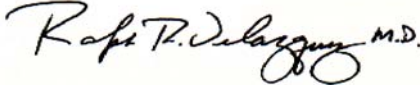




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|-------------------------|--|-----------------------|------------------------|
| Binder: | <u>Provider HMO/POS/QCP Policy and Procedure Manual</u> | | |
| Policy Title: | <u>Dexa Scans in the Office Setting</u> | | |
| Original Author: | <u>Henry Martin del</u> | Original Date: | <u>October 7, 2002</u> |
| | <u>Campo, M.D.</u> | | |
| Replaces: | _____ | Policy Number: | <u>PR917A119</u> |
| Approval: |  | | |
| | Title: Vice President & Chief Medical Officer | | |

POLICY

Bone Densitometry is a provisionally covered benefit. OSF HealthPlans covers bone density studies. In-network providers may provide this service in their office when the following conditions listed below are met. Verification of the criteria is essential for coverage.

PURPOSE

To promote excellence and consistency in provider equipment and utilization for bone densitometry.

PROCEDURE

- A. The in-network provider must verify the following criteria for approval of bone densitometry within their facility:
 - 1. The DEXA scan must provide axial testing (perform hip and back methods of scanning).
 - 2. Inspections of the equipment are performed to measure performance and output to ensure guidelines and standards are being met;
 - by the Illinois Emergency Management Agency (IEMA) Division of Nuclear Safety on an annual basisor
 - by the IEMA Division of Nuclear Safety every two years (as required by the Illinois Administrative Code Title 32:Section 320.10) with an inspection by a physicist on the “off years” when an IEMA inspection is not performed.
 - 3. Operator of the equipment must be qualified and licensed:
 - a. certified X-ray technician
 - b. nuclear medicine technician

- B. All DEXA scans require prior authorization from the Health Care Management Department.
 - 1. CPT 76977 – Ultrasound bone density measurement and interpretation does not meet the above requirements for coverage in an office setting and therefore, is not covered.

C. The attached form must be completed and returned with the required documentation:

- 1. Yearly inspection report
- 2. Copy of technicians license

The documents will be reviewed by the Assistant Medical Director and the provider will be informed of his decision.

- D. Provider offices must complete the attached form and submit all required documentation every three (3) years to show continued compliance with this policy. Providers that do not comply with this policy will not receive authorization to perform this test.

OSF HEALTH PLANS

AN AFFILIATE OF
OSF HEALTHCARE 

DEXA SCAN PROVIDER APPLICATION

Office Name: _____

Telephone: _____ Fax: _____

Office Address: _____

Normal Business Hours:

| Mon | | Tues | | Wed | | Thurs | | Fri | | Sat |
|-----|--|------|--|-----|--|-------|--|-----|--|-----|
| | | | | | | | | | | |

Federal Tax ID #: _____ (Please attach a copy of your W-9)

Malpractice/Professional Liability Insurance: (Please attach a copy of the face page)

Policy #: _____ Amount: _____

Company Name: _____ Expiration Date: _____

1. Does your machine provide axial testing? Yes _____ No _____

2. How is your equipment inspected?

a. annually by the IEMA Division of Nuclear Safety Yes _____ No _____

b. by the IEMA every two years with an inspection by a physicist on the "off years" Yes _____ No _____

If yes, please include a copy of the most recent inspection report.

3. Is the operator of your equipment a certified X-ray technician or a nuclear medicine technician? Yes _____ No _____

If yes, please include a copy of the license for all your technician(s).

If you have any questions about our coverage of DEXA scans, please contact your Provider Relations Specialist at 1-800-673-868.