

**\* Measure #24: Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older**

**2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:**  
CLAIMS, REGISTRY

**DESCRIPTION:**

Percentage of patients aged 50 years and older treated for a hip, spine, or distal radial fracture with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

**INSTRUCTIONS:**

This measure is to be reported after each occurrence of a fracture during the reporting period. It is anticipated that clinicians who treat the hip, spine, or distal radial fracture will submit this measure. Each occurrence of a fracture is identified by either an ICD-9-CM diagnosis code for fracture or osteoporosis and a CPT service code OR an ICD-9-CM diagnosis code for fracture or osteoporosis and a CPT procedure code for surgical treatment of a fracture.

Patients with a fracture of the hip, spine, or distal radius should have documentation in the medical record of communication from the clinician treating the fracture to the clinician managing the patient's on-going care that the fracture occurred and that the patient was or should be tested or treated for osteoporosis. If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of reporting will be counted. Claims data will be analyzed to determine unique occurrences. Documentation must indicate that communication to the clinician managing the on-going care of the patient occurred within three months of treatment for the fracture. The CPT Category II code should be reported during the episode of care (e.g., treatment of the fracture). The reporting of the code and documentation of communication do not need to occur simultaneously.

**Measure Reporting via Claims:**

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

**Measure Reporting via Registry:**

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not

need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

**DENOMINATOR:**

All patients aged 50 years and older treated for hip, spine, or distal radial fracture

Eligible cases are determined, and must be reported, if either of the following conditions are met:

**Option 1 - Denominator Criteria (Eligible Cases):**

Patients aged  $\geq$  50 years on date of encounter

**AND**

**Diagnosis for hip, spine or distal radial fracture (ICD-9-CM):** 733.00, 733.01, 733.02, 733.03, 733.09, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8

**AND**

**Patient encounter during the reporting period (CPT) – Service codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215,

OR

**Option 2 - Denominator Criteria (Eligible Cases):**

Patients aged  $\geq$  50 years on the date of encounter

**AND**

**Diagnosis for hip, spine or distal radial fracture (ICD-9-CM):** 733.00, 733.01, 733.02, 733.03, 733.09, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8

**AND**

**Patient encounter during the reporting period (CPT) – Procedure codes:** 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

**NUMERATOR:**

Patients with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

**Definition:**

**Communication** – May include documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, DXA report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**  
**Post Fracture Care Communication Documented**

**CPT II 5015F:** Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

**OR**

**Post Fracture Care not Communicated for Medical or Patient Reasons**

Append a modifier (**1P** or **2P**) to CPT Category II code **5015F** to report documented circumstances that appropriately exclude patients from the denominator.

**5015F with 1P:** Documentation of medical reason(s) for not communicating with physician managing on-going care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

**5015F with 2P:** Documentation of patient reason(s) for not communicating with the physician managing on-going care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

**OR**

**Post Fracture Care not Communicated, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **5015F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**5015F with 8P:** No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified

**RATIONALE:**

Patients who experience fragility fractures should either be treated or screened for the presence of osteoporosis. Although the fracture may be treated by the orthopedic surgeon, the testing and/or treatment is likely to be under the responsibility of the physician providing on-going care. It is important the physician providing on-going care for the patient be made aware the patient has sustained a non-traumatic fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of osteoporosis, should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.

**CLINICAL RECOMMENDATION STATEMENTS:**

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (ACE)

BMD measurement should be performed in all women 40 years old or older who have sustained a fracture. (ACE)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH) Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (AGA)

**\* Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older**

**2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:**  
CLAIMS, REGISTRY

**DESCRIPTION:**

Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

**INSTRUCTIONS:**

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. Female patients aged 65 years and older should have a central DXA measurement ordered or performed at least once since the time they turned 60 years or have pharmacologic therapy prescribed to prevent or treat osteoporosis. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

**Measure Reporting via Claims:**

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

**Measure Reporting via Registry:**

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

**DENOMINATOR:**

All female patients aged 65 years and older

**Denominator Criteria (Eligible Cases):**

Patients aged  $\geq 65$  years on date of encounter

**AND**

**Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

**NUMERATOR:**

Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

**Definitions:**

**Pharmacologic Therapy** – U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).

**Prescribed** – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Central DXA Measurement Ordered or Performed or Pharmacologic Therapy Prescribed**

**G8399:** Patient with central Dual-energy X-Ray Absorptiometry (DXA) results documented or ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

**OR**

**Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed for Documented Reasons**

**G8401:** Clinician documented that patient was not an eligible candidate for screening or therapy for osteoporosis for women measure

**OR**

**Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed, Reason not Specified**

**G8400:** Patient with central Dual-energy X-Ray Absorptiometry (DXA) results not documented or not ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis not prescribed

**RATIONALE:**

Patients with elevated risk for osteoporosis should have the diagnosis of osteoporosis excluded or be on treatment of osteoporosis.

**CLINICAL RECOMMENDATION STATEMENTS:**

The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. (B Recommendation) (USPSTF)

The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures. Use of risk factors, particularly increasing age, low weight, and non-use of estrogen replacement, to screen younger women may identify high-risk women. (B Recommendation) (USPSTF)

BMD measurement should be performed in all women beyond 65 years of age. Dual x-ray absorptiometry of the lumbar spine and proximal femur provides reproducible values at important sites of osteoporosis-associated fracture. These sites are preferred for baseline and serial measurements. (AACE)

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

BMD testing should be performed on:

- All women aged 65 and older regardless of risk factors
- Younger postmenopausal women with one or more risk factors (other than being white, postmenopausal, and female)
- Postmenopausal women who present with fractures (NQF)

The decision to test for BMD should be based on an individual's risk profile. Testing is never indicated unless the results could influence a treatment decision. (NQF)

Markers of greater osteoporosis and fracture risk include older age, hypogonadism, corticosteroid therapy, and established cirrhosis. (Level B Evidence) (NQF)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (NQF)

Pharmacologic therapy should be initiated to reduce fracture risk in women with:

- BMD T-scores below -2.0 by central dual x-ray absorptiometry (DXA) with no risk factors
- BMD T-scores below -1.5 by central dual x-ray absorptiometry (DXA) with one or more risk factors
- A prior vertebral or hip fracture (NQF)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

**\* Measure #40: Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older**

**2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:**  
CLAIMS, REGISTRY

**DESCRIPTION:**

Percentage of patients **aged 50 years and older** with fracture of the hip, spine, or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed

**INSTRUCTIONS:**

This measure is to be reported after each occurrence of a fracture during the reporting period. It is anticipated that clinicians who treat hip, spine or distal radial fractures will submit this measure. Each occurrence of a fracture is identified by either an ICD-9-CM diagnosis code for fracture or osteoporosis and a CPT service code OR an ICD-9-CM diagnosis code for a fracture or osteoporosis and a CPT procedure code for surgical treatment of fractures.

Patients with a fracture of the hip, spine, or distal radius should have a central DXA measurement ordered or performed or pharmacologic therapy prescribed. The management (DXA ordered or performed or pharmacologic therapy prescribed) should occur within three months of the initial visit with the reporting clinician following the fracture. If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of reporting will be counted. Claims data will be analyzed to determine unique occurrences. Patients with documentation of prior central DXA measurement or already receiving pharmacologic therapy would automatically meet the intent of this measure.

**Measure Reporting via Claims:**

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** G-code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

**Measure Reporting via Registry:**

ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

**DENOMINATOR:**

All patients aged 50 years and older with a fracture of the hip, spine, or distal radius

Eligible cases are determined, and must be reported, if either of the following conditions are met:

**Option 1 - Denominator Criteria (Eligible Cases):**

Patients aged  $\geq$  50 years on date of encounter

**AND**

**Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM):** 733.00, 733.01, 733.02, 733.03, 733.09, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8

**AND**

**Patient encounter during the reporting period (CPT) - Service codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

OR

**Option 2 - Denominator Criteria (Eligible Cases):**

Patients aged  $\geq$  50 years on date of encounter

**AND**

**Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM):** 733.00, 733.01, 733.02, 733.03, 733.09, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8

**AND**

**Patient encounter during the reporting period (CPT) - Procedure codes:** 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

**NUMERATOR:**

Patients who had a central DXA measurement ordered or performed or pharmacologic therapy prescribed

**Numerator Instructions:** Modifiers may be appended to any of the CPT Category II codes for medical reasons, patient reasons, system reasons, or reasons not otherwise specified.

**Definitions:**

**Pharmacologic Therapy** – U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).

**Prescribed** – May include prescription given to the patient for treatment of osteoporosis (as listed above) at one or more encounters during the reporting period, or documentation that patient is already taking pharmacologic therapy for osteoporosis, as documented in the current medical list.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Central DXA Measurement Ordered or Results Documented or Pharmacologic Therapy Prescribed**

**CPT II 3096F:** Central Dual-energy X-Ray Absorptiometry (DXA) ordered

**OR**

**CPT II 3095F:** Central Dual-energy X-Ray Absorptiometry (DXA) results documented

**OR**

**G8633:** Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

**OR**

**Central DXA Measurement not Ordered or Results not Documented for Medical, Patient, or System Reasons**

Append a modifier (**1P, 2P or 3P**) to CPT Category II codes **3096F or 3095F** to report documented circumstances that appropriately exclude patients from the denominator.

**3096F or 3095F with 1P:** Documentation of medical reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement

**3096F or 3095F with 2P:** Documentation of patient reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement

**3096F or 3095F with 3P:** Documentation of system reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement

**OR**

**Pharmacologic Therapy not Prescribed for Documented Reasons**

**G8634:** Clinician documented patient not an eligible candidate to receive pharmacologic therapy for osteoporosis

**OR**

**Central DXA Measurement not Ordered or Results not Documented, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **3096F or 3095F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3096F or 3095F with 8P:** Central dual energy X-ray absorptiometry (DXA) measurement was not ordered or performed, reason not otherwise specified

**OR**

**Pharmacologic Therapy not Prescribed, Reason not Specified**

**G8635:** Pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified

## **RATIONALE:**

Patients with a history of fracture should have a baseline bone mass measurement and/or receive treatment for osteoporosis. Given that the majority of osteoporotic fractures occur in patients with a diagnosis of osteoporosis by bone mass measurement, exclusion of osteoporosis by bone mass testing does not preclude treatment of osteoporosis in a patient with a history of fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of osteoporosis, should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.

## **CLINICAL RECOMMENDATION STATEMENTS:**

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

BMD measurement should be performed in all women 40 years old or older who have sustained a fracture. (AACE)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (AACE)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

Pharmacologic therapy should be initiated to reduce fracture risk in women with:

- BMD T-scores below -2.0 by central dual x-ray absorptiometry (DXA) with no risk factors
- BMD T-scores below -1.5 by central dual x-ray absorptiometry (DXA) with one or more risk factors
- A prior vertebral or hip fracture (NOF)

**\* Measure #41: Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older**

**2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:**  
CLAIMS, REGISTRY

**DESCRIPTION:**

Percentage of patients **aged 50 years and older** with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months

**INSTRUCTIONS:**

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. Patients with a diagnosis of osteoporosis should be prescribed pharmacologic therapy to treat osteoporosis. It is anticipated that clinicians who provide services for patients with the diagnosis of osteoporosis will submit this measure.

**Measure Reporting via Claims:**

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

**Measure Reporting via Registry:**

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

**DENOMINATOR:**

All patients aged 50 years and older with the diagnosis of osteoporosis

**Denominator Criteria (Eligible Cases):**

Patients aged  $\geq 50$  years on date of encounter

**AND**

**Diagnosis for osteoporosis (ICD-9-CM):** 733.00, 733.01, 733.02, 733.03, 733.09

**AND**

**Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

**NUMERATOR:**

Patients who were prescribed pharmacologic therapy for osteoporosis within 12 months

**Definitions:**

**Pharmacologic Therapy** – U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).

**Prescribed** – May include prescription given to the patient for treatment of osteoporosis (as listed above) at one or more encounters during the reporting period, OR documentation that patient is already taking pharmacologic therapy for osteoporosis, as documented in the current medication list.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Pharmacologic Therapy Prescribed**

**CPT II 4005F:** Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

**OR**

**Pharmacologic Therapy not Prescribed for Medical, Patient, or System Reasons**

Append a modifier (**1P, 2P or 3P**) to CPT Category II code **4005F** to report documented circumstances that appropriately exclude patients from the denominator.

**4005F with 1P:** Documentation of medical reason(s) for not prescribing pharmacologic therapy for osteoporosis

**4005F with 2P:** Documentation of patient reason(s) for not prescribing pharmacologic therapy for osteoporosis

**4005F with 3P:** Documentation of system reason for not prescribing pharmacologic therapy for osteoporosis

**OR**

**Pharmacologic Therapy not Prescribed, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **4005F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4005F with 8P:** Pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified

**RATIONALE:**

Pharmacologic therapy is an evidence-based recommendation for the treatment of osteoporosis.

**CLINICAL RECOMMENDATION STATEMENTS:**

Agents approved by the FDA for osteoporosis prevention and/or treatment include (in alphabetical order) bisphosphonates (alendronate, ibandronate, risedronate), salmon calcitonin, estrogen, raloxifene, and teriparatide. All act by reducing bone resorption, except for teriparatide, which has anabolic effects on bone.

Although estrogen is not approved for treatment of osteoporosis, there is level 1 evidence for its efficacy in reducing vertebral fractures, nonvertebral fractures, and hip fractures.

Level 1 evidence of efficacy in reducing the risk of vertebral fractures is available for all the agents approved for treatment of osteoporosis (bisphosphonates, calcitonin, raloxifene, and teriparatide). Prospective trials have demonstrated the effectiveness of bisphosphonates and teriparatide in reducing the risk of nonvertebral fractures (level 1), but only bisphosphonates have been shown to reduce the risk of hip fractures in prospective controlled trials (level 1). (AACE)

US Food and Drug Administration-approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, alendronate plus D, ibandronate, and risedronate, risedronate with 500 mg of calcium as the carbonate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modulators or SERMS (raloxifene). (NOF)