proposed Notice would result in increases in Medicare payment for some of the services that we provide most notably evaluation and management services we are concerned that, by the end of the transition period, the Proposed Notice would result in payment reductions in the range of 25% for the most common combination of echocardiography procedures (transthoracic echocardiogram with spectral and color flow Doppler (CPT codes 93325, 93320 and 93325).

Echocardiography is a crucial tool in the diagnosis of a broad range of cardiac disease, including congestive heart failure, congenital heart disease, valve disorders, and coronary artery disease. The performance of echocardiography requires the acquisition and maintenance of costly medical equipment and the retention of highly trained cardiac sonographers who are in increasingly short supply. We are concerned that payment reductions of the magnitude outlined in the Proposed Notice may have an adverse impact on the overall quality of the echocardiography services provided to our patients at the very time that the federal government is seeking to improve quality through pay for performance and similar quality-related initiatives.

While I am not in a position to provide a complete technical analysis of the Proposed Notice, I understand that the American Society of Echocardiography (ASE) is conducting such an analysis and will be submitting comprehensive comments. I support those comments, and strongly urge you to consider making the changes suggested by ASE in the Final Rule.

Thank you for your attention to this most important matter.

Sincerely yours,

Ben D. McCallister, Jr., M.D., FACC, FASE, FASNC
President
Michigan Heart, PC
Ann Arbor, MI
734-712-8000

**Submitter :** Dr. Victor Shpilberg **Date:** 07/31/2006

**Organization :** Dr. Victor Shpilberg

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

Please do not approve a reduction in reimbursement for code 93701. Thoracic biompedance disposables are increacing and the RVU amount should be sustained or increased to justify the increased cost of providing this test. Instead, you are proposing to decrease it, which is completely at odds with real world costs.

**Submitter :** **Dr. Peggy Duke** **Date: 07/31/2006**

**Organization :** **GSA/ASA**

**Category :** **Academic**

**Issue Areas/Comments**

**Other Issues**

Other Issues

CMS simply can not continue reducing physician payment for care given to medicare and medicaid patients. In no other specialty does the payment depend on what the government has decided is the amount based on information that simple is not correct and then rearranges the amounts to various entities based on who has most recently lobbied. Please look at the payment schedules for physicians and make them reasonable. The proposed cuts will further weaken the resolve of many physicians to continue practicing, will encourage others to retire earlier and may impact the number of the brightest students who want to pursue medicine.
I have practiced for over 26 years. I am intensely proud of being a physician. Providing high quality, professional care to patients is what I have done all these years.
Reconsider the reduction in payments to physicians. It is simply the wrong thing to do.
Thank you for reading my email.
I will be happy to talk to anyone at any time.
Sincerely,
Peggy G. Duke, MD
Atlanta, Georgia
30305

**Submitter :** **Dr. Scott Murtha** **Date: 07/31/2006**

**Organization :** **Dr. Scott Murtha**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

July 18, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

RE: Proposed change in PE Methodology

Dear Sir or Madam:

I am opposed to the proposed change in PE methodology used to calculate Medicare payment rates. Implementation of this change would severely cut payments to anesthesiology and other specialties to supplement the overhead cost increases for a small number of specialties.

This change will hurt anesthesiology more than other specialties because our reimbursement is already based on flawed and outdated overhead expense information that underestimates our actual expenses. Medicare reimbursement rates for anesthesiology are already below our costs to provide such services. Medicare anesthesia rates are 20-30% of market rates, whereas other specialties are paid 70-90% of market rates by Medicare. Implementing this PE Methodology change will impose cuts on rates that are already unreasonable.

The data CMS is using to implement this new methodology is already a decade old. CMS needs to gather new data. The ASA, many other specialties, and the AMA are committed to financially support a comprehensive, multi-specialty practice expense survey. CMS should take immediate action to launch this much needed survey which will greatly improve the accuracy of information for all practice expense payments. The proposed change in PE methodology needs to be delayed until a new survey is completed and analyzed.

CMS has thus far neglected to address the significant undervaluation of anesthesia care by Medicare. The work component of anesthesia care used in determining anesthesia reimbursement was and continues to be significantly undervalued. CMS needs to address this issue before our nation experiences a certain shortage of anesthesiology medical care in operating rooms, pain clinics and throughout critical care medicine.

Iowans are already underserved in many, if not most, medical specialties. Recruiting physicians to Iowa with its current low Medicare reimbursement rates is difficult. Further cuts in Medicare reimbursement will only exacerbate and accelerate this deficiency.

I urge you to cancel or postpone the implementation of a change in PE methodology until timely, accurate information may be analyzed.

Sincerely,

Scott D. Murtha, M.D.

**Submitter :** Dr. Robert Gong **Date:** 08/01/2006

**Organization :** Siena Hills Primary Care

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Evaluation and Management
Services**

Discussion of Comments- Evaluation and Management Services

Dear Sir/Madame:
I wish to encourage CMS to finalize the recommended work RVU increases for evaluation and management (E/M) services.
I am a primary care doctor taking care of many elderly patients with chronic illnesses. The scope and complexity of primary care for chronic conditions has increased dramatically in the past 10 years. We are seeing more elderly patients with multiple complex chronic problems who take numerous medications that have side effects and interactions. What is most important and what the patients value the most is our time spent together discussing their diagnoses, treatments, and alternatives. To provide good care, we must also spend significant time giving education about these chronic conditions as well as providing emotional supportive care. This is at the heart of health care. The lack of this attention and time is what drives most patients' complaints about our current health care system.
Unfortunately, the current payment system for E/M services unfairly devaluates our time spent in this endeavor. Our reimbursement for our face-to-face time and care of patients pales in comparison to payments for diagnostic tests and procedures. One of many examples is that of nuclear medicine cardiac stress testing, which is used to evaluate for coronary heart disease. The payment for this brief test is over 20 times the amount paid for a physician to sit down with a patient, interpret and explain the test results, advise treatment, and develop a long-term plan based on these results. Patients actually value the physician's time and attention over the actual test itself, but the current system over-values the "test" and devaluates our time.
Those of us who serve patients in primary care medicine such as Internal Medicine particularly suffer from this disparity in payments that values tests and procedures over E/M services. The great majority of our time is spent in E/M services, and because we refer to other specialists for diagnostic tests, we do not have the income from these tests to offset the devaluated reimbursements that we receive for our E/M efforts. As a result of this disparity, there are fewer physicians entering primary care fields, which will compound the shortage of primary care physicians nationwide and lead to a decrease in access to care by Medicare beneficiaries unless this flawed payment system is corrected.
There are many medical specialties which provide a lot of tests and procedures and currently benefit greatly by this payment disparity. Undoubtedly some of these physicians will push to reject any changes that would lower their reimbursements and increase those for E/M services. Please consider that this disparity has been in existence for over a decade, and it is time to correct the problem for the benefit of our Medicare beneficiaries.

Thank you for you attention.

Robert Gong, MD
Henderson, NV
702-614-0850

**Submitter :** Dr. steve fischer **Date:** 08/01/2006

**Organization :** safischermdpc

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

aneshesia services are currently provided at a significant discount compared to surgical providers. there is an inherent disincentive to do medicare cases in a timely fashion especially after hours not to mention the fact that the medicare patient is frequently the sickest and most challenging patients we care for and yet we are accorded the lowest reimbursement rate which grossly undervalues the service rendered this patient population. practices that exceed 50% medicare are not sustainable on their own and require subsidies to maintain solvency. ultimately you get what you pay for.

**Submitter :** Mr. Andrew Whitman **Date:** 08/01/2006

**Organization :** The National Electrical Manufacturers Association

**Category :** Device Association

**Issue Areas/Comments**

**Other Issues**

Other Issues

Comment - Docket: CMS-1512-PN - Five Year Review of Work Relative Value Units Under the Physician Fee Schedule

CMS-1512-PN-908-Attach-1.DOC

#908

NEMA
Setting Standards for Excellence

**Andrew Whitman**
Vice President, Medical Products

NATIONAL ELECTRICAL MANUFACTURERS ASSOCIATION
1300 North 17th Street • Suite 1752 • Rosslyn, VA 22209
Tel: 703-841-3279 / Fax: 703-841-3379
Email: Andrew_Whitman@nema.org

August 1, 2006

Mr. Herb Kuhn
Director, Center for Medicare Management
Centers for Medicare and Medicaid Services
Mail Stop C5-01-14
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: DOCKET No. CMS-1512-PN: Request for Extension of Comment Period on the "Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology" (June 29, 2006).**

Dear Director Kuhn:

The National Electrical Manufacturers Association ("NEMA") hereby requests an extension to the comment period for the Center for Medicare & Medicaid Services' ("CMS") proposed notice entitled "Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology." *See* 71 Fed. Reg. 37169 (June 29, 2006). NEMA believes that without additional necessary data or regulatory language on the proposal, many of the provisions could result in significant unintended consequences to Medicare beneficiaries.

NEMA, established in 1926, is the nation's largest electronic industry trade association. The Diagnostic Imaging and Therapy Systems Division of NEMA represents the manufacturers of over 95% of the X-Ray imaging (including mammography), CT, Radiation Therapy, Magnetic Resonance, Diagnostic Ultrasound, Nuclear Medicine Imaging and Medical Imaging Informatics equipment used in the United States. NEMA is also the world's primary standards-development organization for medical imaging equipment. Such standards establish commonly-accepted methods of design, production, and distribution for medical imaging products. Sound technical standards benefit the user, as well as the manufacturer, by improving safety, fostering efficiencies, eliminating misunderstandings between manufacturer and purchaser, and assisting the purchaser in selecting and obtaining the appropriate product.

NEMA is concerned the proposed notice does not include regulatory language. Rather, it outlines a step-by-step process that would be used to calculate PE-RVUs. In addition, the proposed notice states that CMS has accepted supplemental survey data from thirteen medical specialty groups. It is possible that CMS will use this data to calculate practice expenses. However, the proposed notice states that CMS has "not received updated aggregate cost data from most specialties." *See id* at 37245. Consequently, without adequate data or regulatory

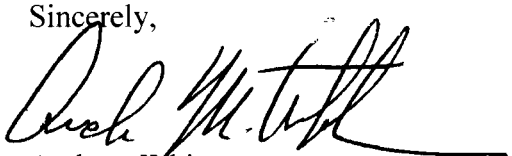
language, CMS has placed NEMA in the difficult position of analyzing and commenting on a fundamentally incomplete, yet exceeding complex, proposal.

Without this material, NEMA and its members are unable to ascertain the true and complete impacts of the proposal. There is legal precedent that states that administrative rulemaking must be sufficiently descriptive of subjects and issues involved so that interested parties may offer informed criticism and comments. Also, agency notice must describe the range of alternatives being considered with reasonable specificity; otherwise, interested parties will not know what to comment on, and notice will not lead to better-informed agency decision-making.

NEMA is committed to working with CMS on this proposed notice. We plan on submitting detailed comments in response to the proposed notice, which we trust will assist CMS. However, an extension of the comment period is warranted due to the lack of data or regulatory language. An extension would allow the regulated community the time it requires to appropriately respond to the proposed notice.

Thank you for consideration of our request.

Sincerely,



Andrew Whitman
Vice President, Medical Products

**Submitter :** **Dr. David Beddow** **Date: 08/01/2006**

**Organization :** **Unity Hospital**

**Category :** **Physician**

**Issue Areas/Comments**

**Discussion of Comments-
Evaluation and Management
Services**

Discussion of Comments- Evaluation and Management Services

I would like to submit my support for the proposed CMS work RVU increases for 2007. I have been a practicing Hospitalist in Minnesota for the past 3 years and the complexity of patients and their care has steadily increased. Furthermore, it is very difficult to recruit new physicians to do hospitalist work. The nights and high volume of patients is leading to burnout in the Hospitalist profession also. The fee increases proposed would help stabilize the specialty and help recruit. Thanks.

David Beddow, MD
Chief of Staff Mercy and Unity Hospital

**Submitter :** **Dr. William Branch** **Date: 08/01/2006**

**Organization :** **Emory University School of Medicine, Grady Memoria**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I urge acceptance of the recommended increases in Medicare reimbursement for Evaluation and Management Services. As Director of a Division that sees over 100,000 outpatient healthcare visits per year plus many inpatients cared for at Grady Memorial Hospital in Atlanta, of which Medicare is our largest source of payments to sustain these operations, I can tell you that E@M services have been grossly under-reimbursed over the years, our patients are complex and needy, our budgets are extremely tight and tenuous and the recommended changes are most welcome and will definitely help sustain our efforts to care for underserved patients. It is really time for Medicare to readjust the payments to reflect the highly complex work of general internists and other providers who are on the front lines taking responsibility for the care of patients many of whom have multiple medical problems that will affect their health. Sincerely yours, William Branch, MD, Chief, General Internal Medicine, Grady Memorial Hospital, Emory University School of Medicine

**Submitter :** Dr. Sunil Kripalani **Date:** 08/01/2006

**Organization :** Emory University

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Evaluation and Management
Services**

Discussion of Comments- Evaluation and Management Services

I applaud CMS for considering in increase in payments for evaluation and management services. Historically low reimbursements have made primary care unattractive to many graduating medical students. Recent data that inflation-adjusted physician income has actually decreased by 7%, while that of other professions has increased by a similar amount, show the potential effect of inadequate compensation for physician services in an era when overhead expenses including malpractice premiums are rising, and student debt is at an all-time high. I hope CMS will accept the proposed RVU changes. Without them, we can expect to see a continued decline in primary care in the coming years.

**Submitter :** Dr. Nison Abayev **Date:** 08/01/2006

**Organization :** Dr. Nison Abayev

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

The proposed amout of reimbursement for the 93701 code is not appropriate. The cost of the equipment is higher than $28,625 and the RVU amout should stay the same as it is currently at 0.98. This should be increased to keep up with increased to keep up with increased patient costs.

**Submitter :** Dr. Donald Woocl **Date:** 08/01/2006

**Organization :** Dr. Donald Woocl

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

The proposed RVU amount for CPT code 93701 is unacceptable due to the cost of the equipment and the increased practice expenses for the procedure. Your new methodology for calculating the RVU is significantly flawed and must be reconsidered. Cutting the RVU of 93701 will mean that my practice will lose money by providing the test.

**Submitter :** Dr. Richard Terry **Date:** 08/01/2006

**Organization :** Dr. Richard Terry

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

For CPT 93701, the cost of ICG equipment has not decreased and the cost of personnel to perform this test has increased; thus the practice expense has gone up and the reimbursements should likewise increase rather than decrease.

**Submitter :** Dr. Susan Smith **Date:** 08/01/2006

**Organization :** Palo Alto Medical Clinc

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Evaluation and Management
Services**

Discussion of Comments- Evaluation and Management Services

I fully support the proposed increases in the value of E&M codes. The complexity of office-based care has increased dramatically over the past decade. The majority of my patients bring multiple issues to each visit. Furthermore, to discuss all the evidence-based recommendations takes increasing time. It is comman to see a non-adherent diabetic hypertensive patient in a short visit. We are then trying to disucss specifics of management of their medical problems, trying to discuss the reasons they are having difficulty adhering to the recommendations, trying to get them to comply with blood draws, trying to get them to fill and take prescriptions, and discussing the colonoscopy they are overdue for.
In our practice, only extremely ill patients are hospitalized; the time required to manage those patients effectively has increased significantly.
Fewer medical students are choosing primary care. The job has become increasingly difficult, with long hours and extensive documentation requirements. In addition, particularly in primary care, there is increasing accountability as measured by Pay for Perfomance initiatives, and increasing transparancy, as these measures are published on the intranet. Though I applaud these changes, I don't believe it will be possible to continue to recruit the most qualified medical students into primary care unless the reimbursement more closely matches the time, level or responsibility, and commitment required. The proposed changes are a small step in the right direction.

**Submitter :** Ms. Susan Dimock **Date:** 08/01/2006

**Organization :** Jacobs Institute for Women's Health

**Category :** Consumer Group

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

See Attachement

CMS-1512-PN-916-Attach-1.DOC

CMS-1512-PN-916-Attach-2.DOC

#916


July 7, 2006

The Honorable Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1512-PN

Dear Dr. McClellan:

The Jacobs Institute of Women's Health is a nonprofit organization working to improve health care for women across the lifespan and in all populations. The Institute was founded by the American College of Obstetricians and Gynecologists in 1990, and recently became affiliated with the George Washington University's School of Public Health and Health Services.

Unique in its focus on women's health issues at the intersection of our medical and social systems, the Jacobs Institute brings together interdisciplinary audiences, including health care professionals, researchers, policymakers, consumers, and advocates to discuss ways to advance women's health. A priority of longstanding has been underscoring the importance of cancer screening. American women often put the health care of their families ahead of their own. Preventive services are the most neglected.

Mammography presents a particular challenge. As you know, it is not as available as it should be and once was, leading to long waits in many parts of the country. The diminishing availability of mammography machines and trained radiologists is aggravated in certain populations by other obstacles.

In rural areas, where the population is widely dispersed but specialty health care is clustered in population centers, women who want to be screened are forced to drive several hours, adding to the cost and inconvenience. A study published in our journal, *Women's Health Issues*[1], confirms a significantly lower rate of mammography screening in rural areas. For women who get screened less frequently, quality becomes even more important.

Accordingly, we are writing to express our concern about a proposed Medicare rule, published at the end of June, cutting reimbursement for Computer Aided Detection (CAD) for mammography by more than 50%. CAD helps save women's lives by finding more breast cancers, often at

[1] Larson, Sharon and Rosaly Correa-de-Araujo. 2006. "Preventive Health Examinations: A Comparison Along the Rural-Urban Continuum." *Women's Health Issues* 16(2):80-88.

2021 K Street, NW, Suite 800, Washington, DC 20006 • T 202.296-6922 • F 202.296.0025

earlier stages of the disease. In fact, recently published data indicate that CAD increases the detection rates of small, invasive breast cancers by as much as 164%.[2]

Also important in the fight against breast cancer is stereotactic guided breast biopsy, a minimally invasive alternative to surgical biopsy. It would be cut by 80%, pursuant to the proposed rule.

Over the last decade or so, minimally invasive procedures have displaced surgery as the preferred approach to breast biopsy. These procedures require some form of image guidance, either ultrasound or stereotactic (x-ray based). We understand that stereotactic imaging, unlike ultrasound, makes it possible to see micro-calcifications -- sub-centimeter tissue abnormalities -- critical in determining the early presence of breast cancer. If the proposed reimbursement cut of 80% is retained as part of the final rule, many women won't be able to afford the minimally invasive procedure and will find themselves back in the surgical suite.

Cuts of this magnitude to reimbursement for CAD as an adjunct to mammography, and for stereotactic guided biopsies have no place in a modern Medicare program. They would put critical, life-saving technologies beyond the reach of many women who are most at risk for breast cancer. Surely that was not your intent.

Thank you for your attention to this matter. We look forward to hearing from you.

Sincerely,

Susan Halebsky Dimock, PhD
Program Manager

[2] Cupples, Tommy E., Cunningham, Joan E. and Reynolds, James C. 2005. "Impact of Computer-Aided Detection in a Regional Screening Mammography Program." *American Journal of Roentgenology (AJR)* 185: 944-950.

**Submitter :** Ms. Susan Arnold **Date:** 08/01/2006

**Organization :** Aegis Women's Healthcare

**Category :** Other Technician

**Issue Areas/Comments**

**Background**

Background

I have been doing the Central DXA's @ our office for the past 8 years. Since I work in an OB/GYN office I find patient's lose BMD after going off of HRT. If the patient did not have a DXA scan they would never be aware of this loss. Many of my patient's wait on the BMD report to decide on whether to begin treatment. Sometimes they will opt not to go off of the HRT. This test is critical for them to make their decision.

**Submitter :** Dr. glenn kotz **Date:** 08/01/2006

**Organization :** alpine medical grou[

**Category :** Physician

**Issue Areas/Comments**

**Other Issues**

Other Issues

regarding decrease of outpatient reembursement bone density.

I am sure you are aware of the promary care finacial crisis.
As a primary care provider our income has decreased by 40% over the past 10 years. this is actual income. we work the same 60 hour weeks.
as CMS decreases any code it makes it more difficult for physicians to manage disease states and support a staff. The result of the poor decisions on physician reembursement always come back to patients and patient care.
Some one MUST see that medical care in the USA does not rate among the best in the world . This system is failing and CMS continues with the same approach to medical reembursement. This decsion will impact patient care in a negative manner. Please reconsider.

**Submitter :** **Date: 08/01/2006**

**Organization :**

**Category :** **Health Care Provider/Association**

**Issue Areas/Comments**

**Discussion of Comments-
Radiology, Pathology, and Other
Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

Please do not allow regulations to cut DXA. This will cause an increase in hip fractures and will be much more expensive for CMS.

**Submitter :** Dr. Augusto Focil **Date:** 08/01/2006

**Organization :** Focil Med

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

My practice is directed to the underserved hispanic comunnity in Oxnard California where the impact of the complication of the ospeorosis is a reality . The hispanic population is underdiagnosed , undertreated and in the latest report by silverman show the only one who increased the hip fracture rates in comparison with other group.
Reducing the already low reimbursement in DXA and VFA will delay even more the already existing problem.
We urge not to pass this law in the contrary we would like to see and strong support for the osteoporosis prevention program and community awareness in all the population.

**Submitter :** **Date: 08/01/2006**

**Organization :**

**Category :** **Physician**

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

As an anesthesiologist, I am opposed to the PE methodology changes as it hurts anesthesiology more than other specialties due to CMS's use of outdated data to calculate overhead expenses and its underestimation of actual expenses. As the policy currently stands, anesthethiology and other specialties face huge payment cuts to supplememnt the overhead cost of a handful of specialties. CMS should obtain new overhead expense data to replace the decade old data currently being used. The ASA and AMA and other specialties are committed to financially support a comprehensive, multi-specialty practice expense survey, and CMS should take immediate action to launch this greatly needed survey which will improve the accuracy of all practice expense payments. CMS must address the issue of anesthesia work undervaluation or our nation's most vulnerable populations will face a certain shortage of anesthesiology medical care in operating rooms, pain clinics, and intensive care units. My group practice is actively seeking to employ more anesthesiologists to staff an expanded number of operating rooms but are having difficulty recruiting because of undervaluation, so there is already a shortage of providers resulting in curtailment of services.

**Submitter :** Dr. Robert Sonnemaker **Date:** 08/01/2006

**Organization :** St. John's Health System

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

The proposed reduction of fees for providing BMD (bone mineral density) physician services will severely compromise the care provided medicare beneficiaries for the management and prevention of osteoporosis. The temporary monetary gain from reduction of services reimbursement will pale in light of the overwhelming cost increase in caring for this patient population as a result of the inevitable loss of quality of care.

**Submitter :** Dr. Fergus McKiernan **Date:** 08/01/2006

**Organization :** Center for Bone Diseases

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Radiology, Pathology, and Other
Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

The value of an expertly executed and interpreted dual X-ray absorptiometry (DXA) scan, upon which thousands of dollars of treatment are based in millions of patients, is surely worth more than the cost of having someone look under the hood of my car or at my dripping faucet. Your proposed cuts in reimbursement for DXA execution and interpretation would suggest not. Please be reasonable.

**Submitter :** Dr. M. David East **Date:** 08/01/2006

**Organization :** Lake Internal Medicine

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

re CPT 93701

1. The proposed RVU amount for CPT 93701 is not accepatble. My BioZ machine cost $34,000 2 years ago and the expenses for electrodes are additional.

2. The new methodology used to calculate the RVU amounts for practice expense for CPT 93701 results in a significant decrease in the reimbursable amount that is not compatible with increasing practice expenses for the procedure

a. Thoracic impedance equipment prices are increasing
b. Thoracic impedance equipment disposable prices are increasing.
c. Nurse/Technician costs are increasing.
d. Overhead is increasing.

In summary, it is very difficult to operate a private practice. Costs increase every year and reimbursement decreases each year, yet we have to offer the latest technology to our patients to help diagnose and treat.

All other business in this country increase their fees periodically to keep up with rising costs. Only Medicine has to deal with increasing cost and decreasing reimbursement. We are dealing with the health of our population, not a sporting event, or some other optional item.

If you have questions, please call me.
M. David East, DO, FACOI
980 Executive Drive
Suite D
Osage beach, MO 65065

phone 573-348-6700
fax 573-348-3310

**Submitter :** **Dr. Robert Yood** **Date: 08/01/2006**

**Organization :** **Fallon Clinic**

**Category :** **Physician**

**Issue Areas/Comments**

**Discussion of Comments-**
**Radiology, Pathology, and Other**
**Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

I am writing to comment on proposed cuts in reimbursement for bone density studies. My multispecialty group practice does perform bone density studies for evaluation of patients with possible osteoporosis and for management of patients with osteoporosis. These studies are critical for evaluation and treatment so as to reduce fractures. There are proposed quality measures for osteoporosis, which include bone density studies.

I participate in reading bone density studies in our group. My colleagues and I have additional training to do this; all of us are certified by the International Society for Clinical Densitometry. It takes me an average of 6 minutes per study to prepare a report. This is on top of the time spent by our technicians who obtain historical information from the patient about prior fractures, risk factors (e.g. menopausal status, family history and certain medications) and treatment and then perform the bone density test. My technicians schedule patients every half hour.

This service cannot be provided for the $40 projected payment per test projected by 2010. Such a payment will result in providers discontinuing bone density tests. I conclude that some of the assumptions used for calculation the fee schedule must be inaccurate.

I hope you will reconsider the payment change in light of information such as the above.

Sincerely,

Robert A. Yood MD
Fallon Clinic
425 North Lake Avenue
Worcester, MA 01605

**Submitter :** **Dr. Sarah L Morgan** **Date: 08/01/2006**

**Organization :** **The University of Alabama at Birmingham**

**Category :** **Physician**

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

I am an internist who is interested in providing high quality skeletal health care. I am the director of the University of Alabama at Birmingham Osteoporosis Clinic and the Bone Densitometry Service. At the present time dual-energy x-ray absorptiometry (DXA) and vertebral fracture analysis (VFA) are cornerstones in my practice for making the diagnosis of osteoporosis and identifying vertebral compression fractures, and monitoring patients on medications for osteoporosis. The proposed cuts in the reimbursement for DXA and VFA will seriously impair my ability to perform DXA and VFA exams on my patients and will negatively impact my ability to optimally care for these patients.

The proposed cuts are at odds with multiple Federal initiatives to reduce the personal and societal cost of osteoporosis. The Bone Mass Measurement Act, the US Preventative Task Force recommendations and the Surgeon General's Report on Osteoporosis all underscore the importance of DXA in the prevention and treatment of osteoporosis.

The Federal Initiatives listed above, coupled with the introduction of new medications for the prevention and treatment of osteoporosis have improved skeletal health and dramatically reduced osteoporotic fractures. It is the result of these patient directed initiatives, not excessive use of imaging, that have increased the clinical use of central DXA bone densitometry in my practice over the past ten years.

Some of the assumptions used to recalculate the Medicare Physician Fee Schedule are inaccurate. For example:

1. CMS calculated the practice expense (technical component), utilizing pencil beam instrumentation at a cost of $41,000 instead of the $85,000 assigned to VFA, which is done on fan beam densitometers. Since fan beam instruments comprise the vast majority of densitometers currently available in practice, argue that the equipment costs for DXA should be listed at $85,000.
2. CMS assumed that all diagnostic equipment is in use 50% of the time, based on high volume imaging centers. However, diagnostic equipment such as DXA and VFA, used to evaluate single disease states, should be expected to have lower utilization rates estimated at 15-20%.
3. In determining practice expenses, additional densitometry costs such as phantoms, necessary service contracts/software upgrades and office upgrades to allow electronic image transmission were omitted.
4. I disagree with the CMS conclusion used to calculate the physician work component for DXA. Specifically, CMS felt 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. As a physician who is certified by the International Society for Clinical Densitometry (CCD certified Clinical Densitometrist), I can assure you that reading DXAs is more than looking at T-scores. There are numerous intricacies related the acquisition and quality of the scan and interpretation of change that make DXA reporting now more detailed and time-consuming.

I am deeply concerned about the proposed cuts will reduce the availability of high quality bone density measurements and allow a decline in osteoporosis care. I urge you to not support the proposed cuts related to DXA scans and VFA.

Sincerely yours,

Sarah L. Morgan, MD, RD, CCD
Professor of Nutrition Sciences and Medicine
Medical Director, UAB Osteoporosis Prevention and Treatment Clinic

**Submitter :** Dr. Lehman Godwin **Date:** 08/01/2006

**Organization :** Ferrell-Duncan Clinic

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Radiology, Pathology, and Other
Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

I am a primary care physician(general internist)practicing in a multispecialty clinic in Springfield, Mo. I am very concerned about CMS proposed regulations that cut payments for performance DXA bone density scans(for diagnosing and monitoring osteoporosis) and VFA (CPT codes 76075 and 76077). It is my understanding that these cuts are in addition to already planned cuts for radiology services. It is my understanding that these combined cuts by 2010 result in a more than 75% decrease in reimbursement for CPT cod 76075. If these planned cuts proceed then we will have no other choice but to stop offering DXA scans because reimbursement no longer covers overhead cost(DXA machine purchase, software updates, maintainance and employing and training DXA technologists). By limiting patient access, I am very concerned many cases of osteoporosis will go undiagnosed until fractures occur resulting in expensive hospital stays and complications. Osteoporosis related fractures are potentially preventable if patients have access to screening and are appropriately treated. Sometimes you have to spend a dime in order to save a dollar. I ask that you please reconsider these proposed cuts. Thank you!
Lehman Godwin MD

**Submitter :** **Mrs. Judith Kandiguranis** **Date: 08/01/2006**

**Organization :** **Progressive Wellness Diagnostics**

**Category :** **Health Care Professional or Association**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am a health care providor performing Dexascans and VFA exams in an outpetient setting. I provide this service for 11 physicians and do approximately 100 scans per month. This is an important service to the patients in these practices. There have been many newly diagnosed cases of osteoporosis and vertebral fractures identified because of these procedures. If these cuts are enacted, not only will I be out of a job, but the patients will suffer. There are numerous studies showing the value and importance of DXA and VFA. Would you not want to know if your spouse or parent had osteoporosis and could be spared the pain and suffering of fractures by taking one tablet a week or changing their eating/exercise habits? I urge you to reconsider this regulation change. It is of vital importance to our community and our obligation to serve our patients. Thank you for your consideration.

**Submitter :** Dr. Alvin Wells **Date:** 08/01/2006

**Organization :** Rheumatology and Immunotherapy Center

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am a rheumatologist in a suburb of Milwaukee. I see patients everday that have been mis-managed in regards to osteoporosis. Limiting the fees that we generate will only worsen this problem. I see that all patients will suffer. The only ones who will benefit will be the surgeons who repair fractures. I hope that this scary trend can be reversed.

**Submitter :** Dr. Eduardo Fraifeld **Date:** 08/01/2006

**Organization :** Dr. Eduardo Fraifeld

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

Being familiar with this issue I have reveiwed the CMS proposal. The policy currectly proposed is flawed in it's rationale and results in a huge cut to Anesthesiologists i feel is unfair and results in Anesthesia and a few otehr specialites suporting other fiels with an unfair financial burden on Anesthesiology.
The propose d changes are flawed in their methadodlogy and I beleive inacurate data that has not been updated ahs resulted in this discrepancy.
CMS needs to gather new data and not rely on data over 10 years old to develp this study. Anesthesia is already burdened and this additional and unjust fianancial penalty will result in furtehr burdens to the elderly and more vulneralbe popolation of CMS patients.
I support completing the MGMA study to get more reasonalbe data.
Sincerely
Eduardo m fraifeld, MD

**Submitter :** Dr. Maoras Padmanabhan **Date:** 08/01/2006

**Organization :** Dr. Maoras Padmanabhan

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

The proposed RVU amount for CPT code 93701 is not acceptable at the rate of 0.91 for 2007, going down to 0.71 in 2010. This will reduce the procedure reimbursement by 25% which is greater than the profit margin for the test. The formula you are using is flawed. Pleaes maintain the RVU amount at 0.98 or increase it.

**Submitter :** Dr. Merle Turner **Date:** 08/01/2006

**Organization :** Warner Family Practice

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Radiology, Pathology, and Other
Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

The proposed reduction of reimbursement for DXA imaging is a serious threat to the health of an aging population. With cost of a quality DXA unit in excess of $100,000 and the need for a qualified tech to perporm the test at a range of $25-30 per hour along with the length of time it takes to do a DXA (2 per hour), the level of reimbursement is absolutely ridiculous. This is a serious threat to quality care.

**Submitter :** Dr. E. Sidney White **Date:** 08/01/2006

**Organization :** Dr. E. Sidney White

**Category :** Physician

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

I do not understand the expense portion of the RVU calculation for CPT 93701 expenses are steadily increasing. If a major portion of your salary were based on living expenses would you be expecting a large pay cut this year? Pleaes revise your method to calculate RVUs such that the RVU values are not at odds with the increase in costs we are facing with overhead, technicians and equipment pricing.

**Submitter :** **Dr. Robert Cater** **Date: 08/01/2006**

**Organization :** **Dr. Robert Cater**

**Category :** **Physician**

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

It is critical that the practice RVU for Bioimpedence Cardiography be maintained at current levels (practice RVU=0.98) if it cannot be increased. 93701 is a well studied alternative to Echo cardiogram for the non invasive Cardiovascular assessment for patients with hypertension. It is much less expensive than Echo, but if reimbursement declines it will chill adoption by primary care practices. Inflation is 3% per year so reimbursement must keep pace. My Bio Z machine is $54,000 over 5 years, rather than the $28,625 now used to calculate practice expense. Your urgent attention is appreciated.

**Submitter :** Dr. Vance Bray **Date:** 08/01/2006

**Organization :** Denver Arthritis Clinic

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Radiology, Pathology, and Other
Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

I am concerned about the proposed reduction in reimbursement for bone density assessment (DXA; CPT code 76075) and VFA (vertebral fracture assessment; CPT code 76077). My understanding is that the proposed reduction largely results from an American College of Radiology statement that the work RVU should be reduced to 0.2 'because the workgroup believed that the actual work is less intense and more mechanical than the specialty society's description of the work.' This is absolutely false.

Bone density studies performed by some imaging centers often generate reports with very generic information, and in those cases the amount of work may be minimal. However, there is much more to providing a quality study than just generating a computer printout. The physician should review each study to be certain it is performed properly. A quality report also requires significant effort on the part of the interpreting physician. The International Society for Clinical Densitometry has specific guidelines for a proper DXA report, seen on page 8 of their position statement brochure (http://www.iscd.or/Visitors/pdfs/ISCD_OP2005_000.pdf). A proper report requires that the physician review patient-specific information regarding risk factors for osteoporosis and fracturing, personal habits, other medical problems, and medications. This report also should give specific recommendations about further evaluation, non-pharmacologic interventions, and treatment. This requires much more time and effort than the computer generated forms, but also provides the patient's physician with a great deal of useful information.

Osteoporosis is already underdiagnosed and undertreated, as recently reported by the Surgeon General. Decreasing reimbursement for bone density assessment will only decrease access for patients to appropriate testing, and greatly diminish the quality of reports issued by the testing sites. Patients who do not receive proper care are more likley to suffer fractures. Patients who suffer hip fractures frequently are hospitalized and then institutionalized long-term, all at a significant expense to the government. Prevention of fractures thru better access to testing and quality DXA interpretations would be a cost-effective maneuver. Decreasing reimbursement, and consequently access to these studies, is not.

**Submitter :** Dr. James Wang **Date:** 08/01/2006

**Organization :** Dr. James Wang

**Category :** Physician

**Issue Areas/Comments**

**Other Issues**

Other Issues

I am writing in oppostion to the proposed cuts in reimbursements for osteoporosis screening, diagnosis,a nd management using DEXA scans. I am a practicing ob/specialist, and a large portion of my practice consists of menopausal women. I am and have been actively involved in the prevention, diagnosis, and ,management of osteoporosis.
The proposed cuts in reimbursement fees will limit the ability of practioners to obtain accurate bone mineral density testing. I anticipate that the proposed cuts would force me to surrender my central DEXA macine 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 botht he 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 osteporosis 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 form one scan to the next are properly correlated. It is not unusual for me to spend 30 to 40 mins 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, deblitation, increased nursing home admissions, and uncecessary morbidity and mortality should these cut-backs come to pass.

Please do remember that medicine is striving to PREVENT disease, and the the DEXA for screening, diagnosisng and treating osteoporosis is a critical tool that should not be taken away.

James Wang, MD, FACOG
Women's Health Associates
65 Springfield Rd
Westfield, MA 01085

**Submitter :** **Dr. Robert Lonian** **Date: 08/01/2006**

**Organization :** **Dr. Robert Lonian**

**Category :** **Physician**

**Issue Areas/Comments**

**Practice Expense**

Practice Expense

Decreasing the RVU for 93701 will dramatically impace the amount of diagnostic testing that will be available to our entire patient population. As it is now, we are barely able to cover the costs of these diagnostic tests and the patiens are unable to afford higher medical cost, that will ultimately be passed along to the patient. The methodology used by CMS to reduce the RVU from 0.98 to 0.91 next year will simply not allow the costs of the test to be recovered.

**Submitter :** Dr. Raymond Cole **Date:** 08/01/2006

**Organization :** Dr. Raymond Cole

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-
Radiology, Pathology, and Other
Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

Dear Sir:

I am Raymond Cole D.O.,C.C.D. Director of the Osteoporosis Testing Center of Michigan at 107 Chicago St. in Brooklyn, Michigan. I am writing to address the recently proposed regulations reducing reimbursement for the performance of DXA (CPT code 76075) from the current ~$140 to ~$40 by 2010 and VFA (CPT code 76077) from the current ~$40 to ~$25. I am writing to ask that this regulation not be passed because these cuts will create a serious decrease in quality osteoporosis care.

DXA and VFA testing is the basis for the detection and management of patients with osteoporosis. These cuts will markedly and adversely affect physician's ability to diagnose and adequately treat osteoporosis. The Surgeon General, Richard Carmona, stated in his 2004 report, Bone Health and Osteoporosis, that Osteoporosis is just as serious a health threat to our society as obesity and smoking. These cuts are in conflict with Federal initiatives, and will not in the long run reduce the personal and societal cost of osteoporosis, but rather increase it. The Bone Mass Measurement Act, the US Preventative Task Force recommendations and the Surgeon General's Report on Osteoporosis all emphazsize the importance of DXA in the prevention and treatment of osteoporosis. Federal initiatives and new medications for the prevention and treatment of osteoporosis, have reduced osteoporotic fractures.

Some of the assumptions upon which the reduction is based and used to recalculate the Medicare Physician Fee Schedule appear inaccurate. For example:

CMS calculated the practice expense (technical component) utilizing pencil beam instrumentation at a cost of $41,000 instead of the $85,000 assigned to VFA, which is performed on fan beam densitometers. Pencil beam is older technology. Fan beam instruments comprise the vast majority of densitometers currently now available The equipment costs should be listed at $85,000, not $41,000.

CMS assumed that diagnostic equipment in offices is in use 50% of the time based on high volume imaging centers. However, diagnostic equipment such as DXA and VFA, used in offices to evaluate single disease states,has much lower utilization rates usually 15-20%.

In determining practice expenses, additional densitometry costs such as phantoms, necessary service contracts/software upgrades, and office upgrades to allow electronic image transmission were omitted. Service contracts and software upgrades alone on the typical Hologic or Lunar Scanners after the 1st year warranty are approximately $800 to $1100 per month.

4. I am in disagreement with the CMS conclusion regarding the physician work component for DXA, in particular that the actual physician work of DXA interpretation is "less intense and more mechanical" than was accepted previously. High quality DXA reporting requires high skilled interpretation.

I am writing to ask that this regulation not be passed.

Sincerely,

Raymond E. Cole D.O.,C.C.D.
Director-Osteoporosis Testing Center of Michigan
107 Chicago St.
Brooklyn, MI 49230
Ph- 517 592-3275

**Submitter :** Dr. Abayomi Osunkoya **Date:** 08/01/2006

**Organization :** East Carolina Medical Center

**Category :** Physician

**Issue Areas/Comments**

**Discussion of Comments-**
**Radiology, Pathology, and Other**
**Misc. Services**

Discussion of Comments- Radiology, Pathology, and Other Misc. Services

I am a practising internist with special training in geriatric medicine. Since I moved to my current location in Jacksonville NC I have seen significant number of older adults and geriatric population with either age related, medical condition related or therapy related osteoporosis and the use of DXA evaluation have been very helpful in convincing patient that treatment is necessary before sustaining fracture and debility as well as improved compliance with therapy. Lack of service access will be a problem if there is continued reduction in rebursement for this service. Also, it will create worsening lack of interest in this area among the general physician population and community awareness will suffer. As we continue to pay attention to geriatric care and with the fall assessment for older people act it will be prudent on the part of regulatory bodies to realized that the end result of fall is fracture and with greater propensity in patients with osteoporosis. Assessing for fall is a good clinical decision in older people but having the ability to also identify and treat patients with osteoporosis will not only make good medical practice but sound healthcare economic sense if all the associated cost of fracture comorbidities, dependency and quality of life issues are considered. I strong recommend on behave of all my patients that will benefit from this service that the impending cut be stopped. As a practicing physician and certified member of ISCD it wil be an encouragement to continue our effort at providing this needed service with justified medical necessity to our patient population. Proper interpretation of DXA, recommendations and time spent communicating with patient and providers to enhance adequate and proper caring go beyond acqusition of the radiographic imaging. Cutting the physician fee schedule will creat alot of dissatisfaction. Thank you for your time and consideration in this matter.