



AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS

AMERICAN COLLEGE OF RHEUMATOLOGY

THE INTERNATIONAL SOCIETY FOR CLINICAL DENSITOMETRY

THE ENDOCRINE SOCIETY



August 18, 2010

Dr. Niles R. Rosen  
Medical Director  
National Correct Coding Initiative  
Correct Coding Solutions LLC  
PO Box 907  
Carmel, IN 46082-0907

RE: Proposed NCCI Edits for DXA and VFA

Dear Dr. Rosen:

The American Association of Clinical Endocrinologists (AAACE), the American College of Rheumatology (ACR), the International Society for Clinical Densitometry (ISCD) and The Endocrine Society (TES), thank you for the opportunity to comment on the recent CMS proposal that would designate vertebral fracture assessment (77082) and dual energy X-ray absorptiometry (77080) as mutually exclusive. We appreciate that for those not familiar with the technology, the shared descriptor employed by the AMA for these unique CPT codes: "dual energy X-ray absorptiometry (DXA) bone density study, 1 or more sites, spine..", could create the confusing impression that both technologies are used for the same purpose.

In fact, these two procedures are distinctly different. DXA provides a quantitative areal measurement of bone mass, routinely referred to as bone mineral *density* (BMD). In the spine, the patient is evaluated in the anterior-posterior (AP) supine position with measurement of the bone mineral content (BMC) and area of each of the four vertebral bodies L1, L2, L3 and L4. The sum of the BMC of each vertebrae is divided by the sum of the area of each vertebrae to determine the BMD of L1-L4. This measurement is used to calculate a T-score, which compares the BMD of the individual with that of a young normal control population. A low resolution AP image of the lumbar spine is generated solely for placement of soft tissue markers to determine the region of interest.

In contrast, vertebral fracture assessment (VFA) provides a detailed visual image of a much larger part of the spine with evaluation typically performed from T4 through L4. The healthcare provider would obtain VFA to visually look for the presence of vertebral fractures based on the image provided. The VFA image is diagnostic and can be used with near comparable specificity and sensitivity to plain radiographs when looking for moderate and severe vertebral fractures. Additional software incorporated in VFA allows for 6 point measurement of selected vertebrae (anterior/middle/posterior; superior and inferior margins) in the lateral view to assist in the determination of fracture grade (mild, moderate or severe). It should be noted that when performing a classical DXA study for the purposes of BMD determination, a low resolution AP image of the lumbar spine is generated for placement of markers to determine the region of interest of individual vertebrae to allow calculation of the numerical area and BMC.

Both DXA and VFA are used in the assessment of an individual patient's fracture risk but provide distinctly different information (BMD/T-score for DXA and presence of prevalent fracture for VFA). As noted in the current National Osteoporosis Foundation (NOF) Clinician's Guide, treatment to reduce fracture risk using FDA approved pharmacologic therapy is recommended for the post-menopausal woman or older man with T-scores (using DXA) of less than or equal to -2.5. Treatment is also recommended if prevalent vertebral fracture (using VFA or plain radiograph) is identified. Similarly, FRAX incorporates a BMD/T-score measurement as well as a determination of prevalent fractures, including vertebral fracture, to calculate a 10 year risk for future fracture.

Indications for when to obtain a DXA or VFA are also different. The Bone Mass Measurement Act of 1998 provided a NCD for DXA testing in certain Medicare qualified beneficiaries: estrogen deficient women; those with vertebral abnormalities including osteoporosis, osteopenia or prior fracture; hyperparathyroidism; those on prednisone in doses of  $\geq 7.5$  mg/d for  $\geq 3$  mos., and those on pharmacologic therapy to monitor response. Indications for VFA are currently provided in local coverage determinations by two Medicare carriers (Palmetto GBA and National Government Services) when a vertebral fracture assessment is required, symptoms of fracture are present and the results of the test will be used in management of the patient. Both CIGNA and FCSO distinguish VFA from the national coverage determination of DXA and subject to individual determination.

The ISCD has provided indications for VFA testing in its 2007 Official Positions. Unlike DXA, VFA is not viewed as a screening test but would be ordered in individuals where the finding of a vertebral fracture would alter the clinical treatment course. This would include individuals with osteopenia who had certain specified levels of historical height loss, measured height loss, history of prior vertebral fractures not well documented or other secondary causes of metabolic bone disease associated with high risk for fracture.

In October 1999, the VFA software packages to allow DXA devices to perform spinal imaging received FDA 501(k) marketing clearance. The AMA approved the CPT code 76077 for VFA effective January 1, 2005. In a housekeeping maneuver in 2006, the AMA CPT committee grouped bone density imaging procedures together so that beginning January 1, 2007, the new code for VFA, 77082 and for DXA 77080, took effect.

As part of the most recent Five Year Rule, CMS reviewed the RVUs for a variety of CPT codes including DXA and VFA. CMS and the AMA recognized VFA as separate and distinct from DXA with different RVUs based on separate and additional technologist time for positioning of the patient, analysis and transmittal of results as well as physician time for analysis and interpretation. Importantly, not all DXA machines include VFA software. DXA and VFA are distinctly different tools that evaluate separate functions (BMD/T-score for DXA ; vertebral fracture for VFA) even though they are contained in the same instrument.

The American Association of Clinical Endocrinologists (AACE) is a medical professional community of clinical endocrinologists committed to providing the highest quality care in Endocrinology. The American College of Rheumatology (ACR) is the largest rheumatology association for physicians, health professionals, and scientists that advance rheumatology through programs of education,

research, advocacy and practice support which foster excellence in the care of people with arthritis, rheumatic and musculoskeletal diseases. The International Society for Clinical Densitometry (ISCD) is a multidisciplinary, nonprofit organization with over 5,000 members that provides a central resource for a number of scientific disciplines with an interest in the assessment of skeletal health. Dedicated to advancing excellence in the assessment of skeletal health, the ISCD achieves this mission through a variety of activities including educational and certification programs for clinicians and technologists in the field of bone mass measurement and other skeletal health assessment technologies. The Endocrine Society (TES) is the world's largest professional organization of endocrinologists dedicated to quality research, patient care and education. AACE, ACRh, ISCD and TES recommend that the use of NCCI modifiers continue to be allowed for these procedures.

We appreciate your favorable consideration of these comments. Should you have any questions, please contact Anita Henderson-Sumpter, AACE Director of Socioeconomics & Member Advocacy, at (904) 353-7878, extension 142; Antanya Chung, ACRh Director of Practice Management, at (404) 633-3777, extension 818; Donna Fiorentino, ISCD Legislative Counsel, at (860) 402-2159; or Stephanie Kutler, TES Director of Government Affairs, at (301) 941-0254.

Sincerely,



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