Executive Summary

Comments Submitted by
American Association of Clinical Endocrinologists (AACE)
American Society for Bone and Mineral Research (ASBMR)
International Society for Clinical Densitometry (ISCD)
National Bone Health Alliance

On the
Draft Report on the Screening and Monitoring Tests for
Osteopenia/Osteoporosis

• Despite US costs estimated at $25 billion in 2025, and despite the capability to reduce fractures once discovered, osteoporosis evaluation with DXA remains underutilized: fewer scans are performed and fewer providers offer DXA services – 18% fewer in Washington State in 2012 than in 2008

• A National Coverage Determination does exist through CMS for bone densitometry, validating the importance of DXA in the eyes of CMS, and creating a level national playing field: see Chapter 15, Section 80.5 of Pub. 100-02. Medicare Benefit Policy Manual. Effective date 01/01/2007. Implementation date 07/02/2007.

• Important research regarding Key Question #1 was not included: population-based studies from large Health Maintenance Organizations Kaiser Permanente of Southern California and The Geisinger Health Plan showed significant reductions in fracture rates and cost-of-care when formal systems to increase DXA screenings were implemented.

• Regarding Key Question #2, the reliance on the “Gourlay” article (“Bone Density Testing Interval and Transition to Osteoporosis in Older Women” Gourlay et. al., NEJM, Jan 19, 2012) for the majority of evidence addressing the question is misguided at best. The study suffers from: 1) lowest-risk sub-selection, 2) exclusion of only a minority of patients with clinically important vertebral fractures, 3) arbitrary and un-recognized sub-classification of patients with low bone mass, 4) insufficient capture of patients at risk when utilizing hip bone density only, 5) allowing limited applicability without understanding of rapid bone loss in the menopausal transition, and 6) an antiquated understanding of notion of fracture risk based in T-score only. Similarly the “Frost” article (Frost, SW, Nguyen DN, Timing of Repeat BMD Measurements: Development of an Absolute Risk-Based Prognostic Model, Journal of Bone and Mineral Research, Volume 24, Number 11, 2009, Published online on May 4, 2009; doi: 10.1359/JBMR.090514 Ó 2009.) also calculates screening intervals based on T-score based thresholds, which just do not represent actual risks to patients since most patients who fracture do not have T-scores less than -2.5.

• The cost effectiveness calculations in Key Question #3 and #5 are heavily dependent on outdated DXA reimbursement values. Using the present actual values would result in significantly better cost-effectiveness, since the present value is two-thirds less than the inflation-adjusted 2010 value cited in the evidence.