INSTRUCTIONS FOR USE
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Coverage Policy

In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Coverage of bone mineral density measurement for screening for osteoporosis is generally subject to the terms, conditions and limitations of a preventive services benefit as described in the applicable benefit plan’s schedule of copayments. Please refer to the applicable benefit plan document and schedules to determine benefit availability and the terms, conditions and limitations of coverage.

If coverage for bone mineral density measurement for screening for osteoporosis is available, the following conditions apply.

Screening
Cigna covers bone mineral density measurement as medically necessary for ANY of the following indications:

- woman age ≥65 years
- woman age <65 years whose 10-year fracture risk is equal to or greater than that of a 65-year-old white woman without additional risk factors (a 9.3% 10-year risk for any osteoporotic fracture) as determined by FRAX® score
- man age >50 years with at least one factor related to an increased risk of osteoporosis (i.e., age > 70, low body weight, weight loss >10%, physical inactivity, corticosteroid use, androgen deprivation therapy, hypogonadism and previous fragility fracture

Cigna covers repeat bone density measurement every two years.
Fracture Risk Assessment (FRAX®) tool, developed by the World Health Organization (Sheffield, United Kingdom)

Monitoring
Cigna covers bone mineral density measurement as medically necessary for EITHER of the following indications:

- prior to and during pharmacologic treatment for osteoporosis
- child or adolescent with a disease process known to adversely effect the skeleton

Cigna covers repeat bone density measurement no earlier than one year following a change in treatment regimen, and only when the results will directly impact a treatment decision.

Other
Cigna covers bone mineral density measurement as medically necessary for EITHER of the following indications:

- known osteoporotic fracture
- individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture

When bone mineral density testing is medically necessary, Cigna covers ANY ONE of the following techniques:

- central or peripheral dual-energy x-ray absorptiometry (DXA or DEXA)
- peripheral single-energy x-ray absorptiometry (SXA)
- central or peripheral quantitative computed tomography (QCT)
- peripheral quantitative ultrasound densitometry (QUS)

Cigna does not cover vertebral fracture assessment by dual-energy x-ray absorptiometry (DXA) for any indication because it is considered experimental, investigational or unproven.

General Background

Osteoporosis is the most common bone disease in humans; characterized by low bone mass, deterioration of bone tissue and disruption of bone architecture, compromised bone strength and an increase in the risk of fracture. Osteoporosis is a silent disease until it is complicated by fractures—fractures that can occur following minimal trauma. These fractures are common and place an enormous medical and personal burden on individuals during aging. Osteoporosis can be prevented, diagnosed and treated before any fracture occurs. Importantly, even after the first fracture has occurred, there are effective treatments to decrease the risk of further fractures. The National Osteoporosis Foundation (NOF) has estimated that more than 10 million Americans have osteoporosis and an additional 33.6 million have low bone density of the hip (NOF, 2013).

Dual-energy x-ray Absorptiometry (DXA) and Bone Mineral Density (BMD)

Dual-energy x-ray absorptiometry (DXA) measurement of the hip and spine is the technology now used to establish or confirm a diagnosis of osteoporosis, predict future fracture risk and monitor patients by performing serial assessments. Areal bone mineral density (BMD) is expressed in absolute terms of grams of mineral per square centimeter scanned (g/cm²) and as a relationship to two norms: compared to the BMD of an age-, sex-, and ethnicity-matched reference population (Z-score), or compared to a young-adult reference population of the same sex (T-score). The difference between the patient’s BMD and the mean BMD of the reference population, divided by the standard deviation (SD) of the reference population, is used to calculate the T-score and Z-score. Peak bone mass is achieved in early adulthood, followed by a decline in BMD. The rate of BMD decrease accelerates in women at menopause and continues to progress in postmenopausal women and men age 50 and older. The BMD diagnosis of normal, low bone mass (osteopenia), osteoporosis and severe or established osteoporosis is based on the World Health Organization (WHO) diagnostic classification:
• Normal: BMD is within 1 SD of a “young normal” adult (T-score at -1.0 and above).
• Low bone mass (osteopenia): BMD is between 1.0 and 2.5 SD below that of a “young normal” adult (T-score between -1.0 and -2.5).
• Osteoporosis: BMD is 2.5 SD or more below that of a “young normal” adult (T-score at or below -2.5).

Patients in this group who have already experienced one or more fractures are deemed to have severe or “established” osteoporosis.

(Based on BMD measurement at the spine, hip or forearm by DXA; NOF, 2013).

FRAX®

The FRAX® tool (Fracture Risk Assessment) has been developed by World Health Organization Collaborating Centre for Metabolic Bone Diseases (Sheffield, United Kingdom) to evaluate fracture risk of patients. It is based on individual patient models that integrate the risks associated with clinical risk factors as well as BMD at the femoral neck. The FRAX models have been developed from studying population-based cohorts from Europe, North America, Asia and Australia. In their most sophisticated form, FRAX is available on newer DXA machines or with software upgrades that provide the FRAX® scores on the bone density report. The FRAX tool is computer-driven and is available online. Also, several simplified paper versions, based on the number of risk factors are also available, and can be downloaded for office use. The FRAX algorithms give the 10-year probability of fracture. The output is a 10-year probability of hip fracture and the 10-year probability of a major osteoporotic fracture (clinical spine, forearm, hip or shoulder fracture).

Professional Societies/Organizations

National Osteoporosis Foundation (NOF): The NOF (2013) states BMD testing should be performed:

• in women age 65 and older and men age 70 and older, recommend BMD testing.
• in postmenopausal women and men age 50-69, recommend BMD testing based on risk factor profile.
• recommend BMD testing and vertebral imaging to those who have had a fracture, to determine degree of disease severity.
• BMD testing should be performed at DXA facilities using accepted quality assurance measures.

United States Preventive Services Task Force (USPSTF): The USPSTF (2011) recommendations on screening for osteoporosis:

• The USPSTF recommends screening for osteoporosis in women aged 65 years or older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
  Rating: B Recommendation.
• The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis in men.
  Rating: I Statement.

The USPSTF used the FRAX tool (WHO Collaborating Centre for Metabolic Bone Diseases, Sheffield, United Kingdom) to estimate 10-year risks for fractures because this tool relies on easily obtainable clinical information, such as age, body mass index (BMI), parental fracture history, and tobacco and alcohol use.

Based on the U.S. FRAX tool, a 65-year-old white woman with no other risk factors has a 9.3% 10-year risk for any osteoporotic fracture. White women between the ages of 50 and 64 years with equivalent or greater 10-year fracture risks based on specific risk factors include but are not limited to the following persons:
1) a 50-year-old current smoker with a BMI less than 21 kg/m2, daily alcohol use, and parental fracture history;
2) a 55-year-old woman with a parental fracture history;
3) a 60-year-old woman with a BMI less than 21 kg/m2 and daily alcohol use; and
4) a 60-year-old current smoker with daily alcohol use.

The FRAX tool also predicts 10-year fracture risks for black, Asian, and Hispanic women in the United States. In general, estimated fracture risks in nonwhite women are lower than those for white women of the same age.
Although the USPSTF recommends using a 9.3% 10-year fracture risk threshold to screen women aged 50 to 64 years, clinicians also should consider each patient’s values and preferences and use clinical judgment when discussing screening with women in this age group. Menopausal status is one factor that may affect a decision about screening in this age group.

**American Association of Clinical Endocrinologists (AACE):** The AACE medical guideline for clinical practice for the diagnosis and treatment of postmenopausal osteoporosis (2010) are limited to postmenopausal women.

**Indications for BMD testing:**

- all women 65 years of age or older
- all postmenopausal women
  - with a history of fracture(s) without major trauma after age 40 to 45 years
  - with osteopenia identified radiographically
  - starting or taking long-term systemic glucocorticoid therapy (≥3 mo)
- other perimenopausal or postmenopausal women with risk factors for osteoporosis if willing to consider pharmacologic interventions
  - low body weight (<127 lb or body mass index <20 kg/m2)
  - ever use of long-term systemic glucocorticoid therapy (≥3 mo)
  - family history of osteoporotic fracture
  - early menopause
  - current smoking
  - excessive consumption of alcohol
- secondary osteoporosis

**Important risk factors for osteoporosis-related fractures are:**

- prior low-trauma fracture as an adult
- advanced age
- low bone mineral density
- low body weight or low body mass index (not significant if adjusted for bone mineral density)
- family history of osteoporosis
- use of corticosteroids
- cigarette smoking
- excessive alcohol consumption
- secondary osteoporosis (for example, rheumatoid arthritis)

**American College of Physicians (ACP):** The ACP clinical practice guideline ‘Screening for Osteoporosis in Men’ noted the population screen included as low as age 50. The ACP recommends assessing men before age 65 for risk factors; recommending DXA scans only for those with an increased risk of osteoporosis based on the presence of one or more risk factors and are candidates for drug therapy (i.e., age > 70, low body weight, weight loss >10%, physical inactivity, corticosteroid use, androgen deprivation therapy, and previous fragility fracture (Qaseem, et al., 2008).

**American College of Obstetricians and Gynecologists (ACOG):** ACOG Practice Bulletin Osteoporosis (2012) states:

All major guidelines state that DXA screening should begin at age 65 years for women. Most guidelines also agree that DXA screening can be used selectively for women younger than 65 years if they are postmenopausal and have other risk factors for fracture. Alternatively, FRAX can be used in women younger than 65 years to determine which women should have a DXA scan. Those women with a FRAX 10-year risk of major osteoporotic fracture of 9.3% could justifiably be referred for DXA because that is the risk of fracture found in a 65-year-old Caucasian woman with no risk factors. Routine screening of newly menopausal women is not recommended nor is a “baseline” screen recommended. After treatment initiation, one DXA scan 1 year or 2 years later can be used to assess the effect of treatment. If the BMD is improved or stable (no significant change), the DXA does not usually need to be repeated in the absence of new risk factors. Testing generally should not be undertaken before 2 years after initiation of treatment because it often takes 18–24 months to document a clinically meaningful change.
When to Screen for Bone Density Before Age 65 Years
Bone density should be screened in postmenopausal women younger than 65 years if any of the following risk factors are noted:

- Medical history of a fragility fracture
- Body weight less than 127 lb
- Medical causes of bone loss (medications or diseases)
- Parental medical history of hip fracture
- Current smoker
- Alcoholism
- Rheumatoid arthritis

Recommendations regarding screening:

- Bone density screening for women should begin at age 65 years. Dual-energy X-ray absorptiometry screening can be used selectively for women younger than 65 years if they are postmenopausal and have other significant risk factors for osteoporosis or fracture
- In the absence of new risk factors, DXA screening should not be performed more frequently than every 2 years
- In the absence of new risk factors, DXA monitoring of therapy should not be repeated once BMD has been determined to be stable or improved

American College of Radiology (ACR): The ACR Practice Guideline for the Performance of Dual-energy x-ray Absorptiometry (DXA) (2013) states DXA is a clinically proven method of measuring bone mineral density (BMD) in the lumbar spine, proximal femur, and forearm. It is used primarily in the diagnosis and management of osteoporosis and other disease states characterized by abnormal BMD, as well as to monitor response to therapy for these conditions. Indications for DXA include, but are not limited to individuals with established or clinically suspected low BMD, including:

1. All women age 65 years and older and men age 70 years and older (asymptomatic screening).
2. Women younger than age 65 years who have additional risk for osteoporosis, based on medical history and other findings. Additional risk factors for osteoporosis include:
   a. Estrogen deficiency.
   b. A history of maternal hip fracture that occurred after the age of 50 years.
   c. Low body mass (less than 127 lbs or 57.6 kg).
   d. History of amenorrhea (more than 1 year before age 42 years).
3. Women younger than age 65 years or men younger than age 70 years who have additional risk factors, including:
   a. Current use of cigarettes
   b. Loss of height, thoracic kyphosis.
4. Individuals of any age with bone mass osteopenia, or fragility fractures on imaging studies such as radiographs, computed tomography (CT), or magnetic resonance imaging (MRI).
5. Individuals age 50 years and older who develop a wrist, hip, spine, or proximal humerus fracture with minimal or no trauma, excluding pathologic fractures.
6. Individuals of any age who develop 1 or more insufficiency fractures.
7. Individuals receiving (or expected to receive) glucocorticoid therapy for more than 3 months.
8. Individuals beginning or receiving long-term therapy with medications known to adversely affect BMD (e.g., anticonvulsant drugs, androgen deprivation therapy, aromatase inhibitor therapy, or chronic heparin).
9. Individuals with an endocrine disorder known to adversely affect BMD (e.g., hyperparathyroidism, hyperthyroidism, or Cushing’s syndrome).
10. Hypogonadal men older than 18 years and men with surgically or chemotherapeutically induced castration.
11. Individuals with medical conditions that could alter BMD, such as:
    a. Chronic renal failure.
    b. Rheumatoid arthritis and other inflammatory arthritides.
c. Eating disorders, including anorexia nervosa and bulimia.
d. Organ transplantation.
e. Prolonged immobilization.
f. Conditions associated with secondary osteoporosis, such as gastrointestinal malabsorption or malnutrition, sprue, osteomalacia, vitamin D deficiency, endometriosis, acromegaly, chronic alcoholism or established cirrhosis, and multiple myeloma.
g. Individuals who have had gastric bypass for obesity. The accuracy of DXA in these patients might be affected by obesity.

12. Individuals being considered for pharmacologic therapy for osteoporosis.
13. Individuals being monitored to:
   a. Assess the effectiveness of osteoporosis drug therapy.
   b. Follow-up medical conditions associated with abnormal BMD.

14. Children or adolescents with medical conditions associated with abnormal BMD including but not limited to:
   a. Individuals receiving (or expected to receive) glucocorticoid therapy for more than 3 months.
   b. Individuals receiving radiation or chemotherapy for malignancies.
   c. Individuals with an endocrine disorder known to adversely affect BMD (e.g., hyperparathyroidism, hyperthyroidism, growth hormone deficiency or Cushing’s syndrome).
   d. Individuals with bone dysplasias known to have excessive fracture risk (osteogenesis imperfecta, osteopetrosis) or high bone density.
   e. Individuals with medical conditions that could alter BMD, such as:
      i. Chronic renal failure.
      ii. Rheumatoid arthritis and other inflammatory arthritides.
      iii. Eating disorders, including anorexia nervosa and bulimia.
      iv. Organ transplantation.
      v. Prolonged immobilization.
      vi. Conditions associated with secondary osteoporosis, such as gastrointestinal malabsorption, sprue, inflammatory bowel disease, malnutrition, osteomalacia, vitamin D deficiency, acromegaly, cirrhosis, HIV infection, prolonged exposure to fluorides.

15. DXA may be indicated in the diagnosis, staging, and follow-up of individuals with conditions that result in pathologically increased BMD, such as osteopetrosis or prolonged exposure to fluoride.

16. DXA may be indicated as a tool to measure regional and whole body fat and lean mass (e.g., for patients with malabsorption, cancer, or eating disorders) (ACR, 2013).

The ACR Practice Guideline for the Performance of Quantitative Computed Tomography (QCT) Bone Densitometry (2013) states that QCT bone densitometry is a clinically proven method of measuring BMD in the spine, proximal femur, and distal forearm. QCT is used primarily in the diagnosis and management of osteoporosis and other disease states that may be characterized by abnormal BMD, as well as to monitor response to therapy for these conditions. The primary goal of QCT is to measure BMD accurately and reproducibly and compare that measurement to reference population standards and/or to an individual’s previous bone densitometry examination(s). This comparison contributes to the diagnosis of osteoporosis, helps in determining future fracture risk, and the need for pharmacologic therapy and fracture prevention programs. It is also useful in evaluating the effectiveness of prior or current therapy.

QCT has some advantages over DXA. DXA BMD estimates may be significantly biased by severe degenerative changes of the hip or spine, vascular calcifications, oral contrast agents, and foods or dietary supplements containing significant quantities of calcium or other heavier minerals or elements. QCT is often more accurate in patients with extreme obesity or low body mass index. There are well-documented differences in the response of cortical and trabecular bone to aging and therapeutic interventions. QCT spine BMD measurements are used to characterize only trabecular bone, while hip area density measurements obtained using QCT predominantly characterize cortical bone. QCT spine BMD measurements provide a sensitive indication of spine fracture risk and a somewhat less sensitive indication of hip fracture risk. For pediatric applications, peripheral QCT (pQCT) is commonly performed in children. It has the advantage of lower radiation dose.
BMD measurement is indicated whenever a clinical decision is likely to be directly influenced by the result of the test. QCT may be considered in place of or in addition to DXA in adults with established or clinically suspected low BMD, including:

1. All women age 65 years and older and men age 70 years and older (asymptomatic screening).
2. Women younger than age 65 years who have additional risk for osteoporosis, based on medical history and other findings. Additional risk factors for osteoporosis include:
   a. Estrogen deficiency.
   b. A history of maternal hip fracture that occurred after the age of 50 years.
   c. Low body mass (less than 127 pounds [57.6 kg]).
   d. History of amenorrhea (more than 1 year before age 42 years).
3. Women younger than age 65 years or men younger than age 70 years who have additional risk factors, including:
   a. Current use of cigarettes
   b. Loss of height, thoracic kyphosis.
4. Individuals of any age with osteopenia or fragility fractures on imaging studies, computed tomography (CT) or magnetic resonance imaging (MRI) examinations.
5. Individuals age 50 years and older who develop a wrist, hip, spine, or proximal humerus fracture with minimal or no trauma, but excluding pathologic fractures.
6. Individuals of any age who develop 1 or more insufficiency fractures.
7. Individuals receiving (or expected to receive) glucocorticoid therapy for more than 3 months.
8. Individuals beginning or receiving long-term therapy with medications known to adversely affect BMD (e.g., anticonvulsant drugs, androgen deprivation therapy, aromatase inhibitor therapy, or chronic heparin).
9. Individuals with an endocrine disorder known to adversely affect BMD (e.g., hyperparathyroidism, hyperthyroidism, or Cushing’s syndrome).
10. Hypogonadal men older than 18 years and men with surgically or chemotherapeutically induced castration.
11. Individuals with medical conditions that could alter BMD, such as:
   a. Chronic renal failure.
   b. Rheumatoid arthritis and other inflammatory arthritides.
   c. Eating disorders, including anorexia nervosa and bulimia.
   d. Organ transplantation.
   e. Prolonged immobilization.
   f. Conditions associated with secondary osteoporosis, such as gastrointestinal malabsorption, sprue, malnutrition, osteomalacia, vitamin D deficiency, endometriosis, acromegaly, chronic alcoholism or established cirrhosis, and multiple myeloma.
   g. Individuals who have had gastric bypass for obesity.
12. Individuals being considered for pharmacologic therapy for osteoporosis.
13. Individuals being monitored to assess the effectiveness of osteoporosis drug therapy or to follow-up medical conditions associated with abnormal BMD.
14. Individuals with extremes of obesity or low body mass index (ACR, 2013).

**Serial BMD**
The NOF (2013) states:

- Perform BMD testing 1 to 2 years after initiating therapy to reduce fracture risk and every two years thereafter.
- More frequent testing may be warranted in certain clinical situations.
- The interval between repeat BMD screening may be longer for patients without major risk factors and who have an initial T-score in the normal or upper low bone mass range.

The USPSTF states "evidence is lacking about optimal intervals for repeated screening" (2011).

**BMD Testing Methods**
In addition to DXA, the following bone mass measurement technologies are capable of predicting both site-specific and overall fracture risk. When performed according to accepted standards, these densitometric
techniques are accurate and highly reproducible. However, T-scores from these technologies cannot be used according to the WHO diagnostic classification because they are not equivalent to T-scores derived from DXA.

- **Quantitative computed tomography (QCT)** measures volumetric trabecular and cortical bone density at the spine and hip and bone structure and bone strength measures whereas peripheral QCT (pQCT) measures the same at the forearm or tibia. High resolution pQCT (HR-pQCT) at the radius and tibia provides measures of volumetric density, bone structure and microarchitecture. In postmenopausal women, QCT measurement of spine trabecular BMD can predict vertebral fractures whereas pQCT of the forearm at the ultra-distal radius predicts hip, but not vertebral fractures. There is lack of sufficient evidence for fracture prediction in men. QCT and pQCT are associated with greater amounts of radiation exposure than central DXA or pDXA.

The following technologies are often used for community-based screening programs because of the portability of the equipment. Results are not equivalent to DXA and abnormal results should be confirmed by physical examination, risk assessment and central DXA:

- **Peripheral dual-energy x-ray absorptiometry (pDXA)** measures areal bone density of the forearm, finger or heel. Measurement by validated pDXA devices can be used to assess vertebral and overall fracture risk in postmenopausal women. There is lack of sufficient evidence for fracture prediction in men. pDXA is associated with exposure to trivial amounts of radiation. pDXA is not appropriate for monitoring BMD after treatment.

- **Quantitative ultrasound densitometry (QUS)** does not measure BMD directly but rather speed of sound (SOS) and/or broadband ultrasound attenuation (BUA) at the heel, tibia, patella and other peripheral skeletal sites. A composite parameter using SOS and BUA may be used clinically. Validated heel QUS devices predict fractures in postmenopausal women (vertebral, hip and overall fracture risk) and in men 65 and older (hip and non-vertebral fractures). QUS is not associated with any radiation exposure (NOF, 2013).

**Vertebral Fracture Assessment (VFA)**

The gold standard for diagnosing vertebral fractures is lateral spine x-rays. Image quality of VFA by DXA has been reported in studies as equal to and inferior to radiography, with sensitivity and specificity ranging from 0.65–0.84 and 0.97–0.98, respectively. If a vertebral fracture is identified in an asymptomatic individual, studies do not report the impact of that finding on long-term health outcomes (Fuerst, et al., 2009). The NOF (2013) does not cite any studies supporting the impact of VFA on long-term health outcomes. There is insufficient evidence in the peer-reviewed scientific literature to support VFA.

The NOF states to “consider vertebral imaging tests in the following individuals:

- In all women age 70 and older and all men age 80 and older.
- In women age 65 to 69 and men age 75 to 79 if BMD T-score is -1.5 or below.
- In postmenopausal women age 50 to 64 and men age 50 to 69 with specific risk factors:
  - Low trauma fracture
  - Historical height loss of 1.5 inches or more (4 cm)
  - Prospective height loss of 0.8 inches or more (2 cm)
  - Recent or ongoing longterm glucocorticoid treatment (NOF, 2013).

**Use Outside of the US**

**International Society for Clinical Densitometry (ISCD):** The ISCD Official Adult Position (2013) indications for BMD Testing:

- Women aged 65 and older
- For post-menopausal women younger than age 65 a bone density test is indicated if they have a risk factor for low bone mass such as:
  - Low body weight
  - Prior fracture
  - High risk medication use
  - Disease or condition associated with bone loss.
• Women during the menopausal transition with clinical risk factors for fracture, such as low body weight, prior fracture, or high-risk medication use.
• Men aged 70 and older.
• For men < 70 years of age a bone density test is indicated if they have a risk factor for low bone mass such as:
  - Low body weight
  - Prior fracture
  - High risk medication use
  - Disease or condition associated with bone loss.
• Adults with a fragility fracture.
• Adults with a disease or condition associated with low bone mass or bone loss.
• Adults taking medications associated with low bone mass or bone loss.
• Anyone being considered for pharmacologic therapy.
• Anyone being treated, to monitor treatment effect. Anyone not receiving therapy in whom evidence of bone loss would lead to treatment.

Note: Women discontinuing estrogen should be considered for bone density testing according to the indications listed above.

Summary
Evidence in the published, peer-reviewed scientific literature supports the clinical utility of bone mineral density measurement in individuals with conditions, diseases and/or on certain medications that cause or contribute to osteoporosis and fractures. In addition bone mineral density measurement is supported by specialty societies and in consensus guidelines. Measurement of bone mineral density using dual energy x-ray absorptiometry (DXA), single energy x-ray absorptiometry (SXA), quantitative computer tomography (QCT) or quantitative ultrasound (QUA) is acceptable. There is insufficient evidence in the published peer-reviewed scientific literature to support the clinical utility of DXA for screening for vertebral fractures (i.e., vertebral fracture assessment [VFA]).

Coding/Billing Information

**Note:** 1) This list of codes may not be all-inclusive.

2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

**Covered when medically necessary:**

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<td>Ultrasound bone density measurement and interpretation, peripheral sites, any method</td>
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<td>77078</td>
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<td>Single energy x-ray absorptiometry (SXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)</td>
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**Experimental/Investigational/Unproven/Not Covered:**

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<th>CPT® Codes</th>
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Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment

References


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