Priority Health

**MEDICAL POLICY**
**No. 91494-R9**

# BONE DENSITY STUDIES

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| **Effective Date: November 22, 2023** | **Review Dates: 01/05, 12/05, 12/06, 12/07, 12/08, 10/09, 10/10, 10/11, 10/12, 10/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, 11/19, 11/20, 11/21, 11/22, 11/23, 11/24** |
| **Date Of Origin: January 19, 2005** | **Status: Current** |

## I. POLICY/CRITERIA

A. A one-time measurement of bone mineral density (BMD), using one method only, may be considered medically necessary to assess fracture risk and the need for pharmacologic therapy in the following patients considered at risk for osteoporosis, who are also considering treatment to prevent osteoporotic fracture:

1. All women aged 65 and older regardless of risk factors.
2. Men or women with a fracture risk (10-year probability of fracture using FRAX $\geq$ 9.3%) (Calculate FRAX @ http://www.shef.ac.uk/FRAX/index.aspx)
    a. A FRAX Assessment is done to identify patients for BMD testing when any of the following criteria are met:
        i. Personal history of fracture as an adult
        ii. History of fragility fracture in a first degree relative
        iii. Estrogen deficiency at an early age (<45 years)
        iv. Current cigarette smoking
        v. Low body weight (<127 lbs.)
        vi. Alcohol 3 or more units per day
        vii. Use of oral corticosteroid therapy for more than 3 months
        viii. History of osteopenia or osteopenia diagnosed via x-ray
        ix. History of Depro-Provera® use
        x. Individuals who are at increased risk for fractures due to diseases, conditions or treatments including, but not limited to primary hyperparathyroidism, renal failure (patients on dialysis), decreased mineralization noted on other studies, lifelong low calcium intake, impaired vision, dementia, recent falls, low physical activity, poor health/frailty, use of aromatase inhibitor therapy, and long-term anti-convulsant therapy (e.g., phenytoin therapy).
3. Individuals beginning or on glucocorticoid therapy, provided intervention is an option. The most commonly used glucocorticoids include prednisone, prednisolone, betamethasone, dexamethasone, and decadron.
4. Transplant patients.
5. Men with hypogonadism or receiving androgen deprivation treatment.

6. Post-menopausal women who present with fractures (to confirm diagnosis and determine disease severity).

B. If the initial BMD measurement was medically necessary as defined above, serial measurements of BMD to monitor treatment response may be considered medically necessary when performed no more frequently than 24 months apart and when a change in treatment plan may be made based on BMD results. When the need for serial measurements is anticipated in high-risk patients who are likely to require treatment, and for obtaining serial measurements, a central DXA BMD measurement should be obtained.

C. More frequent bone mass measurements may be considered medically necessary in any of the following circumstances:
   1. Monitoring individuals on long-term glucocorticoid (steroid) therapy of more than 3 months duration; **or**
   2. For a confirmatory baseline bone mass measurement to permit monitoring of individuals in the future if the initial bone mass test was performed with a technique that is different from the proposed testing method; **or**
   3. Monitoring of individuals with uncorrected primary hyperparathyroidism.

D. When it is not feasible to obtain a central DXA, a forearm DXA may be medically necessary.

E. Peripheral DXA sites (wrist, fingers, heel, etc.) other than forearm DXA are not medically necessary as results from these tests are not comparable to central DXA.

## II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the Priority Health Provider Manual.

## III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** ***This policy applies to insured HMO/EPO plans.***
- **POS:** ***This policy applies to insured POS plans.***
- **PPO:** ***This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***

- **ASO:** ***For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.***
- **INDIVIDUAL:** ***For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.***
- **MEDICARE:** ***Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.***
- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

## IV. DESCRIPTION

Osteoporosis, defined as low bone mass leading to an increased risk of fragility fractures, is an extremely common disease in the elderly due to age-related bone loss in both sexes and menopause-related bone loss in women. Current practice guidelines published by the Bone Health and Osteoporosis Foundation recommend that measurement of bone mineral density (BMD) be performed in all women over the age of 65 and in postmenopausal women with additional risk factors. Additional risk factors include a personal history of fracture as an adult, history of fracture in a first-degree relative, current cigarette smoking, and low body weight (<127 lbs). Patients receiving glucocorticoid therapy are also at risk for bone loss, no matter what the age. Therefore, BMD measurements are often performed prior to initiating therapy.

Bone mineral density (BMD) can be measured with a variety of techniques in a variety of sites. Sites are broadly subdivided into central sites (e.g., hip or spine) and peripheral sites (e.g., wrist, finger, heel). While BMD measurements are predictive of fragility fractures at all sites, central measurements of the hip and spine are the most predictive. Additionally, fractures of the hip and spine (e.g., vertebral fractures) are the most clinically relevant. The most commonly used techniques are Dual X-ray Absorptiometry (DXA), Quantitative computed tomography (QCT), and Ultrasound Densitometry.

BMD is one of the key determinants of the need for pharmacologic therapy. BMD is typically expressed in terms of the number of standard deviations (SD) the BMD falls below the mean for young, healthy adults. This number is termed the T score. The NOF guidelines recommend that pharmacologic therapy be initiated in women with T scores≤−2.5 at the femoral neck, total hip, or lumbar spine by DXA and in

postmenopausal women and men age 50 and older with low bone mass (T-score between −1.0 and −2.5, osteopenia) at the femoral neck, total hip, or lumbar spine by DXA and a 10-year hip fracture probability ≥3 % or a 10-year major osteoporosis-related fracture probability ≥20 % .Current pharmacologic options include hormone replacement therapy, bisphosphonates such as alendronate (Fosamax), selective estrogen receptor modulators (SERMs) such as raloxifene (Evista), and calcitonin. While BMD measurements are typically used to determine the need for pharmacologic therapy, serial monitoring of BMD to determine treatment response is also performed.

Dual-energy x-ray absorptiometry (DXA) is considered the gold standard because it is the most extensively validated test against fracture outcomes. In general, a central DXA BMD measurement should be strongly considered for initial screening purposes due to its reproducibility and ability to simultaneously establish the diagnosis of osteoporosis and provide a baseline if one is needed. Biomechanical studies have shown a strong correlation between mechanical strength and BMD measured by DXA. This approach is endorsed by the National Osteoporosis Foundation's Clinician's Guide to Prevention and Treatment of Osteoporosis as well as the Michigan Quality Improvement Consortium Guideline: Management and Prevention of Osteoporosis

When used in the same patients, DXA machines from different manufacturers differ in the proportion of patients diagnosed to have osteoporosis by 6 to 15 percent. Published studies consistently show that the probability of receiving a diagnosis of osteoporosis depends on the choice of test and site. One analytical study, for example, found that 6 percent of women older than 60 years of age would receive a diagnosis of osteoporosis if DXA of the total hip were used as the only test, compared with 14 percent for DXA of the lumbar spine, 3 percent with quantitative ultrasonography, and 50 percent with quantitative computed tomography (Faulker, 1999).

A meta-analysis assessed 23 publications from 11 separate prospective cohort studies published before 1996. Nearly all of the data were from women in their late 60s or older. No studies of ultrasonography were included. The meta-analysis indicated that DXA at the femoral neck predicted hip fracture better than measurements at other sites, and was comparable to forearm measurements for predicting fractures at other sites. For bone density measurements at the femoral neck, the pooled relative risk per decrease of one SD in bone density was 2.6 (CI, 2.0-3.5). In direct comparisons, heel ultrasonography was slightly worse than but comparable to DXA of the hip in women older than 65 years of age). For both tests, a result in the osteoporotic range is associated with an increased short-term probability of hip fracture. No data compare DXA and ultrasonography for prediction of fracture in women younger than 65 years of age.

***Special Note:*** Guidelines on the appropriate use of BMD include information from the National Osteoporosis Foundation and Priority Health's guidelines in conjunction with the Michigan Quality Improvement Consortium. This policy is also based on the recommendations of Priority Health's Technology Assessment Committee on December 3, 2004.

## V. CODING INFORMATION

**ICD-10 Codes** that may apply:

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| E05.00 - E05.91 | Thyrotoxicosis |
| E07.0 | Hypersecretion of calcitonin |
| E20.1 – E20.9 | Hypoparathyroidism |
| E21.1 – E21.5 | Hyperparathyroidism and other disorders of parathyroid gland |
| E23.0 | Hypopituitarism |
| E24.0 – E24.9 | Cushing's syndrome |
| E28.310 - E28.39 | Primary ovarian failure |
| E29.1 | Testicular hypofunction |
| E34.2 | Ectopic hormone secretion, not elsewhere classified |
| E43 | Unspecified severe protein-calorie malnutrition |
| E44.0 – E44.1 | Protein-calorie malnutrition |
| E45 | Retarded development following protein-calorie malnutrition |
| E46 | Unspecified protein-calorie malnutrition |
| E64.0 | Sequelae of protein-calorie malnutrition |
| E83.50 - E83.59 | Disorders of calcium metabolism |
| E89.40 | Asymptomatic postprocedural ovarian failure |
| E89.41 | Symptomatic postprocedural ovarian failure |
| K50.00 - K50.919 | Crohn's disease |
| K51.00 – K51.919 | Ulcerative colitis |
| K90.0 – K90.9 | Intestinal malabsorption |
| K91.2 | Postsurgical malabsorption, not elsewhere classified |
| M40.00 - M40.299 | Kyphosis |
| M48.40xA – M48.48xS | Fatigue fracture of vertebra |
| M48.50xA – M48.58xS | Collapsed vertebra |
| M80.00xA - M80.88XS | Osteoporosis with current pathological fracture |
| M81.0 – M81.8 | Osteoporosis without current pathological fracture |
| M83.0 – M83.9 | Adult osteomalacia |
| M84.30xA – M84.9 | Disorder of continuity of bone |
| M85.80 – M85.9 | Disorder of bone density and structure |
| M89.9 | Disorder of bone, unspecified |
| M94.9 | Disorder of cartilage, unspecified |
| N18.1 – N18.9 | Chronic kidney disease |
| N25.0 – N25.9 | Disorders resulting from impaired renal tubular function |
| N91.0 – N91.5 | Absent, scanty and rare menstruation |
| N95.0 – N95.9 | Menopausal and other perimenopausal disorders |
| Q61.00 – Q61.9 | Cystic kidney disease |
| Q96.0 – Q96.9 | Turner's syndrome |
| R29.890 | Loss of height |

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| S12.000A - S12.9xxS | Fracture of cervical vertebra and other parts of neck |
| S14.101A – S14.9xxS | Injury of nerves and spinal cord at neck level |
| S22.000A - S22.089S | Fracture of thoracic vertebra |
| S24.101A – S24.159S | Other and unspecified injuries of thoracic spinal cord |
| S32.000A - S32.2xxS | Fracture of lumbar spine |
| S34.101A - S34.3xxS | Injury of lumbar and sacral spinal cord |
| S72.001A - S72.26XS | Fracture of neck of right femur |
| S79.001A - S79.099S | Physeal fracture of upper end of femur |
| T38.0x1A – T38.0x5S | Poisoning by, adverse effect of and under dosing of glucocorticoids and synthetic analogues |
| Z08 | Encounter for follow-up examination after completed treatment for malignant neoplasm |
| Z09 | Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm |
| Z40.02 | Encounter for prophylactic removal of ovary |
| Z78.0 | Asymptomatic menopausal state |
| Z79.3 | Long term (current) use of hormonal contraceptives |
| Z79.51 | Long term (current) use of inhaled steroids |
| Z79.52 | Long term (current) use of systemic steroids |
| Z79.891 | Long term (current) use of opiate analgesic |
| Z79.899 | Other long term (current) drug therapy |
| Z90.721 | Acquired absence of ovaries, unilateral |
| Z90.722 | Acquired absence of ovaries, bilateral |
| Z90.79 | Acquired absence of other genital organ(s) |

**ICD-10 Diagnoses** that support screening central DEXA (77080, 77085) for female commercial members:

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| Z00.00 | Encounter for general adult medical examination without abnormal findings |
| Z00.01 | Encounter for general adult medical examination with abnormal findings |
| Z13.820 | Encounter for screening for osteoporosis |
| Z78.0 | Asymptomatic menopausal state |

**ICD-10 Diagnoses** that support peripheral DEXA (77081) for female commercial members:

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| M85.831 | Other specified disorders of bone density and structure, right forearm |
| M85.832 | Other specified disorders of bone density and structure, left forearm |

**CPT/HCPCS Codes**

*No Prior Authorization required:*

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| 77080 | Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine) |
| 77081 | Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel) *(Covered for* |

*Medicare only)* For Commercial and Medicaid *when 77080 cannot be performed for the forearm only.*

77085 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine), including vertebral fracture assessment

77086 Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)

G0130 Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel) *(Medicare only)*

76977 Ultrasound bone density measurement and interpretation, peripheral site(s), any method

Pre-authorization required:

***Note: eviCore provides prior authorization medical necessity review services on behalf of Priority Health for participating providers. Prior authorization for out-of-network providers must be requested through Priority Health. Bone density studies may be covered when eviCore criteria are met.***

77078 Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)

Not covered:

0554T Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report (covered for Medicare only)

0555T Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data (covered for Medicare only)

0556T Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone mineral density (covered for Medicare only)

0557T Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; interpretation and report (covered for Medicare only)

0691T Automated analysis of an existing computed tomography study for vertebral fracture(s), including assessment of bone density when performed, data preparation, interpretation, and report

0743T Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density, with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and bone mineral density and classification of any vertebral fractures, with overall fracture risk assessment, interpretation and report

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| 0749T | Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X ray data, assessment of bone strength and fracture-risk and BMD, interpretation and report; |
| 0750T | Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X ray data, assessment of bone strength and fracture-risk and BMD, interpretation and report; with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD |
| 0815T | Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine |
| 77089 | Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual X-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture-risk |
| 77090 | Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere |
| 77091 | Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only |
| 77092 | Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture-risk only by other qualified health care professional |
| 78350 | Bone density (bone mineral content) study, one or more sites; single photon absorptiometry |
| 78351 | Bone density (bone mineral content) study, one or more sites; dual photon absorptiometry, one or more sites |
| G0130 | Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel) (*Covered for Medicare only)* |

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