

## 2.04.15 Bone Turnover Markers for the Diagnosis and Management of Osteoporosis and Diseases Associated With High Bone Turnover

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<b>Section:</b>	2.0 Medicine	<b>Page:</b>	Page 1 of 18

### Policy Statement

- I. Measurement of bone turnover markers is considered **investigational** to determine fracture risk in individuals with osteoporosis or with age-related risk factors for osteoporosis.
- II. Measurement of bone turnover markers is considered **investigational** to determine response to therapy in individuals who are being treated for osteoporosis.
- III. Measurement of bone turnover markers is considered **investigational** in the management of individuals with conditions associated with high rates of bone turnover, including but not limited to **any** of the following indications:
  - A. Paget disease
  - B. Primary hyperparathyroidism
  - C. Renal osteodystrophy

**NOTE:** Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

### Policy Guidelines

The following CPT codes describe bone turnover marker measurements:

- **82523:** Collagen cross links, any method
- **83937:** Osteocalcin (bone gla protein)

There is no specific CPT code for bone-specific alkaline phosphatase (B-ALP), but several laboratories' websites identify the following CPT code as being used for the Ostate test:

- **84078:** Phosphatase, alkaline; heat stable (total not included)
- **84080:** Phosphatase, alkaline; isoenzymes

### Description

Bone turnover markers are biochemical markers of either bone formation or bone resorption. Commercially available tests are available to assess some of these markers in urine and/or serum by high-performance liquid chromatography or immunoassay. Assessment of bone turnover markers is proposed to supplement bone mineral density measurement in the diagnosis of osteoporosis and to aid in treatment decisions. Bone turnover markers could also potentially be used to evaluate treatment effectiveness before changes in bone mineral density can be observed.

### Related Policies

- Bone Mineral Density Studies
- Vertebral Fracture Assessment with Densitometry

### Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract

language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

## Regulatory Status

Several tests for bone turnover markers have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. Examples are listed in Table 1. FDA product codes: NEO, JMM, CIN.

**Table 1. FDA-Cleared Tests for Bone Turnover Markers**

Test	Manufacturer	Year	Indication
<b>Pyrilinks<sup>®</sup></b>	Metra Biosystems	1995	Collagen type 1 cross-link, pyridinium
<b>Osteomark<sup>®</sup></b>	Ostex International	1996	Cross-linked N-telopeptides of type 1 collagen
<b>Serum CrossLaps<sup>®</sup> ELISA</b>	Immunodiagnostic Systems	1999	Hydroxyproline
<b>Ostase<sup>®</sup></b>	Beckman Coulter	2000	Bone-specific alkaline phosphatase
<b>N-MID<sup>®</sup> Osteocalcin One-Step ELISA</b>	Osteometer BioTech	2001	Osteocalcin
<b>Elecsys<sup>®</sup> N-MID Osteocalcin</b>	Roche Diagnostics	2005	Osteocalcin
<b>IDS-iSYS Ostase<sup>®</sup> BAP</b>	Immunodiagnostic Systems	2020	Bone-specific alkaline phosphatase

ELISA: enzyme-linked immunosorbent assay; FDA: U.S. Food and Drug Administration.

## Rationale

### Background

#### Bone Turnover

After cessation of growth, bone is in a constant state of remodeling (or turnover), with initial absorption of bone by osteoclasts followed by deposition of new bone matrix by osteoblasts.<sup>1</sup> This constant bone turnover is critical to the overall health of the bone, by repairing microfractures and remodeling the bony architecture in response to stress. Normally, the action of osteoclasts and osteoblasts is balanced, but bone loss occurs if the 2 processes become uncoupled. Bone turnover markers can be categorized as bone formation markers or bone resorption markers and can be identified in serum and/or urine.<sup>2</sup> There is interest in the use of bone turnover markers to evaluate age-related osteoporosis, a condition characterized by slow, prolonged bone loss, resulting in an increased risk of fractures at the hip, spine, or wrist. Measurement of bone turnover markers may aid in the diagnosis (by determining fracture risk) and therapeutic monitoring (by determining response to treatment) of osteoporosis. Bone turnover markers may also be used for the management of other diseases associated with high bone turnover (e.g., primary hyperparathyroidism, Paget disease, renal osteodystrophy). Table 2 summarizes the various bone turnover markers.<sup>3</sup>

**Table 2. Bone Turnover Markers**

Formation Markers	Resorption Markers
<b>Serum osteocalcin</b>	Serum and urinary hydroxyproline
<b>Serum total alkaline phosphatase</b>	Urinary total pyridinoline
<b>Serum bone-specific alkaline phosphatase</b>	Urinary total deoxypyridinoline
<b>Serum procollagen I carboxyterminal propeptide</b>	Urinary-free pyridinoline (also known as Pylilinks)
<b>Serum procollagen type 1 N-terminal propeptide</b>	Urinary-free deoxypyridinoline (also known as Pylilinks-D)

Formation Markers	Resorption Markers
Bone sialoprotein	Serum and urinary collagen type I cross-linked N-telopeptide (also referred to as Osteomark)
	Serum and urinary collagen type I cross-linked C-telopeptide (also referred to as CrossLaps)
	Serum carboxy-terminal telopeptide of type I collagen
	Tartrate-resistant acid phosphatase

### Literature Review

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

For bone turnover markers to be considered clinically useful, studies need to demonstrate that tests for these markers are accurate and reliable and that their use can improve health outcomes. For example, to evaluate their utility for diagnosing osteoporosis as an adjunct to bone mineral density (BMD) measurements using dual-energy x-ray absorptiometry (DXA), studies would also need to show that bone turnover markers independently predict fracture risk beyond BMD and that the additional information provided by information on bone turnover has the potential to influence treatment decisions and clinical outcomes. Similarly, to be considered useful for monitoring osteoporosis treatment beyond follow-up BMD measurements, bone turnover test results would have to impact the decision to continue or change treatment in a way that improves patient outcomes

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

### Bone Turnover Markers to Determine Fracture Risk

#### Clinical Context and Test Purpose

One potential purpose of measuring bone turnover markers in individuals who have osteoporosis or who are at risk of age-related osteoporosis is to inform a decision whether to begin, continue, or discontinue therapy.

The following PICO was used to select literature to inform this review.

#### *Populations*

The relevant population of interest is individuals with osteoporosis or age-related risk factors for osteoporosis.

#### *Interventions*

The test being considered is measurement of bone turnover markers as an adjunct to BMD. Variability in the measurement of bone turnover markers is related to a number of factors including

sample handling and diurnal variation, postprandial status, menopausal status, exercise, alcohol use, medications, health conditions, and recent fractures.<sup>4</sup>

### ***Comparators***

The following practice is currently being used to make decisions of whether to start, continue, or discontinue therapy: bone density measurements with DXA.

Fracture risk is primarily based on measurements of BMD in conjunction with other genetic and environmental factors, such as a family history of osteoporosis, history of smoking, and weight. It is thought that the level of bone turnover markers may also predict fracture risk, possibly through a different mechanism than that associated with BMD. However, it must be emphasized that the presence of bone turnover markers in the serum or urine is not necessarily related to bone loss. For example, even if bone turnover is high, if resorption is balanced with formation, there will be no net bone loss. Bone loss will only occur if resorption exceeds formation. Therefore, bone turnover markers have been primarily studied as an adjunct, not an alternative, to measurements of BMD to estimate fracture risk and document the need for preventive or therapeutic strategies for osteoporosis.

### ***Outcomes***

The general outcomes of interest are test validity and morbid events, more specifically, the association between test results and bone health, and the impact of the test results on bone fracture and health.

The beneficial outcome of a true test result is confirming effective treatment. The beneficial outcome of a true-negative test is to modify ineffective treatment.

Harmful outcomes of a false-positive result are not receiving the correct treatment. Harmful outcomes of a false-negative test are receiving unnecessary treatment.

Changes in bone turnover are expected to be observed in 3 months. The impact of changes in treatment on bone strength would be observed in 2 to 5 years.

### **Study Selection Criteria**

For the evaluation of clinical validity of the tests for bone turnover markers, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores).
- Included a suitable reference standard.
- Patient/sample clinical characteristics were described.
- Patient/sample selection criteria were described.

### **Clinically Valid**

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

### **Systematic Reviews**

A meta-analysis by Tian et al (2019) examined whether bone turnover markers, specifically procollagen type 1 N-terminal propeptide (PINP) and cross-linked C-telopeptide (CTX), are associated with fractures.<sup>5</sup> A total of 11,572 patients from 9 prospective cohort studies were included in the analysis. The crude and adjusted gradient of risk (GR) for PINP were extracted from 2 and 5 studies, respectively, while the crude and adjusted GR for CTX were extracted from 4 and 6 studies, respectively. PINP was not associated with fracture without adjusting covariates (crude GR, 1.03; 95% confidence interval [CI], 0.91 to 1.17). After adjusting for potential confounders (including age, body mass index, mobility score, past fractures, and hip BMD), PINP demonstrated a significant positive association with fracture (adjusted GR, 1.28; 95% CI, 1.15 to 1.42). For CTX, both the crude GR (1.16; 95%

CI, 1.04 to 1.20) and adjusted GR (1.20; 95% CI, 1.05 to 1.37) showed a significant positive association with fractures. A subgroup analysis (performed based on gender, age, and site of fracture) found significant associations in elderly (age >65 years), female, and hip fracture patients. A sensitivity analysis that excluded 1 study per iteration confirmed the stability of the findings. Limitations of this meta-analysis include the use of GR as the metric of predictive power to create a common approximation of risk. The included studies also had different settings for adjustment and various fracture endpoints.

A meta-analysis by Johansson et al (2014) focused on PINP and CTX markers and examined their ability to predict future fracture risk.<sup>6</sup> Reviewers included 10 prospective cohort studies in which bone turnover markers were measured at baseline and incident fractures were recorded. Pooled analyses were performed on a subset of these studies. Meta-analysis of 3 studies found a statistically significant association between baseline PINP and subsequent fracture risk (hazard ratio [HR], 1.23; 95% CI, 1.09 to 1.39). Similarly, a meta-analysis of 6 studies found an association between CTX and fracture risk (HR, 1.18; 95% CI, 1.09 to 1.29). None of the individual studies adjusted for BMD, and consequently, the pooled analyses do not reflect the ability of bone turnover markers to predict fracture risk beyond BMD. A high degree of heterogeneity was noted among the included studies. A systematic review by Biver et al (2012) did not find a statistically significant association between osteocalcin (OC; another bone turnover marker) and fracture risk.<sup>7</sup> When findings from 3 studies were pooled, the mean difference in OC levels in patients with and without vertebral fractures was 1.61 ng/mL (95% CI, -0.59 to 3.81). Heterogeneity of included studies was a limitation of the systematic review.

### **Prospective and Retrospective Studies**

An analysis of the Japanese Population-based Osteoporosis (JPOS) study data by Tamaki et al (2013) included postmenopausal women and adjusted for BMD.<sup>8</sup> The study involved baseline surveys, bone turnover marker assessment and BMD measurements, and 3 follow-ups over 10 years. At baseline, 851 women who participated were ages 50 years or older and eligible for vertebral fracture assessment. Of these, 730 women had BMD measurements taken at the initial examination and at 1 or more follow-ups. Women with early menopause (i.e., <40 years old), with a history of illness or medication known to affect bone metabolism, or with incomplete data were excluded. After exclusions, 522 women were evaluated. Over a median follow-up of 10 years, 81 (15.5%) of 522 women were found on imaging to have an incident vertebral fracture. Risk of incident vertebral fractures adjusted for BMD T-scores was significantly associated with several bone turnover markers, specifically alkaline phosphatase (ALP), urinary total deoxypyridinoline, and urinary free deoxypyridinoline. For example, in a multivariate model adjusting for various covariates including femoral neck BMD, the risk of developing a fracture per standard deviation of change in ALP was increased by 33% (relative risk [RR], 1.33; 95% CI, 1.06 to 1.66). Risk of incident vertebral fracture was not significantly associated with other bone turnover markers including OC and CTX. It is not clear how generalizable findings from this study are, given the association between subsequent fracture risk and certain bone turnover markers, and the lack of association between fracture risk and other bone turnover markers. Study analysis also excluded a large number of women due to incomplete data.

Bauer et al (2009) reported on men in a subgroup analysis of prospectively collected data from the Osteoporotic Fractures in Men (MrOS) study, also adjusted for BMD.<sup>9</sup> Baseline levels of bone turnover markers were compared in 384 men, ages 65 years or older, who had nonspine fractures over an average follow-up of 5 years, with 885 men without nonspine fracture. A second analysis compared 72 hip fracture cases and 993 controls without hip fracture. After adjusting for age and recruitment site, the association between nonspine fracture and quartile of the bone turnover marker PINP was statistically significant (for each analysis,  $p < .05$  was used). The associations between nonspine fracture and quartiles of the 2 other bone turnover markers, beta C-terminal cross-linked telopeptide of type 1 collagen and tartrate-resistant acid phosphatase 5b, were not statistically significant. Moreover, in the analysis adjusting only for age and recruitment site, when the highest quartile of

bone turnover markers was compared with the lower 3 quartiles, the risk of nonspine and hip fractures was significantly increased for PINP and beta C-terminal cross-linked telopeptide of type 1 collagen, but not tartrate-resistant acid phosphatase 5b. After additional adjustment for baseline BMD, or baseline BMD and other potential confounders, there were no statistically significant relations between any bone turnover marker and fracture risk. The authors concluded that their results did not support the routine use of bone turnover markers to assess fracture risk in older men when measuring hip BMD was an option.

Zhang et al (2019) studied the use of multiple bone turnover markers for diagnosis of osteoporosis in a prospective study of 9053 Chinese postmenopausal women (2464 with osteoporosis and 6589 without osteoporosis).<sup>10</sup> The markers were bone-specific alkaline phosphatase, bone sialoprotein, CTX, osteoprotegerin, OC, and soluble receptor activator of nuclear factor kappa-B ligand. When compared to BMD measured by DXA, no individual marker had sufficient diagnostic accuracy. However, a model using all 6 markers was found to have a sensitivity of 0.99, a specificity of 0.99, and an agreement of 0.978 compared to BMD. Several advantages of using serum BTMs compared to DXA were discussed. The study was funded by the National Natural Science Foundation of China, and there is currently no commercially available panel that includes all 6 markers.

Studies have also reported that bone turnover markers might be used along with other factors to determine who is likely to develop osteoporosis, with the goal of beginning treatment before skeletal deterioration.<sup>11,12</sup> For example, a study by Shieh et al (2019) found that baseline urinary N-telopeptide in combination with age, race/ethnicity, and body mass index was found to predict a significant bone loss in perimenopausal women.<sup>12</sup> No evidence was identified that has evaluated whether earlier treatment reduces fracture risk.

### **Clinically Useful**

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

### **Direct Evidence**

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from randomized controlled trials (RCTs). No RCTs were identified that evaluated the effect of measurement of bone turnover markers on health outcomes.

### **Chain of Evidence**

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

To provide clinical utility, bone turnover markers would have to provide information, beyond that offered by BMD measurements, that has an impact on treatment decisions, and/or that leads to improved health outcomes. Bone turnover markers can be measured more frequently than BMD and thus could provide information with clinical utility. For example, biochemical markers of bone turnover might be used to predict the extent of fracture risk reduction when measured 3 to 6 months after starting osteoporosis treatments approved by the U.S. Food and Drug Administration.

### **Section Summary: Bone Turnover Markers to Determine Fracture Risk**

Few studies have directly addressed whether any bone turnover markers beyond BMD measurements are independent predictors of fracture risk. Among the body of evidence, only 1 meta-analysis has investigated the independent role of bone turnover markers in fracture risk prediction (by adjusting for potential confounders including BMD); a statistically significant but modest association between PINP or CTX and future fracture risk was found, although the study was limited since it used GR as the metric of predictive power. Some other studies have found statistically

significant associations between bone turnover markers and fracture risk, but there is insufficient literature on any specific marker. For example, an analysis of MrOS data found a significant association between PINP and risk of nonspine fracture in men, and the JPOS study from Japan found a significant association between ALP, urinary total deoxypyridinoline, and urinary free deoxypyridinoline and risk of incident vertebral fracture in women. Overall, further evidence is needed from well-designed prospective studies that assess bone turnover markers in a standard manner for a single fracture type.

## **Bone Turnover Markers to Determine Response to Osteoporosis Treatment**

### **Clinical Context and Test Purpose**

Bone turnover markers might provide a more immediate assessment of treatment response and predict a change in BMD in response to treatment. Treatment-related changes in BMD occur very slowly. This fact, coupled with the precision of BMD technologies, has suggested that clinically significant changes in BMD could not be reliably detected until at least 2 years. In contrast, changes in bone turnover markers could be anticipated after 3 to 6 months of therapy.

The purpose of measuring for bone turnover markers in individuals who have suspected osteoporosis is to inform a decision whether to change therapy.

The following PICO was used to select literature to inform this review.

### ***Populations***

The relevant population of interest is individuals who are being treated for osteoporosis.

### ***Interventions***

The test being considered is measurement of bone turnover markers as an indicator of response to therapy. Variability in the measurement of bone turnover markers is related to a number of factors including sample handling and diurnal variation, postprandial status, menopausal status, exercise, alcohol use, medications, health conditions, and recent fractures.<sup>4</sup>

### ***Comparators***

The following practice is currently being used to manage osteoporosis: BMD measurements with DXA.

### ***Outcomes***

The general outcomes of interest are test validity and morbid events, more specifically, the association between test results and bone health, and the impact of the test results on bone fracture and health.

The beneficial outcome of a true test result is confirming effective treatment. The beneficial outcome of a true-negative test is to modify ineffective treatment.

Harmful outcomes of a false-positive result are not receiving the correct treatment. Harmful outcomes of a false-negative test are receiving unnecessary treatment.

Changes in bone turnover are expected to be observed in 3 to 6 months. The impact of changes in treatment on bone strength would be observed in 2 to 5 years.

### **Study Selection Criteria**

For the evaluation of clinical validity of the tests for bone turnover markers, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores).
- Included a suitable reference standard.

- Patient/sample clinical characteristics were described.
- Patient/sample selection criteria were described.

### **Clinically Valid**

Studies have examined the ability of bone turnover markers to evaluate response to osteoporosis treatment.

### **Randomized Controlled Trials**

A subgroup analysis of the randomized Fracture Intervention Trial (FIT) by Bauer et al (2006) found that pretreatment levels of the bone turnover marker PINP significantly predicted the anti-fracture efficacy of alendronate.<sup>13</sup> The analysis included 6186 women who completed the FIT trial and had complete baseline and follow-up measurements. Over a mean follow-up of 3.2 years, there were 492 nonspine and 294 vertebral fractures. Compared with the placebo group, the efficacy of alendronate for reducing nonspine fractures was significantly greater in women who were in the highest tercile of PINP (>56.8 ng/mL) than in those in the lowest tercile (<41.6 ng/mL). Baseline bone turnover rates were not associated with alendronate efficacy in reducing vertebral fractures. The authors indicated that this result needed confirmation in additional studies, and, even if verified, the impact on treatment recommendations was unclear.

### **Observational Studies**

Kashii et al (2023) reported a prospective review of 63 treatment-naive patients with postmenopausal osteoporosis commencing 12 months of treatment with romosozumab.<sup>14</sup> Multiple regression analysis revealed that PINP value was significantly and independently associated with at least a 3% increase in BMD in both total hip and femoral neck ( $p=.019$ ). The optimal PINP cutoff was 53.7 mcg/L, with 54.3% sensitivity and 92.3% specificity.

Baxter et al (2013)<sup>15</sup> reported a retrospective review of 200 patients commencing treatment with bisphosphonates for osteoporosis or osteopenia. Investigators found a statistically significant inverse correlation between change in urine N-terminal telopeptide at 4 months and change in spine BMD at 18 months ( $r=-0.33$ ,  $p<.001$ ). There was no significant association between change in urine N-terminal telopeptide and hip BMD.

### **Clinically Useful**

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

### **Direct Evidence**

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs. No RCTs were identified that managed therapy based on results of the test.

Several RCTs have addressed whether measurement of bone turnover markers can improve adherence to oral bisphosphonate treatment. A systematic review by Burch et al (2014) identified 5 RCTs and did not find significant differences in compliance rates between groups that did and did not receive feedback on bone turnover marker test results.<sup>16</sup> Study data were not pooled. Reviewers noted a high baseline compliance rate that limited the studies' ability to detect an impact of feedback. As an example, an industry-sponsored study by Roux et al (2012) from France randomized physicians to manage patients on oral ibandronate given monthly with a collagen cross-links test or usual care.<sup>17</sup> In the collagen cross-links group, bone marker assessment was done at baseline and week 5 for the week 6 visit. A standardized message was delivered to patients regarding a change in CTX since baseline. If the decrease in CTX was more than 30% of the baseline value, patients were told that the treatment effect was optimal. If not, they were told that the treatment effect was

suboptimal and given additional advice. Patients who were told that they had a suboptimal response were retested with CTX at week 13 for the week 14 visit. The primary outcome was the proportion of patients who were adherent at 1 year. After 1 year, rates of adherence to ibandronate were 74.8% in the collagen cross-links group and 75.1% in the usual care group; the difference between groups was not statistically significant ( $p=.93$ ). There was also no statistically significant difference in the proportion of patients having taken at least 10 of 12 pills (82.4% in the collagen cross-links group vs. 80.0% in the usual care group). In this study, monitoring bone markers and providing this information to patients did not improve adherence to oral medication for osteoporosis.

### **Chain of Evidence**

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Evidence is insufficient to support that results of bone marker tests would affect patient management; therefore, no inferences can be made about clinical utility.

### **Section Summary: Bone Turnover Markers to Determine Response to Osteoporosis Treatment**

The available evidence on the association between any specific bone turnover marker and response to osteoporosis treatment is limited in quantity and quality. While some individual studies have reported positive correlations for markers (e.g., PINP in the FIT trial), a body of evidence in support of any specific marker is lacking. As a result, the evidence does not permit conclusions about whether bone turnover markers are an independent predictor of treatment response. Individual RCTs and a systematic review of these RCTs have not found that feedback on bone turnover marker results improves adherence rates. No studies were identified that evaluated whether the use of bone turnover markers leads to management changes that are expected to improve outcomes.

### **Other Conditions Associated With High Rates of Bone Turnover Clinical Context and Test Purpose**

Bone turnover markers have been evaluated as markers of diseases associated with markedly high levels of bone turnover, such as Paget disease, primary hyperparathyroidism, and renal osteodystrophy. The purpose of measuring bone turnover markers in individuals who have conditions associated with high rates of bone turnover is to inform a decision whether to alter management.

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals who have conditions associated with high rates of bone turnover.

#### ***Interventions***

The test being considered is measurement of bone turnover markers.

#### ***Comparators***

The following practices are currently being used to manage other conditions associated with high rates of bone turnover: bone density measurements with DXA and bone scintigraphy.

#### ***Outcomes***

The general outcomes of interest are test validity and morbid events, more specifically, the association between test results and bone health, and the impact of the test results on bone fracture and health. Changes in bone turnover are expected to be observed in 3 months. The impact of changes in treatment on bone strength would be observed within 2 to 5 years.

The beneficial outcome of a true test result is undergoing correct treatment. The beneficial outcome of a true-negative test is to avoid unnecessary or incorrect treatment.

Harmful outcomes of a false-positive result are unnecessary treatment. Harmful outcomes of a false-negative test are not receiving the correct treatment.

### Study Selection Criteria

For the evaluation of clinical validity of the tests for bone turnover markers, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores).
- Included a suitable reference standard.
- Patient/sample clinical characteristics were described.
- Patient/sample selection criteria were described.

### Clinically Valid

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

There is little published literature on the use of bone turnover markers in the management of conditions associated with high rates of bone turnover (e.g., primary hyperparathyroidism, Paget disease, renal osteodystrophy), and many available studies were published 10 or more years ago.

### Systematic Reviews

A systematic review and meta-analysis by Al Nofal et al (2015) assessed the literature on bone turnover markers in Paget disease.<sup>18</sup> Reviewers focused on the correlation between bone markers and disease activity before and after treatment with bisphosphonates. All study design types were included and bone scintigraphy was used as the reference standard. Reviewers identified 18 studies. Seven assessed bone markers in patients with Paget disease before treatment, 6 considered both the pre- and posttreatment associations, and 5 included only the posttreatment period. Only one study was an RCT; the rest were prospective cohort studies. There was a moderate-to-strong correlation between several bone turnover markers (bone ALP, total ALP, PINP, N-terminal telopeptide) and pretreatment disease activity. In a pooled analysis of available data, there was a statistically significant correlation between levels of a bone turnover marker and disease activity after treatment with bisphosphonates ( $p=.019$ ). Reviewers did not address the potential impact on the bone turnover measurement on patient management or health outcomes.

### Observational Studies

A study by Martli et al (2023) reported on 55 patients with primary hyperparathyroidism who underwent parathyroidectomy.<sup>19</sup> The investigators sought to determine the relationship between preoperative PINP and CTx levels and the risk of postoperative hypocalcemia. Results demonstrated that a CTx value exceeding 2.665 pg/dL was an independent risk factor for postoperative hypocalcemia ( $p=.036$ ).

A study by Rianon et al (2012) reported on 198 patients with primary hyperparathyroidism who underwent parathyroidectomy.<sup>20</sup> The investigators found a statistically significant association ( $p<.05$ ) between preoperative serum OC levels and persistent postoperative elevation of parathyroid hormone 6 months after the surgery.

### Clinically Useful

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

### **Direct Evidence**

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

No RCTs on the use of bone turnover markers in these conditions have been identified.

### **Chain of Evidence**

Indirect evidence on clinical utility rests on clinical validity and evidence that test results would change patient management. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Evidence is insufficient to support that results of bone marker tests would affect patient management; therefore, no inferences can be made about clinical utility.

### **Section Summary: Other Conditions Associated With High Rates of Bone Turnover**

There is a lack of evidence on how the measurement of bone turnover markers can change management or improve health outcomes in patients who have diseases associated with high bone turnover other than age-related osteoporosis. Although observational studies have demonstrated an association between bone markers and disease activity, the clinical utility of monitoring bone turnover markers for the management of diseases associated with high bone turnover is uncertain. Large prospective trials are needed to establish clinical validity.

### **Supplemental Information**

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

### **Practice Guidelines and Position Statements**

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

### **American Association of Clinical Endocrinologists and the American College of Endocrinology**

The 2020 guidelines from the American Association of Clinical Endocrinologists and the American College of Endocrinology (AAACE/ACE) gave a Grade B recommendation to consider using bone turnover markers for assessing patient compliance and therapy efficacy.<sup>21</sup> AAACE/ACE reviewed evidence that markers respond quickly to therapeutic intervention, and changes in markers have been associated with bone response to therapy and fracture risk reduction.

### **Bone Health and Osteoporosis Foundation**

In 2022, the Bone Health and Osteoporosis Foundation (formerly the National Osteoporosis Foundation) published updated guidelines on the prevention and treatment of osteoporosis to prevent fractures. Regarding biochemical markers of bone turnover, the guidelines stated: "Biochemical bone turnover markers can play a role in assessing fracture risk in appropriate individuals."<sup>22</sup>

Furthermore, biochemical markers of bone turnover may:

- Predict rapidity of bone loss in untreated postmenopausal women
- Predict extent of fracture risk reduction when repeated after 3–6 months of treatment with FDA [Food and Drug Administration]-approved therapies
- Predict magnitude of BMD [bone mineral density] increases with FDA-approved therapies

- Help determine adequacy of patient compliance and persistence with osteoporosis therapy using a serum CTX for an antiresorptive medication and PINP for an anabolic therapy (least significant change [LSC] is approximately a 40% reduction in CTX)
- Help determine duration of 'drug holiday' and when and if medication should be restarted (Data are quite limited to support this use, but studies are underway.)

### **Endocrine Society**

In 2019, guidelines from the Endocrine Society recommended that in postmenopausal women with a low BMD and at high-risk of fractures who are being treated for osteoporosis, monitoring should be conducted by dual-energy X-ray absorptiometry (DXA) at the spine and hip every 1 to 3 years.<sup>23</sup> The Society considers measuring bone turnover markers (serum C-telopeptide [CTX] for antiresorptive therapy or procollagen type 1 N-terminal propeptide [PINP] for bone anabolic therapy) as an alternative way of monitoring for poor response or nonadherence to therapy. The Society notes that there is uncertainty over what constitutes an optimal response to treatment, but some experts suggest that a meaningful change is approximately 40% when compared from before to 3 to 6 months after starting treatment. A guideline update was published in 2020, in which the statements concerning measurement of bone turnover markers remained unchanged.<sup>24</sup>

The Endocrine Society also published guidelines regarding the management of Paget disease in 2014.<sup>25</sup> The guideline states:

- "We recommend measurement of serum total alkaline phosphatase or, when warranted, a more specific marker of bone formation or bone resorption to assess the response to treatment or evolution of the disease in untreated patients."
- "In patients with monostotic disease who have a normal serum total alkaline phosphatase, we suggest that a specific marker of bone formation and bone resorption be measured, although these may still be normal. Serial radionuclide bone scans may determine the response to treatment if the markers are normal."
- "In assessing the response to treatment: "For most patients, measurement of total ALP [alkaline phosphatase] or other baseline disease activity markers at 6 to 12 weeks, when bone turnover will have shown a substantial decline, is an acceptable and cost-effective option."

### **North American Menopause Society**

In 2021, the North American Menopause Society (NAMS) issued a position statement on the management of osteoporosis in postmenopausal women.<sup>26</sup> Per the NAMS:

- "Bone turnover markers cannot diagnose osteoporosis and have varying ability to predict fracture risk in clinical trials. Bone turnover markers have been used primarily in clinical trials to demonstrate group responses to treatment. Although used by some osteoporosis specialists, the routine use of bone turnover markers in the evaluation of patients with osteoporosis is not recommended."
- "Although changes in bone turnover markers are used by some specialists to assess adherence and effectiveness of therapy, routine use of bone markers is not recommended."

### **International Society for Clinical Densitometry**

In 2011, a joint statement by the International Society for Clinical Densitometry (ISCD) and the International Osteoporosis Foundation on the Fracture Risk Assessment Model (FRAX) fracture risk prediction algorithms indicated that the "Evidence that bone turnover markers predict fracture risk independent of BMD is inconclusive. Therefore, bone turnover markers are not included as risk factors in FRAX."<sup>27</sup>

In the 2019 ISCD position statement on repeating measurement of BMD when monitoring with DXA, there is a comment on bone turnover markers: "Serial BMD testing in combination with clinical assessment of fracture risk, bone turnover markers, and other factors...can be used to determine

whether treatment should be initiated in untreated patients, according to locally applicable guidelines."<sup>28</sup>.

### U.S. Preventive Services Task Force Recommendations

The U.S. Preventive Services Task Force (2018) recommended screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.<sup>29</sup> The Task Force recommended screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. The recommendations on osteoporosis screening addressed DXA testing but did not mention bone turnover markers.

### Medicare National Coverage

In November 2002, the Centers for Medicare & Medicaid Services issued a national coverage determination on collagen cross-links.<sup>30</sup> The Centers for Medicare & Medicaid Services identified a set of clinical conditions for which collagen cross-links would be considered eligible for coverage. The decision is limited to urine-based collagen cross-link tests and does not address serum-based collagen cross-link tests.

Previously, the *Federal Register* (2001) noted that Medicare carriers have the discretion to make their own determinations on the medical necessity of serum-based collagen cross-link tests for assessing or monitoring bone loss therapy.<sup>31</sup> The *Federal Register* also noted that the U.S. Food and Drug Administration approved serum-based collagen cross-link tests under 510(k) review, as substantially equivalent to the urine-based collagen cross-link test. It should be noted that the serum-based collagen cross-link tests are more commonly performed than urine collagen cross-link tests.

Note that the Centers for Medicare & Medicaid Services analysis focused on the technical feasibility of collagen cross-links and anticipated outcomes. The discussion above focused on the impact on health outcomes as documented in controlled studies.

### Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in November 2023 did not identify any ongoing or unpublished trials that would likely influence this review.

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## Documentation for Clinical Review

- No records required

## Coding

*This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.*

*The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.*

Type	Code	Description
CPT®	82523	Collagen cross links, any method
	83937	Osteocalcin (bone gla protein)
	84078	Phosphatase, alkaline; heat stable (total not included)
	84080	Phosphatase, alkaline; isoenzymes
HCPCS	None	

## Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
12/07/2006	BCBSA Medical Policy adoption
10/01/2010	Policy Revision with title change from Collagen Cross Links as Markers of Bone Turnover
08/23/2013	Title change from Bone Turnover Markers for Osteoporosis with position change. Policy placed on No Further Routine Literature Review and Update status.
01/30/2015	Policy revision without position change
02/01/2017	Policy revision without position change and title change from Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover
02/01/2018	Policy revision without position change
03/01/2019	Policy revision without position change
04/01/2020	Annual review. No change to policy statement. Literature review updated.
03/01/2021	Annual review. No change to policy statement. Literature review updated.
03/01/2022	Annual review. No change to policy statement. Literature review updated.
03/01/2023	Annual review. Policy statement and literature review updated.
03/01/2024	Annual review. No change to policy statement. Literature review updated.

## Definitions of Decision Determinations

**Medically Necessary:** Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

## Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider).

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: [MedPolicy@blueshieldca.com](mailto:MedPolicy@blueshieldca.com)

*Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.*

**Appendix A**

POLICY STATEMENT (No changes)	
BEFORE	AFTER
<p><b>Bone Turnover Markers for the Diagnosis and Management of Osteoporosis and Diseases Associated With High Bone Turnover 2.04.15</b></p> <p><b>Policy Statement:</b></p> <ul style="list-style-type: none"> <li>I. Measurement of bone turnover markers is considered <b>investigational</b> to determine fracture risk in individuals with osteoporosis or with age-related risk factors for osteoporosis.</li> <li>II. Measurement of bone turnover markers is considered <b>investigational</b> to determine response to therapy in individuals who are being treated for osteoporosis.</li> <li>III. Measurement of bone turnover markers is considered <b>investigational</b> in the management of individuals with conditions associated with high rates of bone turnover, including but not limited to <b>any</b> of the following indications:                             <ul style="list-style-type: none"> <li>A. Paget disease</li> <li>B. Primary hyperparathyroidism</li> <li>C. Renal osteodystrophy</li> </ul> </li> </ul>	<p><b>Bone Turnover Markers for the Diagnosis and Management of Osteoporosis and Diseases Associated With High Bone Turnover 2.04.15</b></p> <p><b>Policy Statement:</b></p> <ul style="list-style-type: none"> <li>I. Measurement of bone turnover markers is considered <b>investigational</b> to determine fracture risk in individuals with osteoporosis or with age-related risk factors for osteoporosis.</li> <li>II. Measurement of bone turnover markers is considered <b>investigational</b> to determine response to therapy in individuals who are being treated for osteoporosis.</li> <li>III. Measurement of bone turnover markers is considered <b>investigational</b> in the management of individuals with conditions associated with high rates of bone turnover, including but not limited to <b>any</b> of the following indications:                             <ul style="list-style-type: none"> <li>A. Paget disease</li> <li>B. Primary hyperparathyroidism</li> <li>C. Renal osteodystrophy</li> </ul> </li> </ul>