



August 17, 2006

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

Re: Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology

Dear Dr. McClellan:

AMGA is an association that represents medical groups, including some of the nation's largest, most prestigious integrated health care delivery systems. AMGA members' 65,000 physicians deliver health care to more than 50 million patients in 40 states, including 15 million capitated lives. Thank you for the opportunity to comment on the Five Year Review and Practice Expense (PE) proposed rule.

### **Valuation of Dual Energy X-ray Absorptiometry Based on Incorrect Assumptions**

Since there are CPT codes in the Five-Year Review that gain and lose value, and the average size of our member organizations is 273 physicians, including virtually all medical specialties, the impact of the various changes in specific, proposed CPT code values is difficult to assess in the aggregate. We will therefore leave comments on specific CPT codes of the Five-Year Review of work values to the specialty societies, save one code: Dual energy X-ray absorptiometry (DXA; CPT code 76075).

DXA and vertebral fracture assessment (VFA; CPT code 76077) testing is pivotal in the evaluation and management of patients with suspected osteoporosis. This malady is high in the hierarchy of national public health policy initiatives with the objective of reducing the personal and societal costs of osteoporosis.

Some of the elements and suppositions used to compute the Medicare Physician Fee Schedule were not correct: The technical component was tallied using pencil beam instrumentation with a price of \$41,000 instead of the \$85,000 assigned to VFA, which is done on fan beam densitometers. However fan beam instrumentation is what is used in the overwhelming majority of densitometers in doctors' practices today. Hence a more realistic equipment cost component for DXA would have been \$85,000. Secondly, equipment rate utilization assigned to DXA is shown as 50%, the number used for all diagnostic imaging equipment. Given the typical and predominant site of service of DXA and VFA, a more likely utilization rate would be an estimate of 15-20%.

Furthermore, some practice expenses for densitometry such as phantoms<sup>1</sup>, necessary service contracts/software upgrades and office upgrades to allow electronic image transmission capability, were not counted at all, thus not rendering the full cost picture.

Finally, we believe to be erroneous the conclusions of the AMA Relative Value Update Committee (RUC) that DXA interpretation is less intense and more mechanical than the suggested work value of .2 represents. This finding does not properly take into account that high quality DXA reporting requires skilled interpretation of the multiple results the equipment generates.

At the conclusion of the phase-in period in 2010, reductions of reimbursements for this test would amount to 71% for DXA. Since 70% of this testing is done in physicians' offices, we are concerned that the consequences of drastic cuts will make offering DXA economically unfeasible. This may reduce Medicare patient access to these important diagnostic tests and have a profound adverse effect on patient care for osteoporosis. **We therefore ask CMS to revert to the specialty society survey recommendation and restore the work value to .3 from the proposed .2 units.**

### **Budget Neutrality Adjustment and “Bottom-Up” Methodology—Other Issues**

CMS proposes a budget neutrality adjustment to the work RVUs, having noted that it considered but rejected the alternative adjustment to the conversion factor, an approach CMS has used in past five-year reviews. The rationale for this was the putative origin of the impacts as coming largely from the work unit changes. However, AMGA believes changes in work RVUs and the practice expense methodology are inexorably linked. Attributing overall changes to one over the other is not a compelling reason to deviate from past practice. This conclusion is heightened by the fact that the proposed work adjustor would appreciably diminish proposed payment increases for evaluation and management services. Therefore, we recommend that CMS reconsider and opt to apply the budget neutrality adjustment by changing the conversion factor as it had originally contemplated.

AMGA has gone on record as supporting a more transparent, accurate, and simplified system of deriving relative value units and their components. **The proposed shift to a “bottom-up” computation is a step in the right direction, and we support this move.**

### **Multi-specialty Practice Expense Survey**

AMGA believes that the basis CMS used for determining medical practice expenses, the AMA's defunct Socioeconomic Monitoring System (SMS) is beyond antiquated.

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<sup>1</sup> This is an X-ray image of a plastic block (phantom) used to simulate radiographic characteristics of breast tissue, used to assess the ability of the equipment to detect breast disease and cancer. For full facility accreditation such images are mandatory and must be submitted to the accrediting body.

Constant adjustments and recalibration of these numbers has made accuracy of derived information questionable for years. It should have been supplanted long ago by a new, multi-specialty practice expense survey and we support implementation of such an instrument.

The “public-private partnership” between CMS and elements of organized medicine, has been successful in many ways. Using the good offices of national medical organizations as the means for obtaining and distributing practice expense data is both practical and effective. We believe that the division of responsibilities has been unbalanced with organized medicine having made invaluable in-kind as well as real financial cost contributions. CMS has not borne its fair share.

We support CMS’ reliance on specialty societies and other medical organizations for data gathering since we feel the response rates and quality of information, gathered on a voluntary basis, through their good offices, yields results that are, in most cases, statistically powerful and reliable. Since the gathering of such data serves a broad public health policy objective, pricing of physician services for Medicare, we feel that the financial burden should be paid by the government. **We call on CMS to fully fund and implement at the earliest opportunity, a multi-specialty practice expense survey, and there is one such effort by the American Medical Association (AMA) already well underway.**

The extant, emerging multi-specialty survey, whether eventually adopted or supplanted by another, similar CMS effort, raises important questions regarding CMS’ announced intention to allow supplemental PE survey data submitted by several medical societies. Specialties which have conducted supplemental surveys will argue that their data should be implemented and utilized until new data from a multi-specialty practice expense survey are available. Others will call on CMS to refrain from any further practice expense methodological changes until data from a multi-specialty practice expense are available.

**We suggest a conditional approach to deciding on use of the supplemental surveys. If CMS intends to use the current multi-specialty PE survey effort or one of its own creation in the practicably near future, then AMGA suggests that holding in abeyance the use of supplemental data is a preferable course of action. To change PE values now and then perhaps have to readjust many work values considerably (CMS noted that some have suggested that the supplemental surveys have inflated PE) based on new, more reliable data, makes for too much potential dislocation and uncertainty for medical practices’ planning and forecasting needs. If, on the other hand, CMS foresees no realization of a multi-specialty PE survey in a reasonable time, the supplemental data should be accepted.**

## **Discussion of Comments—Evaluation and Management Services**

The findings and analyses of the RUC address inaccuracies and correct them. **We agree with CMS' conclusions and AMGA supports the proposed valuations for Evaluation and Management Services (E/M) and endorses their implementation.**

### **Transition of the Changes**

Medical group practices are facing a difficult year in 2007 with the pending physician fee schedule negative updates, anticipated reductions in payments to imaging services resulting from the Deficit Reduction Act (DRA), and the difficult to predict consequences of the five-year review and PE methodology changes. **Phasing in the changes over a four year period as proposed in the rule will ameliorate the negative effects of these combined changes and we support such a transition.**

AMGA appreciates the opportunity to offer its perspectives for CMS' consideration. Any questions about our comments should be directed to George Roman, Director, Regulatory Affairs, at (703) 838-0033, extension 342.

Sincerely,



Donald W. Fisher, Ph.D.  
President and CEO