THE ENDOCRINE SOCIETY

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August 31, 2007

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue
Washington, D.C. 20201

RE: CMS-1385-P Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008

Dear Mr. Kuhn:

On behalf of The Endocrine Society (Society), representing more than 14,000 physicians and scientists in the field of endocrinology, we appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed revisions to the payment policies under the Physician Fee Schedule for calendar year 2008. The Society looks forward to working closely with the Agency as this proposed rule moves toward implementation.

Founded in 1916, our Society represents physicians and scientists engaged in the treatment and research of endocrine disorders, such as osteoporosis, diabetes, infertility, obesity, and thyroid disease. The following comments focus on three areas of particular importance to our members:

1) Physician Fee Schedule Across-the-Board Cuts
2) Physician Quality Reporting Initiative
3) Thyroid Ultrasound Cuts
4) Cuts to Dual X-Ray Absorptiometry (DXA)

Physician Fee Schedule Across-the-Board Cuts

The Endocrine Society would like to state its opposition to the proposed 9.9 percent across-the-board physician payment cuts as a result of the flawed Medicare sustainable growth rate (SGR) formula. As you are no doubt aware, the SGR does not accurately reflect the cost of caring for Medicare patients and must be replaced. We urge CMS to take administrative action to increase funding for physicians' services and facilitate enactment of legislation to replace the SGR with payment updates based on physicians' practice cost increases. Further, we ask that CMS continue to work diligently with Congress and physician groups to avert the proposed cut for 2008, and to find a long-term solution to the flawed payment formula.

Physician Quality Reporting Initiative

Second, we believe that the $1.35 billion fund established to provide bonus payments to physicians for their participation in the Physician Quality Reporting Initiative (PQRI) should instead be applied to the conversion factor in order to reduce the amount of the 9.9 percent proposed payment cuts. The average internal medicine physician is expected to receive approximately $1400 under the 2007 PQRI bonus payment, a figure that likely does not strongly entice physicians to join the reporting program. In addition, the PQRI is a voluntary program, and one that does not include a majority of Medicare providers. If the $1.35 billion was instead applied toward the conversion factor to reduce the physician payment cut, a greater number of physicians would benefit in a more direct way.

Thyroid Ultrasound Cuts

Our third major concern under the 2008 physician fee schedule relates to thyroid ultrasound. Under the Deficit Reduction Act of 2005 (DRA), thyroid ultrasound codes 76942 (Echo Guide for Biopsy) and 76536 (US exam of head and neck) had payments capped at the level of the Hospital Outpatient Prospective Payment System (OPPS). This has had a negative affect on physician reimbursements for these important services. In addition, CMS has proposed a reduction in the practice expense value for code 10022 (Fine Needle Aspiration with Image), a code not affected by the DRA, from 2.41 in 2007 to 2.32 in 2008. We expect that the reduction in the practice expense for this code will cause the payment for this service to decrease from $137.57 in 2007 to approximately $120.16 in 2008, a change we believe to be unwarranted. As a result, the Society respectfully requests that CMS:

1) Re-examine practice expense values, including equipment and utilization costs, assigned to CPT code 10022.

Cuts to Dual X-Ray Absorptiometry

Finally, another significant area of concern within the Physician Fee Schedule proposed rule relates to procedures used to help diagnose and treat osteoporosis. We continue to be concerned with the affects of the Deficit Reduction Act of 2005 (DRA) that has drastically cut payment for Dual Energy X-Ray Absorptiometry (DXA) & Vertebral Fracture Assessment (VFA). We believe that this policy will continue to have negative and unintended consequences for the more than 10 million Americans with osteoporosis and the 34 million at risk for fractures due to low bone mass (osteopenia). The Society's comments address the following areas:

1) Osteoporosis Patient Care and Access to DXA & VFA
2) Methodology Used to Calculate Practice Expense for DXA & VFA

Osteoporosis is a major health care issue in the United States costing more than $18 billion annually. DXA and VFA are crucial for the detection of osteoporosis and identification of those at highest fracture risk before a fracture occurs. Federal initiatives to identify patients with osteoporosis have led to the increased utilization of DXA and VFA; however, the vast majority of affected individuals continue to remain undiagnosed and untreated.

The Society is concerned that the proposed changes in the physician fee schedule, combined with the DRA cuts would reduce DXA reimbursement from approximately $140 to $40 and VFA from $40 to $25 by 2010. These reductions will force physicians to discontinue offering these vital services, resulting in a severe limitation of patient access to quality bone densitometry and vertebral fracture assessment. While we applaud CMS' agreement with the American Medical Association's Resource-Based Relative Value Scale (RUC) Committee to increase the physician practice expense for DXA services, there still appears to be flaws in data input including inappropriate application of equipment cost, and inappropriate utilization rates. Even combined with an increased physician practice expense, these calculations will significantly contribute to severe cuts in DXA and VFA reimbursement. In fact, a study (methodology and findings attached) funded in part by The Endocrine Society and conducted by The Lewin Group in July 2007 found that only 5 percent of study respondents stated that their costs to perform DXA were equal to or less than the $82 payment rate for 2007. The study details that costs to perform DXA ranged from the 25^{th} percentile cost of $95.07, to the 75^{th} percentile cost of $195.02. The median cost associated with performing DXA services was $134.13, a figure that is over 60 percent higher than the 2007 payment of $82. For these reasons, the Society respectfully requests that CMS:

1) Reassess utilization rates and equipment costs for DXA (CPT codes 77080 and 77081) and VFA (CPT code 77082) and the effects that the DRA has had on these services.

Patient Access to Care Compromised

The cuts contained in the DRA, compounded with the 9.9% physician payment cut included in the CMS Proposed Rule, would profoundly impact patient access to this and other types of imaging procedures. DXA and VFA are low cost procedures that have been directly linked to improvements in patient outcomes; furthermore, both diagnostic options are readily available to primary care physicians and other medical specialties. Reduced access to outpatient DXA scanning resulting from these cuts would also directly conflict with federal initiatives such as the Surgeon General's Report on Osteoporosis from 2005, which supports increasing bone density screening for at-risk groups including patients with fractures, women aged 65 and older, patients on glucocorticoids, and other high risk groups. Finally, these policies would make it even more difficult for primary care physicians to adhere to future "pay-for-performance" measures that may recommend DXA screening and testing for these high risk groups.

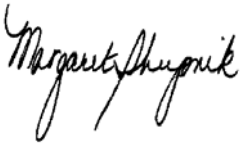
Flawed Methodology Used to Calculate Practice Expense Component for Procedures

The Society is also concerned about the methodology used to calculate Practice Expense for these procedures. The utilization rate of 50 percent was applied across-the-board to all procedures. Imaging procedures utilized in single-disease states, such as DXA and VFA for osteoporosis, have substantially lower relative rates of utilization. The 2002 Medicare data reflect the fact that 70 percent of DXA studies are performed in an office setting (versus only 30 percent in a hospital setting), and 60 percent of studies are performed by non-radiologists. These data indicate that primary care physicians perform DXA on patients as part of routine medical care in their practice, versus the high volume imaging centers that may exhibit significantly higher utilization rates. We believe that a more appropriate utilization rate for DXA and VFA services to be 21 or 22 percent. The Endocrine Society, along with other provider groups, brought this particular issue before the RUC in 2007. The RUC expressed the opinion that they were not the appropriate body to debate issues of utilization and we strongly encourage CMS to consider this issue in its final rule.

Equipment costs given for VFA are based on software additions to current fan beam densitometers (cost approximately $85,000). However, the cost for DXA, which is based on pencil beam instrumentation, is $41,000 in the 2008 proposed rule, even after CMS agreed with our 2007 proposed rule comments and increased the equipment cost for DXA in 2007 to $85,000. Fan beam densitometers comprise the majority of densitometers currently available in practice because one of two largest United States manufacturers of DXA devices no longer produces pencil beam densitometers. Pencil beam densitometers comprise less than 20 percent of sales for the other US manufacturer. Thus, the equipment cost for DXA should remain at the 2007 rate of $85,000.

In conclusion, the Society appreciates the opportunity to submit these brief comments regarding CMS' 2008 Physician Fee Schedule. As always, the Society is grateful to CMS staff for the hard work that went into drafting this proposed rule. Please do not hesitate to contact Janet Kreizman, Senior Director of Government & Professional Affairs, at jkreizman@endo-society.org, if we may provide any additional information or assistance as CMS moves forward in developing this rule.

Sincerely,



Margaret Shupnik, Ph.D.
President
The Endocrine Society

Assessing the Costs of Performing DXA Services in the Office-Based Setting: Methodology and Findings of The Lewin Group Study

The American Association of Clinical Endocrinologists (AACE), International Society of Clinical Densitometry (ISCD), American College of Rheumatology (ACR), and The Endocrine Society (TES), commissioned The Lewin Group to survey office-based providers of dual energy x-ray absorptiometry (DXA) to develop estimates of the costs associated with providing the DXA services.

From the basis of the provider, Lewin was asked to estimate all costs associated with providing DXA, including practice expense, malpractice expense and physician work. Practice expense and malpractice expense estimates were generated by a Lewin Group survey. Physician work estimates were based on a separate clinical survey of multi-specialty densitometry professionals, which provided time required for clinical input (in minutes) for all aspects of DXA provisions. These components were summed to yield total costs. Finally, Lewin compared these costs to the global reimbursement for DXA services in the office-based setting.

I. Findings

Our analysis yields a 2007 median total cost per procedure for DXA of $134.13, $5 less than the 2006 Medicare reimbursement, and about $50 more than the 2007 reimbursement. 2007 payment of $82 represents 61% of our median cost estimate. This payment level also represents 86% of the 25th percentile cost ($95.07) and 42% of the 75th percentile costs ($195.02) (Figure 1).

Figure 1: Ratio of 2007 Payment to Cost per DXA Procedure by 25th, 50th and 75th Percentile

Percentile	2007 Cost	2007 Payment	Loss per Procedure	Number of procedures per year	Ratio Payment:Cost
25th percentile	$95.07	$82	$13.07	360	86%
50% (Median)	$134.13	$82	$52.13	768	61%
75th percentile	$195.02	$82	$113.02	1572	42%

In 2007, only 14% of respondents are being reimbursed by Medicare at or above their costs. No provider will be adequately reimbursed at the fully implemented payment rates in 2010 of $35.

There is a wide variation in the cost of providing DXA procedures, with a minimum value of $42.57 and a maximum value of $788.09 (Figure 2).

Figure 2: 2007 Median Cost per DXA Procedure

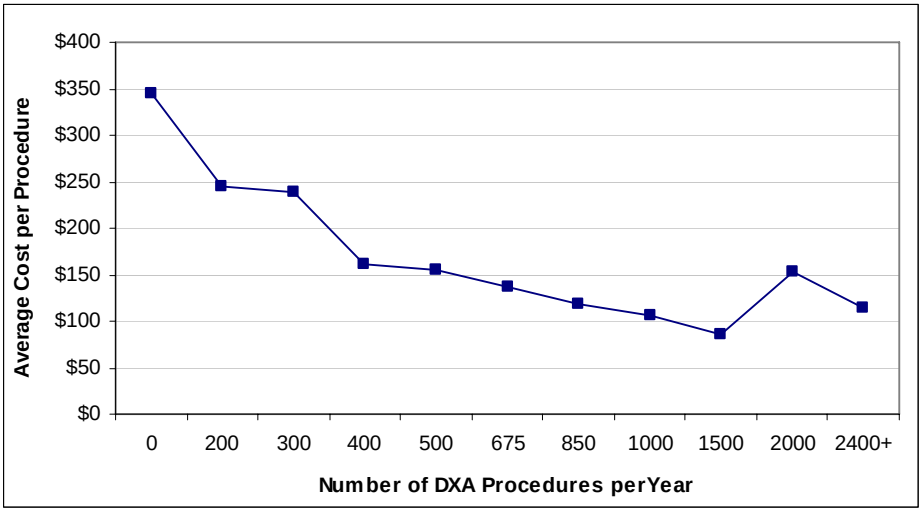
Procedure	Median # of Procedures per year	Cost per Procedure		
		Median	Minimum	Maximum
DXA	768	$134.13	$42.57	$788.09

As Figure 3 demonstrates, there is an inverse relationship between average cost per procedure and the number of DXA procedures performed per year. There is a steady decrease in the average cost per procedures as practices increase the number of procedures performed per year, until they reach 1500 procedures per year. Procedures in excess of 1500 per year often have a higher per procedure cost, possibly attributed to the extra fixed costs and overhead that is associated with operating a practice that can handle the capacity. Providers with high procedure volume are typically identified as efficient and operating with fewer costs per procedures. Across all practices represented in the survey, there is an overall utilization rate for DXA machines of 13%, defined as total annual hours equipment is used for patient-care divided by total annual hours equipment is available for DXA.

Of those practices that have costs under $82, they perform, on average, 2125 procedures per year. This average number of procedures per year is influenced by a number of practices performing DXA in excess of the 90th percentile of procedures performed in a year. This procedure volume is significantly higher than the median number of procedures performed per year of 768, or approximately 3 procedures per day. There are still many providers, however, that are contained in the 86% of providers who have costs that are not covered by payments.

As a result, industry research indicated that many large providers have closed their doors and eliminated DXA as a provided service. (We noted these closures during the conduct of our survey.) After accounting for cost inflation and the continual decline of DXA payments through 2010, even fewer providers will be able to sustain providing DXA services to Medicare beneficiaries in the coming years. The active closure of larger, efficient providers validates our study in that providers typically are not adequately reimbursed for performing DXA.

Figure 3: Relationship between Number of DXA Procedures Performed and Average Cost per Procedure



a. Sensitivity Analysis

In creating the NPRM, CMS assumed indirect expenses account for 63% of the total practice expense. Indirect as direct expenses are defined as the following:

Figure 4: Components of Practice Expense, Indirect and Direct

Indirect expenses	Direct expenses
Non-clinical (administrative) labor	Direct labor for clinical personnel
Office Space	Equipment Expenses
All other expenses not related to directly performing the procedures	Medical Supplies and Equipment

Results of the Lewin survey yield a median indirect percentage of 37% of the total practice expense cost, or $34 dollars of the median cost of $134. Overall, practice expense represents 70% of the total DXA per procedures cost. As a test of sensitivity, we imputed the survey data to reflect the CMS distribution of direct and indirect costs.

Figure 5: Allocation of Practice Expense by Allocation Methodology, Lewin Survey vs. CMS NPRM Inputs

Methodology	Median Total Cost	Practice Expense			Physician Work	Malpractice
		Indirects	Directs	Total	Total	Total
Lewin Survey	$134.13	$34.17	$60.12	$94.29	$38.49	$1.34
CMS NPRM	$202.33	$102.37	$60.12	$162.50	$38.49	$1.34

CMS methodology yields a total cost of $202 per procedure, with $152 allocated to practice expense (Figure 6). Furthermore, this imputation results in an indirect cost per procedures of $102.37, about $68 higher than the Lewin results demonstrates. Overall, this analysis yields a higher total cost per DXA procedure of $202.33 compared to the Lewin analysis of $134.13.

Appendix A

I. Methods

We discuss the methodology for each component below:

b. Practice Expense and Malpractice Expense

1. Survey Administration

The Lewin Group survey was distributed electronically to 14,537 members of AACE, ISCD, ACR and TES. The survey was accessible via the internet, with the option of completing the survey on paper and faxing a copy to The Lewin Group. The survey collected information on the characteristics of the practice and physician (e.g., specialty, geographic region, hours practice is open and available to perform DXA), as well as equipment expenses and financial information (e.g., total salaries, office expenses, malpractice insurance). See Appendix B for the survey collection instrument.

One-hundred sixty three useable surveys were received representing approximately 1% of the sample. Respondents who provided incomplete survey data were contacted via telephone for clarification. Any respondent who was not able to be contacted was excluded from our analysis. As an incentive to complete the survey, The Lewin Group offered to provide the individual practice's cost of providing DXA to the physician at the completion of the survey analysis.

2. Generating Practice Expense and Malpractice Expense Cost Components

The Lewin survey collects expenses for entire individual practices[1]. The analysis consists of first estimating total aggregate DXA costs and then generating a practice expense and malpractice cost per DXA procedure for each practice. We report the median cost, 25th percentile and 75th percentile statistics. Lewin also investigated the range of expenses for different cost categories and the effect procedure volume has on per DXA procedure costs. Consistent with CMS methodology, Lewin used the median as our metric of central tendency to reduce the effect of data outliers.

Financial and utilization measures were collected for the most recent complete fiscal year. To make the costs comparable to the current 2007 payments for DXA, practice expense and malpractice expense cost categories were inflated by the CPI-U, approximately 4.1% for 2007.

[1] For the purpose of this survey, "practice's expenses" are defined as all expenses that are captured in a Profit and Loss (Income) Statement for all services the practice provides. Respondents were not to differentiate between divisions that provide DXA and all other services provided.

Total practice expense and malpractice expense per procedure is calculated based on the sum of the three cost components, divided by the total number of DXA procedures performed annually for each practice. We describe each component below:

- Equipment Costs
- Space allocated to DXA
- An allocation of overhead expenses attributed to DXA (e.g., malpractice expense, non-clinical labor and expenses, medical supplies and materials)

Equipment costs

Equipment costs contain expenses that practices incur annually in the maintenance and upkeep of their DXA machines. These expenses for DXA machines include: 1) cost of interest on loans used to purchase the DXA machine; 2) cost of service contracts; 3) costs of software upgrades; and the 4) cost of the last PAC/DICOM upgrades. These expenses were totaled at the practice level for all machines reported.

Space allocated to DXA

Respondents indicated the total amount of square footage in their practice as well as the square footage attributed to providing DXA. Respondents were to only include areas that are solely used for DXA (i.e., area where the machines are located, and exam rooms that are reserved for DXA patients). The square feet allocated to DXA multiplied times the indicated lease per square foot is included in the cost for providing DXA to be allocated back to the procedure cost. As noted below, we also used the proportion of square feet attributed to DXA services provisions to allocate indirect expenses back to DXA procedures.

Allocation of overhead expenses attributed to DXA

Practices incur numerous indirect expenses that need to be allocated back to providing DXA. Based on the proportion of square feet attributed to DXA to the total number of square feet in the practice, overhead expenses were allocated. Costs included in this allocation include:

- professional medical liability/malpractice insurance;
- salaries for administrative and clerical staff;
- non-clinical office expenses;
- medical materials and supplies; and
- all other indirect expenses.

Survey respondents additionally provided total clinical non-physician payroll expenses (i.e., radiology technicians and registered nurses) and total provider (i.e., physician, physician assistants) payroll expenses. To eliminate the potential for "double-counting" salary expenses for personnel who provide direct labor in DXA procedures, the non-clinical non-physician payroll expense category was excluded in its entirety, due to the inability to indicate which percent of the expenses are attributed to indirect supports. Additionally, total provider payroll expenses were excluded with the assumption that time spent by the physician would be captured in "physician work" on a per-task basis.

As a result, the percent of indirect costs allocated back to DXA may be conservative, for we expect some personnel in these categories to provide DXA services that are not identified in the task breakdown. Additionally, bad debt expense was excluded from the analysis, consistent with CMS' methodology for identifying reimbursable expenses.

c. Physician Work

1. Survey Administration

Physician work was derived from a 2006 clinical survey of multi-specialty densitometry professionals. Administered by ISCD, this survey was distributed electronically to 2884 office-based providers of DXA who were members of AACE, ACR, ISCD, TES, American Society for Bone and Mineral Research (ASBMR), and North American Menopause Society (NAMS). The survey collected information on the characteristics of the practice and the average time and personnel required to perform each task associated with performing one DXA procedure. Four-hundred fifty-three useable responses were received, or 15% of the sample.

Survey data on the average time it takes to perform each task was analyzed, yielding an estimate of a median time per task (in minutes). The proportion of the total time personnel types were performing indicated tasks was calculated as well (i.e., What percent of the time are technician performing this task compared to registered nurses?). The required personnel included physician time, as well as clinical and non-clinical staff.

2. Generating Labor Costs Attributed to Providing DXA

To cost the labor associated with physician and other clinical work, The Lewin Group analyzed the raw data from the 2006 clinical survey of multi-specialty densitometry professionals. Personnel salary data were provided by the United States Department of Labor, Bureau of Labor Statistics (BLS), May 2006, "National Occupations Employment and Wage Estimates". Benefit costs were also provided by BLS in their "Employer Costs for Employee Compensation" survey, September 2006, and included in the salary estimates. A weighted average annual salary was generated based on the proportion of time each personnel category was responsible for performing an indicated task. The annual weighted salary was then calculated as a per minute cost (based on the number of hours the practice was open) and multiplied by the median number of minutes reported for each task. All tasks were totaled to generate a total "labor cost" per procedure.

This labor costing methodology generates a conservative estimate for the cost per procedures. Some practices indicated that they were open in excess of 8 hours a day. In theory, this could require two staff members, rather than just one. Dividing the annual salary per staff member by fewer hours open would result in a higher cost per minute, and ultimately a higher cost per task and procedure. Being unfamiliar with the structure of each practice and the number of staff

members providing the service, we assumed one staff member per task, regardless of the number of hours open.

d. Generating a per Procedure DXA cost

Survey respondents indicated an average number of DXA procedures performed per month per DXA machine. Lewin calculated the average number of DXA procedures per year for each practice. This calculation is used to denominate the sum of the practice expense, malpractice and physician work costs to derive cost per DXA procedure.

e. Utilization Rate

Lewin calculated an overall utilization rate for DXA machines based on the number of hours DXA equipment was used to provide patient care and number of hours equipment is available to provide DXA:

- **Total available equipment hours**: We calculated total available equipment hours for each practice by multiplying the reported hours available each week by the total indicated hours per year the practice is open for in each practice.

- **Total patient-use equipment hours**: We calculated the hours for total patient-use by multiplying the number of DXA procedures performed per year by the RUC approved time per procedure (15 minutes). Due to the inability to estimate the amount of time DXA machines are used in each practices, this estimate may be conservative.

- **Utilization Rate**: Total patient-use equipment hours divided by total available equipment hours.

II. Sample characteristics

Both survey efforts captured data from numerous specialties that provide DXA services. Responses to The Lewin Group survey were received from 8 different specialties. Rheumatology represents 37% of the sample while Primary Care (Internal Medicine, Family Medicine and Gynecology) collectively represent 39% of the responses (Figure 4). Based on 2004 claims data for office-based services, 28% of claims are from Internal Medicine while 24% are Radiology. As a test for representativeness, we re-weighted the final results of our study based on the CMS claims data distribution by specialty and obtained comparable median costs per DXA procedure. This ensured that specialty distribution did not affect our analytic results.

Figure 6: Distribution of Specialty for Lewin and Multi-specialty Survey Compared to 2004 CMS Claims Analysis

Specialty	Lewin Survey (2007)	Multi-Specialty Densitometry Study (2006)	CMS Claims Analysis (Office-based in 2004)
Rheumatology	37%	37%	12%
Internal Medicine	20%	11%	28%
Endocrinology	13%	22%	5%
Family Practice	10%	7%	11%
OB/GYN	9%	9%	7%
Other	6%	6%	14%
Radiology	3%	5%	24%
Orthopedics	2%	3%	-

Responses from the 2006 clinical survey of multi-specialty densitometry professionals represented 18 specialties, which were aggregated in Figure 4. Rheumatology represents 37% of the sample (identical to the Lewin survey) whereas Endocrinology represents 22%. Primary Care (Internal Medicine, Family Medicine and Gynecology) collectively represents 27% of the total sample.

Appendix B

Office Based (Non-Facility) DXA Cost Survey Questionnaire July 9, 2007

Thank you for agreeing to participate in this important survey to help understand DXA costs.

Instructions

To accurately assess DXA costs, we need to collect information on a variety of clinic operating expenses. To ensure the most accurate information, **we suggest that you share this survey with your clinic administrator and/or business manager so they can assist you in its completion**. Please make sure you include all of your practice(s)'s expenses (unless specified), not just those attributed to DXA. The time spent completing this will be invaluable in arriving at a true cost analysis that may **result in a more accurate reimbursement**.

This survey will collect practice level information regarding procedure volume and equipment costs and professional expenses for your most recently completed fiscal year.

To submit this paper survey:

- **Print, complete and fax responses to Audrey El-Gamil at The Lewin Group at 703-269-5501, or**
- **Complete electronically and email responses to Audrey El-Gamil at The Lewin Group at audrey.el-gamil@lewin.com.**

Please make sure that you insert your log-in information at the top of the first page of the survey!

Again, we assure you that The Lewin Group is treating all information as confidential. Under no circumstances will individual practice information be reported or shared with anyone. Furthermore, The Lewin Group will provide only aggregated data across providers.

If you have questions or wish to discuss any issues related to the survey, please call Audrey El-Gamil at The Lewin Group between the hours of 9 am ET and 6 pm ET, or leave a message, at (703) 269-5771. Alternatively, you can email Audrey at audrey.el-gamil@lewin.com.

Information about You

(Please complete this survey only if you are not a hospital based practice billing under the Hospital Outpatient Prospective Payment System (OPPS))

A-1	**Your name:**
A-2	**City where practice is located:**
A-3	**State where practice is located:**
A-4	**Zip code of practice:**
A-5	**Location of practice: (check one)** **_____ Urban _____ Suburban _____ Rural**
A-6	**Specialty you practice: (check one)** **_____ Endocrinology** **_____ Family Practice** **_____ Gynecology** **_____ Internal Medicine** **_____ Orthopedics** **_____ Rheumatology** **_____ Radiology** **_____ Other (specify:_____)**
A-7	**Years practicing specialty:** **_____ years**
A-8	**Are you ISCD Certified as a CCD (Certified Clinical Densitometrist)?** **_____ Yes** **_____ No**
A-9	**Is your practice based in a hospital?** **_____ Yes** **_____ No** **If yes, do you bill for DXA using the Hospital Outpatient Department (HOPD) rate also referred to as the Hospital Outpatient Prospective Payment System (OPPS)?** **_____ Yes** **_____ No** *If you answered "yes" to both questions, please do not complete the rest of the survey. This survey is only for office-based/non-facility based practices whose payment is based on the Medicare Fee Schedule. Thank you for your time! Please fax your*

	responses to Ted Kirby at 703-269-5501.

Information about Your Practice

B-1	**How many:** **_____ physicians are in your practice?** **_____ of those physicians, how many are reading DXAs?** **Do you have non-physician providers (NP, PA) who read DXAs?** **_____ Yes** **_____ No** **If yes, how many?** **_____ non-physician providers**
B-2	**Which central sites do you routinely measure?** **_____ spine only** **_____ one hip only** **_____ spine and one hip** **_____ spine and both hips**
B-3	**Do you do forearm DXAs?** **_____ Yes** **_____ No*** *Skip to Question B-6*
B-4	**If you do forearm DXAs, do you do them:** **_____ in all patients having central DXA?*** *Skip to Question B-6* **_____ only in selected patients?**
B-5	**If only in selected patients, what percent of patients having central DXAs also have forearm DXAs?** **_____ percent having central DXA and forearm DXA** **_____ percent having only forearm DXAs**
B- 6	**How much of your DXA volume comes from your own practice and how much is referred to you from outside of your practice? (total must equal 100%)** **_____% from your practice** **_____% referred to you**
B-7	**When you bill for DXA, do you bill the global fee or the professional component?** **_____ global fee**

	_____ professional component only (-26)
B-8	**What is the average number of hours per week that your office is open for business?** **_____ hours per week**
B-9	**How many days of the week is your office open for business?** **_____ days of the week**
B-10	**How many weeks of the year is your office open for business?** **_____ weeks of the year**
B-11	**What is the average number of hours per week that DXA is available/offered in your office?** **_____ hours per week**
B-12	**How many central DXA procedures are performed in an average month per machine?** **_____ procedures**

Information about VFA

C-1	**Do you have VFA capability?** **_____ Yes** **_____ No**
C-2	**Do you read VFA?** **____ Yes** **____ No*** *Skip to next section*
C-3	**How many VFA procedures are performed in an average month per machine?** **_____ procedures**
C-4	**How many machines are used for VFA?** **_____ machines**
C-5	**What percent of central DXA patients receive VFA?**

	_____%

For the next sections, we suggest that you share the questionnaire with your clinic administrator and/or business manager so they can assist you. The time spent completing this will be invaluable in arriving at a true cost analysis that may result in a more accurate reimbursement for central DXA.

Information about Your Equipment Costs

D-1

Total number of DXA machines in your practice: _____

Please fill out one row in the following table for each DXA machine in your practice.

Please specify if the manufacturer is:

- **Hologic,**
- **Norland/Cooper, or**
- **GE/Lunar**

Machine Number	Manufacturer	Fan or Pencil Beam	Year Purchased	Annual Depreciation Cost per Year	Days per Year Machine is Down for Maintenance
1					
2					
3					
4					

D-2

Cost per year of interest on loan(s) used to purchase your DXA machine(s):

$_____ per year

D-3

Cost per year of any service contract(s) for your DXA machine(s):

$_____ per year

D-4

Cost per year of software upgrade(s) for your DXA machine(s):

$_____ per year

D-5

Cost of the last PAC/DICOM upgrade(s) (ability to transmit radiographic images electronically):

$_____

Information about Your Professional Expenses (your last full fiscal year)

Please answer the remaining sections based on your last full fiscal year. Make sure to include your entire practice's expenses, rather than those just attributed to DXA. We will use this information to calculate the proportion of your clinic's overhead expenses that are attributed to DXA procedures.

For the purpose of this survey, "practice(s)'s expenses" are defined as all expenses that are captured on your Profit and Loss (Income) Statement for all services your practice provides. Do not differentiate between DXA and all other services provided. We list some examples of expenses you should and should not include in your totals:

Do include:

- *Rent and utilities for your entire practice, not just areas attributed to DXA services*
- *Salary amounts (and benefits) for visiting physicians or support staff that are paid by your practice, but also serve or support other practices*

Do not include:

- *Salaries for visiting physicians that use your clinic space but are not paid a salary from your practice*
- *Rent for neighboring practices that share space (i.e., waiting rooms)*

If you have any further questions, please call Audrey El-Gamil at The Lewin Group at (703) 269-5771

E-1	**What is the start and end date of your last full fiscal year?** **Start Date: Month_____ Year _____** **End Date: Month_____ Year _____**
E-2	**What is the total square footage for your practice?** (If practice has more than one location include total square footage of all offices) _____ **sq ft.** **What is the total square footage attributed to DXA use?** (If an exam room is set aside for DXA only, then you would provide the square footage of the exam room itself. If part of the room where DXA machine is located is used for other purposes, then you would list the square footage of that portion of the room reserved for DXA. If practice has more than one DXA machine include square footage reserved for each machine.) _____ **sq ft.** **What is the lease per square foot for your practice(s)? $**_____
E-3	What was your practice's **professional medical liability or malpractice** insurance premium for your last full fiscal year, to the nearest thousand dollars? **$**_____ **Premium Amount**
E-4	What were your practice's **non-clinical non-physician** payroll expenses for your last full fiscal year were solely for individuals involved with administrative, secretarial, or clerical activities (to the nearest thousand dollars)? Include all sites for which your practice bears these costs (e.g. practice managers, schedulers, billing personnel, record clerks, clerical, etc.). **$** _____

E-5	What were your practice's total **clinical non-physician** payroll expenses for your last full fiscal year, including fringe benefits (to the nearest thousand dollars)? Include all sites for which your practice bears these costs (e.g. nurses, technicians). **$**_____
E-6	What were your practice's total **provider** payroll expenses for your last full fiscal year, including current or deferred compensation (to the nearest thousand dollars)? (Physicians, Nurse Practitioners, Physician Assistants). Include all sites for which your practice bears these costs (e.g. salaries, bonuses, dividends, and pension funds). **$**_____
E-7	What were your overall practice's expenses for **medical materials and supplies** not separately reimbursable that are used for clinical purposes for your last full fiscal year (to the nearest thousand dollars)? Include all sites for which your practice bears these costs (e.g. X-ray films, processor chemicals, laundry and disposable medical supplies). Do not include expenses for non-clinical office supplies or medicines which are separately reimbursable. **$**_____

Information about Your Non-Clinical Expenses (your last full fiscal year)

F-1	What were your practice's **non-clinical office** expenses for your last full fiscal year, including non-clinical office equipment and supplies, rent, mortgage interest, depreciation and maintenance costs on office and medical buildings, commercial property insurance, property taxes, utilities and telephone, supplies for billing, scheduling and business functions (to the nearest thousand dollars)? Include all sites for which your practice bears these costs. **$**_____
F-2	What were your practice expenses for **all other** expenses for your last full fiscal year, including marketing expenses, legal fees, accounting, office management services, contracted billing expenses, professional car upkeep and depreciation, professional association memberships, professional journals, continuing education (CME), all employee-provided insurance other than malpractice, and other expenses that have not been listed (to the nearest thousand dollars)? **$**_____
F-3	What were your practice's **bad debts** for services provided in your last full fiscal year (to the nearest thousand dollars)? **$**_____

Do you have any additional comments?

Congratulations, you have finished the survey!
Thank you for your responses.

To submit your complete survey, please fax it to
Audrey El-Gamil at the Lewin Group, 703-269-5501